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General health status and gender as correlates of religiosity

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Abstract
The study examined general health status and gender as correlates of religiosity. 201 Christians with an age range between 21 and 55 years with mean age of 34.91 and standard deviation of 7.49. were selected from three religious centres in Awka. Two instruments were used for the study and they include the General Health Questionnaire (GHQ-12) developed by Goldberg and Williams (1970) and Religious Affiliation Scale (RAS) by Omoluabi (1995). The study was a survey and a correlational design. The Pearson Product Moment Correlation Coefficient was employed as the statistical tool for data analysis. The result indicated a significant relationship between general health and religiosity. Therefore, the first hypothesis was accepted. Also, the second hypothesis which ststaed that there will be a significant relationship between gender and religiosity was accepted. This study underscores the importance of assessing an individual religious belief /history during assessment since its neglect can be devastating to the person involved. Addressing a clients religious needs in clinical practice in a more sensible and sensitive way is also recommended.
Keywords : *Health Status, Gender, Religiosity*

Introduction
Religions of the world claim to link humans to the supernatural or the creator and most powerful being, who is able to solve all problems and even intervene in the affairs of the adherent to their advantage, irrespective of what physical obstacles may exist. Some religious groups, for example, Christians were split into denominations with varying understanding and teachings of the same Supreme Being. Many Christians in this part of the world seem to spend an enormous amount of resources in their quest to be favoured by God. Some go after the miracles of prosperity, marital success, successful child birth, American Visa, examination success, employment, contracts and even get well from HIV/AIDS or cancer without medical treatment, all in the name of deep faith.

These behaviours which to the psychologist may not be rational, considering that scientific knowledge has so advanced that the miracle of blessing a ball pen to make an 'A' grade for instance seems unbelievable and impossible. It is a commonplace observation that most of the people who give all their time and resources to such religious activities do not relate appropriately with others. These observations raise questions to the minds of others and engender scrutiny of the Igbo saying (translated) that "religiosity is a response to uncommon problems".

Little empirical data exist as to whether other factors such as general health status and gender will determine how religious one can be. Since the body of research in this area is lacking and the criticism of Freud, more evidence is needed to determine whether this is indeed a plausible line of inquiry. As a result of a vacuum in the literature in this regard with specific reference to Christians, the current research as to the relationship between general health and gender on religiosity among people living in Awka as they attend religious centres to seek help on diverse issues becomes imperative.

Religiosity is the extent to which an individual holds strongly to religious beliefs and practices. Religion according to Obiefuna and Nwadialor (2015) is a spiritual pilgrimage characterized by a human's acknowledgement of his limitations and self-insufficiency; and the adoption and formulation of paths, doctrinal and practical moral lives, in explanation and answer to the fundamental issues and problems of human existence. Adenugba and Omolawal (2014) defined religion to be faith in a divinely created order of the world, an agreement which is the means of salvation for a community and thus for each individual who has a role in that community. In this sense the term applies principally to such systems as Christianity, Islam and Judaism, which involve a faith in a creed, obedience to a moral code set down in the sacred Scriptures, and participation in common practices**.**

Health status is a factor to be considered in religiosity in an individual. The word health, according to Obi- Nwosu (2014) is a condition of someone's biological or mental well being. It could be a state or a status somewhere at a point is bad (ill health) and at the other is good (devoid of biological/physical, psychological and mental disturbances. Mental health is an inseparable part of general health and well-being. World health organization, defines mental health as a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and is able to make a contribution to his or her community. It is highly essential of our general health, well-being and quality of life. Uwaoma (as cited in Obi-Nwosu & Joe-Akunne, 2013) asserts

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that the ability to form and sustain constructive relationships is a characteristic of good mental health.

STRESS

The World Health Organization (WHO) has described stress as a "worldwide epidemic" because stress has recently been observed to be associated with 90% of visits to physicians (Akinboye, Akinboye & Adeyemo, 2002). They perceived stress as a person's perception by arguing that the way a person interprets and appraises the stressful event determines the effects of the stress. Scientifically, stress refers to the broad domain concerned with how individual adjust to their environment. It became a common term in the performance/efficiency literature during the 1960s. Stress is a person's adaptive response to a stimulus that places excessive psychological and physical demands on that person. Stress is a person's response to an inappropriate level of pressure. Stress according to Onyeizugbo (2009), is a subjective feeling of distress resulting from environmental phenomena that an individual finds threatening to ones overall existence. These subjective experiences can manifest psychologically as anxiety, fatigue, irritability, lack of concentration, depression, confusion, fear. It can also manifest physiologically as insomnia, poor appetite, high blood pressure, peptic ulcer and it can manifest socially as difficulty relating with people, underachievement, poor performance on the job, and neglect of duty and so on.
Lazarus (1966) has developed a convincing conceptual model involving both stress and coping abilities of the person. He defines stress as any situation in which "Environmental demands tax or exceed the resources of the person". If an environmental demand is such that it cannot be met and neutralized somehow, it will cause harmful consequences for the person, affecting moods, fatigue, and motivations, and then gradually producing burnout or illness. The level of stress felt by individual is a result of both the environmental stimulus and the reaction of person to it. Events themselves are neutral and become stressful only when the person interprets them as threatening. Stressors may be either chronic or episodic. Chronic stressors are called "daily hassles" by Lazarus, but they should not be dismissed as merely "the nature of work" or "what comes with the job" Any ongoing aspect of work experience which is felt as annoying or depressing is a chronic stressor regardless of how another person may interpret it.

