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Personality, Religiosity, Religious Performance, Social Support and Helping Behaviour as Correlates of Depression in Aged.

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The study was intended to examine the relationship of personality, religiosity, religious performance, social support, helping behaviour and depression in aged. One hundred aged subjects of both sexes (60 years and above) selected on incidental basis from rural as well as urban areas were administered Eysenck personality questionnaire, religiosity scale, social support questionnaire and especially prepared checklists for measuring religious performance and helping behaviour (help given to others and help received from others in last one month, one year and entire life) and satisfaction derived there of. Results were analysed by Pearson coefficient of correlation and multiple (stepwise) regression was also done. Neuroticism and psychoticism were found to be positively associated with depression however extraversion was negatively related. Giving help to others was negatively related with depression however receiving help from others was positively related. Neuroticism, satisfaction from help given to others, help received in last one month and help given to others in last one year turned out to be the significant predictors of depression in aged accounting 45 per cent of the variance. Implications of the study for researchers and the aged are discussed.

Ageing is a process which takes place during the entire life span of the organism. It is a continuous process which begins with conception and ends with death. Though old age in man is perceived as associated with disease, loneliness and usefulness, but truth about ageing is that it is a natural and universal process. The rapidly occurring technological innovations and advancements, industrial productivity and related economic activity have resulted in several social changes such as migration, urbanization, individualism, lack of funds and resources to meet family needs, breaking of joint family system as well as decreased cohesiveness of family and social bonds with change in values and norms (Jamuna, 1998). The stress and stains of these changes have made the position of elderly vulnerable especially for sick and infirm, resulting into loneliness and depression (Desetty & Patnam, 2000).

Diener, Suh, Lucas and Smith (1999) have reported guilt and shame, sadness, anxiety, worry, anger, stress, depression and envy as the parameters of unpleasant affect, they also reported unpleasant affect as one of the major component of subjective well-being. Depression in older people is often characterized by memory problems, confusion, social withdrawal, loss of appetite, inability to sleep and irritability. Some other characteristics of depression may have components or traits such as hopelessness, loneliness, low self worth and powerlessness.

Old age is often viewed as a problematic period of one's life which brings numerous

problems. The problems of aged are manifold. Depression is a common problem faced by the aged. There are number of psycho-social correlates of depression i.e. personality (Thompson & Soloman, 1991), religiosity (Levine, Chatters & Taylor, 1995), social support (Bowling, 1994), age, sex, socio-economic status (Nolen-Hoeksema, 1987) and helping behaviour (Brown, Nesse, Venokur & Smith, 2003) etc.

Research findings reveal that one's state of well-being is influenced by stable individual characteristics, i.e. personality factors. One conceptual model for the link between personality and well-being is that some people have a genetic predisposition to be happy or unhappy, which is presumably caused by inborn individual differences in the nervous system. It means situational factors may move subjective well-being up or down from baseline levels but stable personality factors should exert a long term influence. Eysenck and Eysenck (1975) found three basic dimensions of personality which he labelled as extraversion – introversion, neuroticism (stable-unstable) and psychoticism. The role of personality traits– extraversion and neuroticism are being studied on pleasant and unpleasant effect (Larsen & Ketelaar, 1991). Extraverted individuals are considered to deal successfully with social situations and thus gain high well-being. Eysenck's model of personality (Eysenck & Eysenck, 1985) suggest that high neuroticism is associated with various psychological problems such as proneness to stress, inability to control impulses, negative perception and unrealistic thinking. Anthony, Helen, Henderson, Patricia, Alisa and Bryan (2000) in a longitudinal study on which 441 persons aged 70 or above were followed over 3-4 years found that neuroticism predicted anxiety and depression. Extraversion was negatively related to anxiety, depression, somatic symptoms and social dysfunction in a sample of Sudanese University students (Hamid, 2004). People with high psychoticism like to live dangerously, inclined to act on the spur of moment, are changeable, detached, unpredictable and irresponsible. Such people are inclined to be overly causal, thoughtless, careless of protocol and socially unreasonable (Eysenck, 1977). Thompson and Soloman (1991) found strong positive correlation between psychoticism and depression.

