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The Relationship between Religiosity and Mental Health in High School Students Using the Mediating Role of Social Support

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Abstract

Background and Objectives: The influence of religiosity on students' perceived social support, in addition to the role these two variables play in mental health are of utmost importance. The aim of this study was to investigate the relationship between religiosity and mental health in high school students in Yasooj using the mediating role of social support.

Methods: The present descriptive-correlational study was conducted on 201 high school students in Yasooj in 2016. Samples were selected by multistage cluster sampling. To collect data, Glock and Stark's Religiosity Scale, 28-item General Health Questionnaire, and Multidimensional Scale of Perceived Social Support were used. Data analysis was conducted using Pearson's correlation coefficient and multivariate regression analysis.

Results: Regression analysis showed that religiosity significantly predicted social support from family (β=0.25, $p<0.01$) and significant other (β =0.21, $p<0.01$). Social support from family (β = -0.26, $p<0.01$) and significant other (β =-0.25, $p<0.01$) could significantly predict students' mental health, and also religion (β =-0.28, $p<0.01$) could significantly predict students' mental health. Findings showed that social support from family and significant other were partial mediators of the association between religiosity and mental health.

Conclusion: The results showed that religiosity, both directly and indirectly, enhanced students' mental health through social support from family and significant other. It is therefore essential for the policy makers in the field of mental health and education to focus on religious beliefs.

Keywords: Social Support, Mental Health, Religiosity, Students.

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Introduction

Education, religion, and health are considered very important arenas in human communities, but education is comparatively more important because it is responsible for educating future generations, and achieving the goals of the other two arenas depends on the realization of the purposes of education (1). Because adolescence is one of the most critical periods of life and students are faced with stressors of adolescence, they are likely to be predisposed to affective disorders. In addition, it is particularly important to study concerns and mental issues of students particularly in critical and stressful phases of development such as adolescence that is associated with several physical and psychological changes (2).

Having faith in God in challenging conditions, having social and spiritual support, and feeling of belonging to a superior source are certain approaches by which people can maintain optimal levels of their psychological conditions in facing traumatic events (3). In addition, many psychotherapists consider social support an important factor for treatment of psychiatric patients. For example, Maslow believes that providing social support for psychiatric patients can help them enhance their self-esteem and cope more effectively with a wide spectrum of individual and social problems and conflicts. Family environment is considered the first place to gain social support followed by other sources such as friends, relatives, neighbors, and classmates. Naturally, the greater the number and amount of such support sources that one receives are and the brighter and more assured about potential assistance his mind is, the more capable of coping with problems he is (4).

Religious rites teach personal discipline and asceticism, two necessities of social life, to people and therefore prepare them for social life. Religious ceremony brings people together, thus consolidating their common ties and strengthening social cohesion. The community members gain an in-depth understanding of their social heritage and maintain the most important elements of social conscience through attending religious ceremonies (5). Studies have demonstrated the association between religiosity and mental health as well as the role that religiosity plays in perceiving social support and consequently improving mental health. Good et al. reported that religiosity and adjustment were positively and significantly correlated in adolescents irrespective of the levels of their religiosity (6). Pender argues that religious beliefs, as an effective variable on social support, are associated with health-promoting behaviors (7). According to research findings, religion and religious beliefs represent one of the most important effective factors on anxiety and stress (8), because religion and religious attitudes influence cognition, attitudes, and behaviors (9).

As a mediator, religion affects intellectual process and evaluation of daily life events. It is widely argued that facing excitement and hard conditions is facilitated with help of faith (8). Taken together, as a set of beliefs, shoulds, and should nots as well as specified and generalized values, religion is considered one of the most effective psychological supports and is able to give meaning to any moment of life (10). Regarding the above-mentioned, the main aim of this study was to investigate the association between religiosity and mental health using the mediating role of social support in high school students in Yasooj, Iran.

Methods

The study population of this descriptive-correlational study consisted of all high school students of Yasouj in 2016 [n: 3642 (1914 girls and 1728 boys)]. Because there is no definite number or fixed proportion of the community members to estimate sample size precisely (11), multiple indices were taken into account to calculate the sample size of this study. With regards to the type of the study, the number of predictor variables in regression analysis, the study of Tabachnik and Fidell (12), administrative considerations, costs, samples, and the number of predictor variables that was decided to be at most 4, the sample size was determined 201.

