RELIGIOSITY AND LONELINESS AMONG THE AGED

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Abstract: *Indian society is changing rapidly. Significant changes are taking place in kinship networks, living arrangements and intergenerational dynamics. Members of joit families are living geographically apart and family structures are increasingly becoming smaller and more independent. The "ascribed" status of the older population is gradually being replaced by the "achieved" status of the younger population. The changing social environment has affected the family structures, individual lifestyles as well as the role of the family as a are-giver influencing the self-concept, incidences of depression, loneliness and decreased psycho-physical health in the immunity for the elderly in India. India has earned the distinction of being a 'greying nation' with about 7.7% of its population consisting of older adults. The size f India's elderly population aged 60 year estimated to increase from 71 million individuals in 2001 to 179 million individuals in 2031 and further to 301 million oder adults by 2051. This would make it the second largest population of the elderly in the world and 13% of India's population by 2025 (Chadha, 1997).*

Keywords: Loneliness, Indian society, depressed symptroms, mental health, Depression, etc.

I. INTRODUCTION

Loneliness is common among older people. It is related to several characteristics that impair the quality of life of older people, like depressive symptoms and decreased subjective health (Tilvis et al. 2000, Victor et al. 2000, Alpass & Neville 2000, Victor et Mansfield & Parpura-Gill 2007). Loneliness may lead to cognitive decline, increased need of help and use of health services, as well a early institutionalization (Geller et al. 1999, Tilvis et al 2000, Jylha 2004). Loneliness may be detrimental for the individuals' long-term survival. Studies have linked loneliness to poor health (Holmen et al., 1992; Perlman et al., 1978), to increased risk of mortality (Penninx et al., 1997), to increased blood pressure (Hawkley et al., 2006), and to impaired immune function (Kiecolt-Glaser et al., 1984; Pressman et al., 2005; Scanlan, Vitaliano, Zhang, Savage, & Ochs, 2001). Loneliness and insecurity have been identified as risks for community-dwelling older people's health and independent living, and as risk factors for disability and dependence. The feeling of loneliness is often experienced as shameful, and older people may also fear being or becoming a burden. Thus, they are reluctant to admit their loneliness. (Killen 1998, Mclnnis & White 2001.) In addition, some older people may live in their homes with very few contacts with the social and health care services. Loneliness is defined as the negative subjective experience resulting from a discrepancey between the desired and achieved levels of interpersonal relationships (De Jong-Gierveld, 1987, 1998; De Jong-Gierveld & Tilburg, 1999). Estimates of loneliness in mid-to-later life ranged from 5% to 27% (Adams et al., 2004; Andersson, 1982; Pinquart & Sorensen, 2001). Risk factors associated with loneliness included reduced quality of social relationships, fewer social contacts, institutionalization, limitations in competence to perform activities of daily living (ADL's), limitations in instrumental activities of daily living (IADLs'), and lower income (Pinquart & Sorenson, 2001). Urbanization has influenced the living conditions of older people since living alone has become more common among the older population (Sundell, 1988). These changes may also have influenced the older people's feeling of loneliness. In addition, there has been a change in how older people are viewed in the society. Aging is viewed as negative and it is mostly examined as a medical problem.

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Although, religious and non-religious people tend to experience equal amounts of stress, it has been observed that religion may help people deal better with negative life events and their attendant stress. Individuals with imperious religious faith report higher levels of satisfaction, greater personal happiness, and fewer negative consequences of traumatic life events. People engaging in religious and spiritual pursuits report being generally happy, cheerful, at peace most of the time, rarely depressed, have excellent physical health, and are satisfied with the meaning and purpose they find in their lives. Depressed patients (Koening, 2007) were significantly more likely to indicate no religious affiliation, more likely to indicate spiritual but not religious, less likely to pray or read scripture, and scored lower on intrinsic religiosity. Among the depressed symptroms was also inversely related to religious indicators. Although much of the literature is suggestive of an overall positive effect of religion on mental health generally, some studies have found that at times religious practice might have a deleterious effect on mental health. Excessive devotion to religious practices might result in family break-up if the sole preoccupation of one spouse is towards religious proactive. Religion can promote rigid thinking, over dependence on laws and rules, an emphasis on guilt and sin, and disregard for personal individuality and autonomy. Excessive reliance on religious rituals or prayer may delay seeking necessary help for their mental health problems, leading to worsening the prognosis of psychiatric disorder.

Aims and objectives of the study:–The objective of the study is to find out whether religious beliefs and practices can affect level of loneliness of the elderly. In India, particularly the urban part of it, wherein old people are getting alienated due to rapid urbanization and modernization and changing social values our deeply entrenched beliefs in rituals and religious practices can act as an antidote to loneliness.