The term religiosity refers to religious faith. According to Galloway (1956) religiosity means, "faith in a power beyond himself whereby he/she seeks to satisfy emotional need and gain stability of life, and he/she expresses these in acts of worship and service." Most of the religions believe in fixed relationship between the human self and some non-human entity, the sacred, the supernatural or the absolute God. Though, it seems that the term religiosity contains the performance aspect also yet for the purpose of present study performing religious rituals, visiting religious places, e.g. temple, mosque, church etc., keeping fast, going for religious journey, tours (e.g. teerthyatras) etc. have been defined here as religious performance. Religious devotion has been linked to lower incidence of depression. Studies have shown positive effects of religious involvement on health and life satisfaction and negative effect on depressive symptoms among older people (Levin et al., 2001). Smith and McCullough (2003) examined the association between religiousness and depressive symptoms with meta-analytic methods across 147 independent investigations (N=98, 975), across all studies, the correlation between religiousness and depressive symptoms was –0.096 indicating that greater religiousness is mildly associated with fewer symptoms of depression. Hahn, Yang, Shih and Lo (2004) in a study in Taiwan found that those old age people participate in religious activity are less likely to suffer from depression. Although, religiosity tends to help older people to cope with physical and social losses and help in maintaining good health and better well-being

yet there are studies which are not in agreement with these findings. Burris (1994) found that extrinsic religiousness was positively predictive of depression unless intrinsic religiousness was either very high or very low. The postulate that extrinsic religiousness is a maladaptive form of religiousness, predictive of negative outcomes such as mental illness as opposed to mental health has been supported by studies of Donahue, 1985; Richards and Bergin (1997). These findings are conceptually similar to claim concerning negative forms of religious coping, such as blaming God for life's problems or avoiding problems through religious activities that may also predict mental illness as opposed to mental health (e.g. Pargament, 1997).

Social support in a broad sense is defined as an asymmetrical exchange of resources between at least two individuals, a recipient and a support provider(s), that is perceived by the recipient to be beneficial Shumaker and Brownell (1984). Being loved, liked, preferred, or approved of, could be thought of as instances of these resources. Similarly, having a large circle of friends who are able and willing to provide these resources is viewed as an index of social support. Social support and social networks exert significant effects on health and functioning among old age persons. A person who is having high in social support has others whom he/she can rely at times of need. Someone who is low in social support lacks these interpersonal resources. A deficiency of social bonds has been observed to be a cause of some form of behavioural dysfunctions, leading to feelings of depression and loneliness. Depressives tend to report the lack of availability of supportive others (Sarason, Levine, Basham & Sarason, 1983).

Linquart, Sarason and Friedrich (2000) stated that the quality of social contact has shown stronger association with well-being as having contact with friends. Thus, the quality of contact was more important than the quantity. Yadav (2001) found that perceived number of persons available for social support and degree of satisfaction from available support correlate positively with well-being. However, the degree of satisfaction one derives from the available support turned out to be strongest predictor of well being. Generally, it is proposed that having supporting relationships to rely on can help people in dealing with stressful situations. Those who lack such relationships are vulnerable to the effect of stress which may consequently affect their well-being. Baarsen and Berna (2002) found contradictory results to the previous findings. They suggested that although emotional support initially reduces the effect of chronic financial strain on depressive symptoms, however, further increments in emotional assistance were associated with increased psychological distress.

Giving assistance to others with a definite goal in mind is known as helping. Regard for the interest of others, without concern for one's self-interest is termed altruism. Both of these, as well actions that benefit others, regardless of the benefits to or self-sacrifices of the actor, fall under the broad heading of pro-social behaviour Hunter and Linn (1980). Helping others is the way to higher individual well-being. It really is more blessed to give than to receive. Krause, Ingersoll, Ellison and Wulff (1999) released a cross-cultural study on ageing, examining the relationship between religion, helping and health in a sample of 2000 elderly people in Japan and found that those who provided more assistance to others were significantly more likely to indicate their physical health to be better. Post (2005) found that people who help others report better physical health, well-being, increased longevity and greater life satisfaction.