Accordingly, 201 people were selected from the study population by multistage cluster sampling. First, the Education Organization provided approval to conduct this study and then the researcher referred to the schools and distributed the questionnaires of interest among the participants. The participants were assured that participation in the study was completely voluntary and data would be analyzed as anonymous. The inclusion criteria were having mental and physical health and providing informed consent to participate in the study. Data collection was performed using 28-item General Health Questionnaire (GHQ-28), Multidimensional Scale of Perceived Social Support (MSPSS), and Glock and Stark's Religiosity Scale.

GHQ-28

The GHQ-28 was developed by Goldberg in 1972 to diagnose mild psychiatric disorders. Currently, 60, 30, 28, and 12-item versions of this questionnaire are available (13). The original version consists of 60 multiple-choice items. The items address the states of boredom and discomfort and, in general, the general health of the respondents, with emphasis on current psychological, physical, and social issues. Through responding to the items, the respondents should select the choices that are more representative of their conditions using 4-point Likert scale (not at all, no more than usual, rather more than usual, Much more than usual).The minimum and maximum possible scores on this questionnaire are 0 and 84, respectively.

For all items, lower scores represent higher levels of health and vice versa. The GHQ-28, as with the original version, consists of four subscales, i.e. physical symptoms, anxiety and insomnia, social dysfunction and depression, each of which are assessed by 7 items (14). In an article published in 1983, Chan and Chan

reported the internal consistency of the GHQ 0.85 by Cronbach's alpha (cited in 15). In an article published in 1994, Chung and Spears reported its Spearman's rank correlation coefficient 0.55 by test-retest and its internal consistency coefficient 0.85 (13). Besides that, the study of Taghavi showed that the GHQ-28 has suitable validity and reliability and that factor analysis could identify the four subscales separately (16).

Glock and Stark's Religiosity Scale

Glock and Stark's Religiosity Scale was developed by Glock and Stark to measure religious attitudes and beliefs and religiosity. To standardize this scale, it has been administered to the followers of Christianity, Judaism, and Islam in different countries in Europe, Americas, Africa, and Asia and has also been adapted to Islam. This scale is a five-dimensional measure to investigate religiosity, consisting of Experimental, Ritualistic, Ideological, Intellectual, and Consequential. The scale used in our study consists of four dimensions and intellectual domain was eliminated due to certain reasons such as formal religious education in Iran. Therefore, the scale to measure religiosity in this study consisted of 26 items [Ideological (7 items), Experimental (6 items), Consequential (6 items), and Ritualistic (7 items)]. The items of the scale used in this study were developed by Serajzadeh.

The items are rated on a 5-point Likert scale from 0 representing absolutely agree to absolutely disagree representing 4. The minimum and maximum possible scores on this scale are 0 and 104, respectively. This scale is highly reliable because of undergoing standardization. The alpha values for Ideological dimension, Experimental dimension, Consequential dimension, and Ritualistic dimension have been reported 0.81, 0.75, 0.72, and 0.83, respectively (17).

MSPSS

The MSPSS was developed by Zimet et al. in 1988 to measure perceived social support from family, friends, and significant other. This scale consists of 12 items to measure three subscales: 1. Family (the items 3, 4, 8, and 11); friends (the items 6, 7, 9, and 12); and significant other (the items 1, 2, 5, and 10). Each item is rated on a 7-point Likert scale from strongly disagree: 1 to strongly disagree: 7. To derive the score on each subscale, its respective items are summed. In addition, to derive the total score on perceived social support, all 12 items are summed. This score ranges between 12 and 84 and higher scores represent higher levels of perceived social support and vice versa (18).

The reliability of the MSPSS has been confirmed. Bruwer et al. reported this scale's Cronbach's alpha coefficient 0.86 (0.86-0.90 for the subscales) in a study with 788 high school students (19). Salimi et al. reported Cronbach's alpha coefficients for the subscales of perceived social support from family, friends, and significant other 0.89, 0.86, and 0.82, respectively (20).