The relationship between stress and ill health can be explained with Selye (1956) which suggests that "General Adaptation Syndrome" manifest as Alarm, Reaction, short term, acute, response patterns. The General Adaptation Syndrome is a pattern of bodily responses resulting from the presence of a

stressor. The sequence of events identified by Selye includes several phases starting with an alarm phase as the organism initially reacts. During this phase there is a concentration of energy and a focusing of effort as the organism begins to be alerted. This phase is relatively short and is soon replaced by the resistance stage as the organism attempts to adjust. During this stage, the biological system seeks to adopt the most optimal defense against the stressor. There are attempts to isolate and encapsulate the stress so as to narrow it to the smallest possible site. However, if such defenses are prolonged and the stress is not resolved, then the wear and tear of adapting leads to deterioration. The phase called exhaustion now is said to occur, characterized by tissue damage, disease and eventually cessation of functioning of the damaged organ or organism. Each organism's unique response to stress is modulated by certain conditional factors like hereditary and constitutional factors as well as memory traces from prior learning and experience. A second factor involves external factors like climate, time of day, season and diet (Suinn, 1990).

While Lazarus and Folkman did not themselves emphasize the importance of religiosity for appraisal, it is not difficult to understand why religious beliefs might have an important influence on this process. Religion serves as a buffer during stressful event. As a result, Koeing, George and Titus (2004) carried out a study on the effect of religion and spirituality on social support, psychological functioning and physical health in medically ill hospitalized old adults. It was discovered that levels of religiousness and spirituality consistently predicted greater social support, fewer depressive symptoms, and better cognitive function. In addition to the above empirical evidence, it is important to note that Clark and Orsolya (2004) have shown that individuals who are religious suffer from significantly lower estimated losses in subjective utility as a result of episodes like unemployment.

Gender and Religiosity

Gender as a variable may relate to an individual's level of religiosity. Some researchers (Miller & Stark 2002; Stark 2002) have tried to explain why women tend to be more religious than men. According to Belenky Clinchy, Goldberer and Tarule, (1986), there are two types of religious thinking: connected knowing and separated knowing. Connected knower's focus on relationships, feelings, and understanding others. Separated knowers take a stance of moral objectivity and restrict their personal feelings. Men may have a predisposition towards separated knowing, while women may be more inclined to be connected knowers. However, this relationship is not gender-specific, meaning that not all women are solely connected knowers and all men are not separated knowers. Wilson (2002) has argued that religion evolved to confer a survival advantage to groups of believers, in which case women would have responsibility for passing

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on beliefs from one generation to the next. If so, the gender gap might be expected to diminish as fertility falls, which falls foul of the evidence that the gender gap is largest in the richer, non-traditional societies where women have many options other than childbearing, Miller and Stark (2002).

Krause, Ellison, and Marcum (2002) explained that women receive more social support in church than men do. This may be because from childhood, women are socialized to be more caring towards others as well as to highly value the development of interpersonal relationships. Thus, it would be easier for women to express their needs with others. In adulthood women may be more inclined to pursue careers in fields which primarily involve helping and taking care of people. This is evidenced by the surpassingly greater numbers of women studying university psychology than men studying psychology. Also, women, more than men, are likely to take primary responsibility for children in the home, despite also maintaining outside careers. Men are from childhood socialized to focus more on competition, independence, and inhibiting emotional expression. This may make it more difficult for them to convey any personal needs to others, especially in a church setting.

The results of Buchko's (2004) study yielded that both men and women attended a church service almost two times per month in the past year. However, women reported more prayer and meditation time than did men, confirming Buchko's first hypothesis. The second hypothesis, that women would sense more of God's activity and presence in day-to-day life, was supported as well. Affirming the third hypothesis, women reported more feelings of devotion and reverence than men. However, the fourth hypothesis, that women would credit the role of religion more in affecting their lives, was not confirmed. Buchko's study may have limited external validity because it studied mostly European Americans and the participants were a non-random sample of students from a single University in the United States. This means that the results may not apply to other racial groups and nationalities or even to other universities in the United States. Also, there were not many representatives of the Jewish, Hindu, Muslim, or Buddhist religions, limiting generalizability once again.