The review of studies cited over here indicate that well-being is influenced by the personality of the person but there is lack of studies which have incorporated all these traits/ factors (i.e. extraversion, neuroticism and psychoticism) and examined their role in well-

being. The efficacy of religiosity is not inevitably positive and points to the need for more sophisticated framing of psychological research in this area. Social support have been reported to negatively related with depression in some studies and positively related in some another studies. Old age is period where one review what he/she has done for others and it may bring satisfaction or dissatisfaction. At the same time it also important what the person is getting from others (including family members and others) i.e. the help one is receiving from others, it may also have bearing for one's well-being or ill- being. In this case it is pertinent to mention here that in majority of studies either one or two of these variables have been taken up i.e. there is a lack of multivariate studies. Old age is considered as the last stage of development and is associated with multiple problems. Depression is a common problem faced by the aged. It was intended to examine how the positive behaviours like religiosity, religious performance, social support and helping behaviour help the elders in countering the feelings of despondency and depression. Thus, the present study was intended to examine the relationship among personality, religious performance, social support, helping behaviour and depression in a sample of aged.

Objective:

To study the relationship of personality, religiosity, religious performance, social support and helping behaviour with depression in aged.

Method

Sample:

A sample of 100 aged subjects of both sexes having age 60 years and above was selected for the present study on the basis on non-random purposive sampling procedure from Rohtak city and adjoining villages and thus the respondents were from rural as well as urban areas. The age of the sample selected for the study ranged from 60 to 84 years with a mean age of 66.35 (SD = 6.04) years.

Tools:

Following tools were used for the study:

1.Hindi version of Eysenck's Personality Questionnaire - Revised (1985) was used to measure psychoticism, extraversion and neuroticism dimension of the personality.

2.Bhushan's Religiosity Scale (1970) was used for measuring religiosity.

3.To measure the religious performance of the aged, a checklist incorporating 21 items relating to actual religious performance was prepared. The items were selected from the literature and on the basis of discussion with the aged and with religious performers. Fourteen items were in 'yes/no' format e.g., item no. 4 was, "Do you visit Temple/Mosque/ Church/Gurudwara etc.?" if endorsed 'yes' a score of one(1) was given and if endorsed 'no' it was scored as zero (0). Five items were such that if endorsed 'yes' by the respondents then they were required to check the frequency of doing or performing that act. For example, item 5 was, "Do you keep fast? if endorsed 'yes' then subjects were required to check the frequency in a week's time by putting a tick (/) mark on the appropriate alternative i.e., 'sometime', 'once', 'twice', 'thrice', 'four times', 'more than four times' and was scored as 1,2,3,4,5 and 6 respectively. Two items were such that if these were endorsed 'yes' then respondents have to check the frequency of performing that act as described (in case of item No. 5) excepting the option of sometime was not there. These were scored as 1,2,3,4 and 5 respectively. The total score ranged from 0 to 54.

4. Hindi Adaptation (Dogra, 1991) of Social Support Questionnaire (Sarason, Levine, Basham & Sarason 1983) was used to measure the social support. It yields two scores (i) the number of persons available for support (SSn) and (ii) the satisfaction derived from available support (Ss).

5. For measuring help received and help given by the subjects, a especially prepared checklist containing 20 items (in which items one to ten (1 to 10) were related to help received by the respondents from others and item number eleven to twenty (11-20) were related to help given by the respondents to others. The items were relating to physical, emotional, social and financial help received and given. The subjects were required to report the number of friends, family members or the persons in their network from where they received help and gave help during last one month, last one year and whole life span. Score ranges for help received and given was calculated on the basis of number (minimum – maximum) of persons helped and received help in a given time period. Responses in month's time were scored on a scale ranging from 0 for none, 2 for six to ten persons, and 3 for eleven to fifteen persons. Responses in year's time were scored on a scale ranging from 0 for none, through 3 for sixteen to twenty one persons. Responses on life time were scored on a scale ranging from 0 for none, through 10 for ninety to hundred persons. Similarly, scoring categories were decided for help given to other's in a month's, year's and for life time.