Result

The average age of the participants was 17.18 ± 1.7 (range; 15-20 years), and the average scores on general health, perceived social support, and religiosity were 30.32, 61.54, and 69.57, respectively (of maximum possible scores of 84, 84, and 104, respectively). Among the aspects of mental health, the highest average score was derived for social dysfunction and the lowest average score for depression (Table 1).

Table 1. Mean (standard deviation) scores on subscales and total score on scales

Variable	Mean±SD	Max	Min	N
Mental health	30.32±13.61	73	9	201
Physical symptoms	6.27±4.06	19	0	201
Anxiety and insomnia	7.69±4.87	19	0	201
Social dysfunction	11.31±3.35	19	3	201
Depression	5.04±5.04	21	0	201
Social support	61.54±12.69	82	26	201
Family	21.97±5.24	28	4	201
Friends	19.48±6.04	28	4	201
Significant others	20.09±6.73	28	4	201
Religiosity	69.57±16.23	93	17	201
Ideological	23.80±5.47	28	5	201
Experimental	18.69±4.61	24	4	201
Consequential	13.43±4.72	24	4	201
Ritualistic	13.65±5.93	25	0	201

The correlation coefficient between mental health and social support was derived -0.40. Because higher scores on the GHQ-28

represent lower levels of mental health, the negative correlation between these two variables indicated that the participants who attained higher scores on social support had higher levels of mental health. In addition, the correlation coefficient between mental health and religiosity was derived -0.28, indicating that the participants who attained higher scores on religiosity had higher levels of mental health. The correlation coefficient between social support and religiosity was derived 0.17 representing a positive and significant correlation between these two variables.

To study the correlation between religiosity and mental health using the mediating role of social support, we used multivariate linear regression using Baron & Kenny's procedures. Overall, the model below was studied (Figure 1).

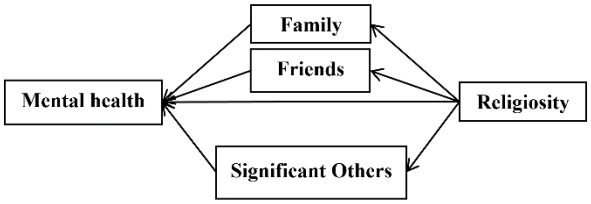

Figure 1: the effect of Religiosity on mental health with mediation of social support

Regarding the first Baron & Kenny's procedure, the results of regression analysis, using the subscales of social support as dependent variables, demonstrated that religiosity significantly predicted the subscales of social support from family and significant other (Table 2).

Table 2. Summary of results of simple regression analysis to predict the subscales of social support using religiosity

Dependent variable	Beta	SEB	B	R^2
Family	0.25**	0.02	0.08	0.06
Friends	-0.07	0.03	-0.03	0.006
Significant Others	0.21**	0.03	0.08	0.04

**p<0.01

For the second Baron & Kenny's procedure, multivariate linear regression was used. The most important presupposition to conduct multivariate regression, was lack of collinearity of the relationship between the independent variables. To investigate this presupposition, tolerance and VIF statistics were used. The tolerance values < 0.01 or VIF values > 10 represent collinearity (Table 3).

Table 3. Summary of results of multivariate regression analysis to predict mental health using the subscales of social support

Variables	Beta	SEB	B	VIF	Tolerance
Family	-0.26**	0.18	-0.68	1.23	0.81
Friends	-0.03	0.15	-0.07	1.06	0.94
Significant Others	-0.25**	0.14	-0.51	1.25	0.80

R^2=0.19 (N=201) **P<0.01

To investigate the third Baron & Kenny's procedure, simple linear regression analysis was used. Results demonstrated that religiosity significantly predicted mental health (β=-0.28, p<0.01). To investigate the final Baron & Kenny's procedure, multivariate linear regression analysis was used. Results demonstrated that religiosity (β=-0.18, p<0.01) and social support from family (β=-0.22, p<0.05) and significant other (β=-0.22, p<0.05) could predict the levels of mental health appropriately (Table 4).