Aim of the Study: – The aim of the present study is to examine the associations between religiosity and the feeling of loneliness in a geriatric population. Based on the existing literature, it was hypothesized that higher score on religiosity would act as a buffer to loneliness.

HYPOTHESES OF THE STUDY: – Based on the findings of the previous studies the following hypothesis has been formulated for the present study. "Persons high on religiosity would be found to be low on loneliness in comparison to those low on religiosity."

II. METHOD

Sample: – One hundred older people in the age group of 60–80 were selected from the present study. All the participants were in a geriatric age group, which was defined as 60 years of age or more. Responses were solicited from individuals who were not suffering from any severe or chronic psycho local or physical disorder.

Tools: – The following tools were administered for the present study.

(A) Personal Data Sheet:-Designed by the researcher, the personal data-sheet comprised details of the sample such as age, education.

(B) Religiosity Scale:-Developed by Prof. 1.1 Bhushan (1971) to measure religiosity or religious faith of an individual. The form (Hindi version) consists of 36 items out of which 25 items are positive and 11 items are negatively. The positive and the negative items are randomly distributed over the scale. The items cover all important dimensions of religiosity. The scale is 5 point Likert type scale and the responses are keyed according to item as negative or positive. The range of the possible score is 36 to 180. The higher the score the greater is the degree of religiosity. The scale has a fairly high reliability (.82). The test has also been found to be high on validity.

(c) Perceived Loneliness Scale (L-Scale)- Perceived loneliness scale by Dr. P.K. Jha wa used to measure the loneliness of the respondents. The scale comprised of 36 items in a five-point Likert format Five response categories are : totally agree, agree, can't say, disagree and totally disagree. The ticket number indicated the subjects score on that particular item. The minimum adn maximum scores range between 36 and 180. High score is to b interpreted as high loneliness and low scroe as low loneliness of the repondents. The reliability and validity of the scale has been found to be quite high.

Procedure: - After establishing a workable rapport, the samples were administered the Religiosity Scale and Perceived Loneliness Scale. The participants were divided into two groups namely those low on the loneliness based on the scores on loneliness. Individuals who scored 72 or more on loneliness scale were grouped on high on loneliness and those below 72 were grouped as low on loneliness. The two groups, namely high on loneliness and low on loneliness were compared on the religiosity. The two groups were compared using "t-test".

Treatment of the Data:-The response sheets of the respondents were scored using the test for significance of difference between the two means "t-test". The following table contains the results:

Group	High on Mean	Loneliness SD	Low on Mean	Loneliness SD	T	Level of significance
N	39	61				
Religiosity	88.36	12.83	103.83	17.69	4.87	>0.01

III. RESULTS AND DISCUSSIONS

The group high on loneliness has got the mean score of 88.36 and an S.D. of 12.83 whereas the group low on loneliness got the mean of 103.26 and S.D. of 17.69 suggesting that the people high on religiosity have got low score on loneliness whereas the people low on religiosity got high score on loneliness suggesting that religiosity help to reduce and protects from loneliness. Thus, the result of the study supports the formulated hupothesis.

The findings of the study have been supported by many other studies that have found and association between measures of religiosity and mental health. Kaldestad et. al. (1996) found a relationship between psychological health and religiosity. Koening et. al (1996) found those with a low frequency of church attendance to have a greater likelihood to have psychiatric disorders. Kendler et al. (1996) conducted a study considering the relation between religious devotion and mental health in twins. Religiosity, defined as personal devotion, was found to be inversely related to depression.

In modern societies where cohesive and supportive family structures are fast getting obliterated, spiritual and religious organizations provide much-needed social support which protects people from social belonging and self-esteem thereby equipping them to cope with stress and negative life events.

Enhanced social support has been hypothesized to mediate some of the observed benefit of religious involvement. It has been theorized that those who participate in religious activities widen their social network and secure instrumental social support, such as transportation, etc., which may contribute to improved health outcomes (George, L.K. et.al. 2002). The largest source of support for oder adults outside of immediate family comes from members f their church (Cutler, 1976).

Meaning and coherence of worldview may also mediate health benefit of religiousness, especially for older adults who may be wrestling with the purpose and meaning of their lives. Feeling that the world is

predictable and makes sense, or feeling the one's time on earth serves a purpose, may convey psychological benefits; this may also ultimately lead to physical health enhancement. (George, L.K. et. al. 2002). Spirituality helps depressive patients figure out a meaning or a purpose in their life which they had lost due to their illness. The resurrection of meaning or a purpose in their life, which they had lost due to their illness. The resumption of meaning and purpose brings back the hope and vigor to face the difficulties of life.

The emerging discipline of positive psychology studies the relationship between positive emotions such as joy, calm, contentment, etc. on health and well-being (Seligman, et.al. 2005). It has been proposed that positive feelings may be a mechanism by which religion alters health outcomes (Koenig et al. 2001).

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