6. For measuring satisfaction derived from help given and help received, single item measures were used and the respondents were asked to rate their level of satisfaction on a six point scale i.e. extremely satisfied (score 6) to extremely dissatisfied (score 1). Thus maximum score for satisfaction from help received from others and given to others ranged from 1 to 6.

7. Hindi version (Mathur, 1981) of Beck Depression Inventory (Beck, Ward, Mendelson, Mock & Erbaugh, 1961) was used for measuring depression in aged.

Procedure:

A demographic profile was used to establish rapport with the elderly and to gather general information about their family, income, their vocational activities and their health. The subjects were assured about the anonymity of their personal identification. After that, the general instructions related to questionnaire / tests/ checklists were given to the respondents. The subjects who had difficulty in understanding the items (especially illiterates and those having vision/ and related problems) were explained each item in easy and comprehensible language and their responses were noted down. Queries put by the respondents were properly clarified by the investigator. Questionnaires were arranged and questions were asked in a way so as to avoid monotony and boredom. The whole session consisted of administration of questionnaires and general discussion.

It was more of a kind of structured interview. The administration of tests/ questionnaires /checklists was very flexible i.e. the respondent was allowed to have a rest of 10-15 minutes whenever the subject desired. An attempt was made to complete the administration of all tests to each subject in a single day. The test administration procedure was kept strictly uniform for all the subjects.

Results

Obtained results were analysed by Pearson coefficient of correlation. To identify the role of personality, religiosity, religious performance and helping behaviour in depression, multiple regression (Stepwise) was done and the findings are given in Table 1 and 2.

The intercorrelation matrix is given in Table1. Results reveal that extraversion was significantly and negatively ($r = –0.27$, $p < 0.01$) correlated with depression. Neuroticism ($r = 0.54$, $p < 0.01$) and psychoticism ($r = 0.40$, $p < 0.01$) were positively and significantly correlated with depression. Religiosity ($r = –0.39$, $p < 0.01$) and religious performance ($r = –0.21$, $p < 0.01$) were negatively and significantly correlated with depression. The number of person's available for support (SS_n) and the satisfaction derived from available

Table-1 Intercorrelation Matrix along with Means and SD's

Variables	Psycho	Extraver	Neuroti	Reli	RP	SSn	SSs	HRM	HRY	HRL	HGM	HGY	HGL	SHR	SHG	D
Psycho	1															
Extraver	-0.32**	1														
Neuroti	0.47**	-0.44**	1													
Reli	-0.26**	0.32**	-0.43**	1												
RP	-0.45**	0.44**	-0.37**	0.33*	1											
.SSn	-0.34**	0.30**	-0.38**	0.17	0.17	1										
SSs	-0.49**	0.30**	-0.48	0.31**	0.30**	0.48**	1									
HRM	0.04	-0.01	0.30**	-0.10	-0.05	0.03	-0.16	1								
HRY	0.06	0.02	0.31**	-0.06	0.02	0.04	-0.18	0.84**	1							
HRL	0.00	0.07	0.13	-0.08	0.01	0.33**	0.02	0.55**	0.71**	1						
HGM	-0.26**	0.19	-0.13	0.14	0.28**	0.25*	0.18	0.18	0.22*	0.24*	1					
HGY	-0.26**	0.24*	-0.12	0.23*	0.42**	0.28**	0.31**	0.24*	0.34**	0.29**	0.76**	1				
HGL	-0.12	0.18	-0.10	0.17	0.19	0.34**	0.28**	0.20*	0.34**	0.48**	0.52**	0.66**	1			
SHR	-0.47**	0.23*	-0.31**	0.30**	0.30**	0.48**	0.64**	-0.03	-0.02	0.17	0.28**	0.35**	0.36**	1		
SHG	-0.44**	0.38**	-0.46**	0.30**	0.34**	0.49**	0.62**	-0.09	-0.12	0.05	0.36**	0.36**	0.37**	0.63*	1	
D	0.40**	-0.27**	0.54**	-0.39**	-0.21*	-0.23*	-0.44**	0.32**	0.26**	0.15	-0.32**	-0.30**	-0.16	-0.25*	-0.50**	1
Mean	4.84	11.98	11.55	143.09	20.28	2.50	4.83	2.66	4.46	9.80	3.03	6.24	14.79	4.95	5.01	10.95
S.D.	2.64	4.76	5.18	14.40	8.41	1.41	.81	2.09	2.68	4.19	1.83	3.04	7.78	1.04	.99	6.41