Table 4. Summary of results of multivariate regression analysis to predict mental health using the subscales of social support and religiosity

Variables	Beta	SEB	B	VIF	Tolerance
Religiosity	-0.18**	0.05	-0.15	1.10	0.90
Family	-0.22**	0.18	-0.58	1.28	0.78
Friends	-0.06	0.15	-0.13	1.08	0.92
Significant Others	-0.22**	0.14	-0.45	1.27	0.79

R^2=0.22 (N=201) **P<0.01

Comparison of the third and fourth procedures showed that the simultaneous inclusion of the independent variable and the mediator variable in the regression analysis, caused the regression coefficient of the independent variable to decrease compared to its simple correlation coefficient with the dependent variable while this coefficient remained significant (-0.28 and -0.18). To investigate the significance of this decrease, the Sobel test was used. Results demonstrated that the mediating effects of social support from family and significant other were significant, and therefore it can be concluded that the subscales of social support from family and significant other are partial mediators in the relationship between religiosity and mental health. In other words, religiosity is associated with mental health both directly and indirectly via the subscales of social support from family

and significant other. Figure 2 illustrates the sizes of direct and indirect effects of the relationship between religiosity and mental health (Figure 2).

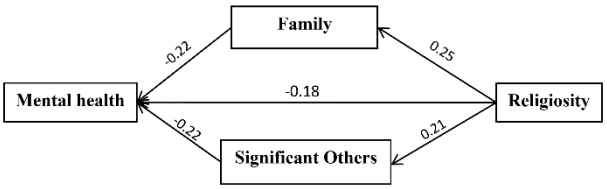

Figure 2: the final model of effect of Religiosity on mental health with mediation of social support

Discussion

The current study was conducted to investigate the association between religiosity and mental health using the mediating role of social support in high school students in Yasouj. Findings showed that the subscales of social support from family and significant other were partial mediators of the association between religiosity and mental health. In other words, religiosity was associated with mental health both directly and indirectly via the subscales of social support from family and significant other, which is consistent with other studies (7-9, 21, 22). To explain these findings, the Durkheimian scholar Harry Alpert classified Durkheim's four major functions of religion as disciplinary, cohesive, vitalizing, and euphoric social forces. Religious rites prepare humans for social life via imposing discipline on their souls. Religious ceremonies bring people together and strengthen social cohesion.

Performing religious ceremony revives the group's social heritage and ultimately confronts the feeling of frustration and the lack of faith in them by provoking a sense of happiness in the believers and a sense of confidence in the legitimacy of the moral world (23).

Regarding religiosity and social support, we can argue that one of the most important needs of human is the need for relationship with others and feeling of belonging to the community. Meanwhile, the ability to establish fruitful relationships with others contributes significantly to mental health. Religious activities have certain functions that help individuals satisfy these needs, love other people, reach equality, and feel being together. In addition, religious people tend to select their best friends from religious people, and attending religious ceremonies, which are usually carried out collectively, lead to the development of relationships and perception of social support (24). Studies have shown the effect of religion on mental health. A study on religion and mortality in the elderly showed that the people who attended religious ceremonies had lower mortality and higher levels of health than those who did not attend such ceremonies (25).

Sanders et al. studied the association between religiosity and the levels of depression, anxiety, and self- confidence in 898 students, which showed that internal religion, spiritual maturity, and self-excellence significantly predicted mental health and positive psychological functioning (21). Some studies have reported an inverse correlation between high social support and development of depression (21,26). On the other hand, social support plays an important role in maintaining health and reducing the adverse effects of stress that is largely due to the environment and the community. In addition, this factor affects quality of life directly and reduces predisposition to stress, depression, and different psychiatric and physical diseases (27)

The people with wide social connections (the married, close relatives, and the members of scientific associations) have longer longevity and develop diseases due to stress less frequently compared to those with lower social support (28).

This study suffered from certain limitations. One limitation was that all samples were high school students and therefore our findings should be generalized to other populations cautiously. It is therefore recommended to select samples from other populations such as students and teachers in additional studies.

Conclusion

This study showed that religiosity significantly predicted two subscales of social support from family and significant other. In addition, these two subscales of perceived social support significantly predicted the students' mental health, and also religiosity could significantly predict mental health. It can be therefore concluded that the

subscales of social support from family and significant other play a partly mediating role in the relationship between religiosity and mental health. In other words, religiosity is associated with mental health both directly and indirectly via the subscales of social support from family and significant other. Taken together, it is essential to hold workshops for education professionals and parents to help them understand the significance of religious attitude and its association with mental health and other optimistic variables.

Conflict of interest

The authors declare no conflict of interest.

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