Note:- **significant at .01 level
* significant at .05 level

Index :

Psycho = Psychoticism
Extraver = Extraversion
Neuroti = Neuroticism
Reli = Religiosity
Rp = Religious performance
SSn = No. of persons available for social Support
SSs = Satisfaction from the available support
HRM = Help received in month
HRY = Help received in a year
HRL = Help received in life time
HGM = Help given in Month
HGY = Help given in year
HGL = Help given in life time
SHR = Satisfaction from help received
SHG = Satisfaction from help given
D = Depression

support (SS_s) were significantly associated with depression and the direction was negative (Table-1).

The helping behaviour checklist had two components i.e. (i) help given and help received, in a month, year and all over the life and (ii) the satisfaction derived from help given and received. Results revealed that help received in a month's ($r = 0.32$, $p < 0.01$) and in a year's time ($r = 0.26$, $p < 0.01$) was positively and significantly correlated with depression. Help given in a month's time ($r = -0.32$, $p < 0.01$) and over a year's time ($r = -0.30$, $p < 0.01$) were significantly but negatively correlated with depression. Help received and help given in the entire life span were not found to be significantly related with depression in aged. The subjective feelings of satisfaction derived from help received from others ($r = -0.25$, $p < 0.01$) and from help given to others ($r = -0.50$, $p < 0.01$) were also significantly and negatively related to depression.

To identify the determinants of depression stepwise multiple regression was done taking depression as the criterion and personality, religiosity, religious performance, social support (i.e. number of persons available for support, SSn; satisfaction derived from available support, SSs) and helping behaviour (help received and given in last month, last year and entire life and the subjective feeling of satisfaction from help received and given) as predictors. In all there were 15 predictors and one outcome (dependent) variable. From the results (Table-2), it is evident that neuroticism, satisfaction from help given, help received in a month time and help given in a year time turned out to be the significant predictors $F(4,95)=19.19$; $p<0.01$ of depression. The multiple correlation was 0.67, taken together neuroticism satisfaction from help given, help received in a month's time and help given to others in a year's time accounted 45% of the variance of depression amongst the aged.

Discussion

Results of the study (Table-1) revealed that extraversion was significantly and negatively correlated with depression. Findings imply that extraverts tend to experience less depression. Findings of the present study are in agreement with earlier study of (Hamid, 2004) who reported negative correlation between extraversion and depression. In the present study, neuroticism correlated positively and significantly with depression (Table-1) and emerged as the strongest predictor of depression (Table-2) in aged.

Table 2: Stepwise Multiple Regression of Depression on other Variables

$R = 0.67$ $R^2 = 0.45$

X_{20} (X_3, X_{18}, X_{11}, X_{15}) $F = 19.19$, $df = 4, 95$ $p = 0.01$

	Variables	Mean	Regression Coefficients (b)	SE
X_{20}	Depression	10.95		
X_3	Neuroticism	11.55	0.40	0.11
X_{18}	SHG	5.01	–1.52	0.59
X_{11}	HRM	2.66	0.81	0.26
X_{15}	HGY	6.24	–0.50	0.18
	Constant	14.98		

$X_{20} = (X_3 \times b_3) + (X_{18} \times b_{18}) + (X_{11} \times b_{11}) + (X_{15} \times b_{15}) + \text{Constant}$

$10.95 = (11.55 \times 0.40) + (5.01 \times -1.52) + (2.66 \times 0.81) + (6.24 \times -0.50) + 14.98$

People with high score on neuroticism, due to their temperamental characteristics such as loneliness, isolation, pessimistic attitude toward life, lack of satisfaction in life, lack of confidence in coping, anxiety gloomy outlook are more prone to depression. Loneliness is a major cause leading to depression in these people because individuals who belong to poorly functioning social support system tend to develop emotional disturbance. Findings attest the results of Farmer, Harris and Redman (2000), who have reported that neuroticism and depression correlate positively; and the study of Anthony et al. (2000) who have found that neuroticism predicted depression. Psychoticism was found to be positively related with depression (Table- 1). Those who score high on psychoticism dimension are anxious, lack responsibility, troublesome and maladaptive, changeable and unpredictable, detached, expedient and self- interested in their dealings with other people. As one could expect, persons with these characteristics tend to experience negative affect, poor life satisfaction, psychological problems and depression. Study of Mathews, Dorn and Glendon (1991) provide support this point.

Religiosity and religious performance were negatively and significantly correlated with depression (Table-1). Findings imply that old age persons who are religious, believer in God, perform religious activities tend to experience better well-being, less distress and depression. There may be several reasons why religious involvement could be associated with pleasant affect and negative association with unpleasant affect i.e. anxiety and depression. Among the primary features of religion is its ability to impart a sense of coherence, cohesion and control of one's life. Religious communities are all effective in regulating a range of individual behaviour so as to encourage activities that directly promote physical and mental health and interpersonal networks as well as curtailing activities and life styles that increase the risk of stressors. Religious frame of reference may be important in deriving meaning from life and personal events both blessings and misfortunes. Specific mental health benefits may be associated with certain worship styles which involve singing, shouting and physical activities, which encourage emotional catharsis. Findings support the results of earlier studies of (Levine et al., 1995) reporting negative correlation of religiosity with depression.

The number of persons available for support (SSn) and the satisfaction derived from available support (SSs) were significantly and negatively associated with depression in aged (Table-1). There are many ways in which satisfaction from social support reduce stress, anxiety and depression. When people encounter a strong stressor those people with high level of social support may be less, likely to appraise the situation as stressful. As a result, they can meet the demands and decide that situation is not very stressful. Findings of the study are in agreement with those of (Yamashita, Kobayashi & Tsunematsu, 1992) who concluded that living alone is more depressing and less satisfying than living with family.

Help received for others in month's time and last one year's time was positively related with depression in aged (Table-1). However, help received in last one month's time predicted depression significantly and positively in aged (Table -2). Help given in month's time and over a year's time were significantly and negatively correlated with depression (Table-1) Help given to others during last one year's time turned out to be significant predictor of depression (Table-2).

It appears that help received from others was not viewed positively by the aged i.e. one who received help from others might not have viewed themselves as competent and self-sufficient and may perhaps be taken as one's weakness and thus was positively related with

depression whereas giving help to others might be adding to their feeling of worth, competence and self-sufficiency and might have been adding and/or enhancing their selves and their self- esteem, consequently giving help to others was negatively related to depression. The satisfaction one derive from helping others is all the more important. It signifies that it is not the extent (less or more) per se, rather the satisfaction one derives from helping other matters the most, as satisfaction from help given to others was a significant predictor of depression in the aged (Table-2). Helping others and the satisfaction one derives from it may help in countering the depressive and/ or despondency feelings of the aged. Thus, the findings are in agreement with those of Schwartz, Meisenhelder, Ma and Reed (2003) reporting a strong relationship between better mental health and giving help than between mental health and receiving help.

Another point which needs to be emphasized here is that it is the recency which matters in either giving or receiving help, as time passes its effect weakens. However, there seems to be one confounding variable that is the role of recent life events which has been reported (Paykel & Hollyman, 1984; Dang, Shyam & Kumar, 1998) to be significant in depression, although, all the subjects who participated in the study were healthy and were free from chronic ailments, yet the adverse / negative life events in their lives were not assessed and controlled, hence this need to be verified by further studies.

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