Bryant (2007) administered the 2000 Cooperative Institutional Research Program (CIRP) Freshman Survey to representative samples of incoming freshman at 434 colleges and universities. This survey covered multiple topics, including the students' values, activities, attitudes, and self-assessments. Three years later, a subset of the original sample completed the 2003 College Students'

Beliefs and Values Survey (CSBV), which dealt with spirituality and the effect of college on students' spirituality. The results of this study indicated that women scored higher than men in religiosity (Bryant, 2007). However, the gap between women and men on the construct of religious practice was smaller than it was on the construct of religious belief. Thirty-five percent of women were committed to religious belief compared to twenty-seven percent of men. Twenty-two percent of women were committed to religious practice compared to eighteen percent of men. Women were found to have higher spirituality scores. In addition, a general decline in religiosity was found in both men and women after a few years of college. This study may be limited, however, by attrition of participants from the initial survey to the second one.

The reported differences between men and women on spirituality may be misleading. Simpson, Cloud, Newman, and Fuqa (2008) studied 250 church goers and religious school staff from a southeastern and southwestern state. These participants completed the Spiritual Well-Being Scale (SWBS), the Religious Orientation Scale- Revised (IlE-R), the Quest Scale, the Spiritual Assessment Inventory (SAI), and the Bem Sex Role Inventory-Short Form (BSRI-S). Opposed to the majority of research, this study found that there was no significant difference between men and women in religious participation. This was consistent for three types of participation: level of involvement in religious activities, church attendance, and private or personal acts of religiosity. Neither was there a difference between men and women's relationship with God. This lack of difference was also found between masculine, feminine, and androgynous gender orientations. These results call into question the presumption that women are more religious than men. They also dispute the idea that there are spiritual differences between gender orientations. However, these results are limited to religious circles in their generalizability. Generalizability is also limited because the sample was mostly college educated, Christian Caucasians.

An empirical work done by Pew research center (as cited in Geggel, 2016) collected data from 2008 to 2015, they found out that women are more likely than men to pray daily in many countries in 36 of the 84 countries survey but in 46 of the countries, men and women equally said that religion was very important to them. Israel and Mozambique are the only countries that had results which revealed that men were more likely to consider religion more important than women.

Hypothesis

1. There will be a significant relationship between general health status and religiosity

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2. There will be a significant relationship between gender and religiosity.

Participants
Two hundred and one (201) participants were selected through convenience sampling from three religious worship centers in Awka Anambra State.Their age were between 21 and 55 with the mean age of 34.91 and standard deviation of 7.49. 106 females and 95 males participated in the research.

Instruments
Two standardized instruments were used for the study and they include General Health Questionnaire (GHQ-12) developed by Goldberg and Williams (1970) and Religious Affiliation Scale (RAS) by Omoluabi (1995).

The General Health Questionnaire – 12 (GHQ-12)
The General Health Questionnaire (GHQ-12) consists of 12 items, assessing the inability to carry out normal functions and the appearance of new and distressing phenomena over the past few weeks using a 4-point scale (from 0 to 3). The score was used to generate a total score ranging from 0 to 36, with higher scores indicating worse/poor conditions. It is a method to quantify the risk of developing psychiatric disorders or detect possible minor psychiatric morbidity in a population. The GHQ contains items as have you recently: ''been able to concentrate in whatever you are doing?'' ''Felt constantly under stain?'' ''Been able to face up to your problems?'' ''Been feeling unhappy or depressed?'' ''Lost much sleep over worry?'' Items 1, 3, 4, 7, 8 and 12 in the GHQ are scored in reverse direction. This instrument has been used in research with Nigerian Samples (Ifeagwazi 2008). Previous researchers (Ifeagwazi, Chukwuorji & Zacchaues, 2014) have reported the reliability and validity of the GHQ across several studies in Nigerian samples and it has been consistently found to be a psychometrically sound measure of psychological distress. Chukwuorji, Amanze & Ekeh (2016) obtained a cronbach alpha of 0.71.

Religious Affiliation Scale (RAS)
This is a 21-item scale standardized psychological inventory developed by Omolabi (1995). It is designed to assess the extent to which individual engage in religious activities, hold religious views and believe in prescribed religious practices. Omoluabi (1995) reported a three weeks test –retest reliability of 0.97. Erinoso (1996) correlated Religious Affiliation Scale with life satisfaction index-z (Neugarten, Havinghurst &Tobin, 1961) and established a divergent validity of .26.

Procedure

The researcher obtained permission from the authorities of the selected religious worship centre's to conduct the research with a letter of introduction by the head of department. The participants were individually administered the inventories by the researcher and research assistants. The participants were instructed on how to complete the questionnaires and were encouraged to do so honestly. Participants provided informed consent and received no monetary reward for participating in the study. Out of 230 copies of questionnaires administered, 201 copies were properly filled and considered in the present study, 19 copies were not properly filled, while 10 copies were not returned. The properly filled copies were analyzed using the appropriate statistic.

Design and Statistics

This is a correlational design. Pearson Product Moment Correlation was employed as the statistical tool for data analysis.

Results

Table 1: Correlation coefficients between General health , gender and Religiosity

	1	2	3
1. GHQ	1		
2. GENDER	-.114	1	
3. RELIGIOSITY	-.263**	.356**	1

The result confirmed the correlation between GHQ and religiosity was r = -.263 and between Gender and religiosity was r = .356. (see Table 1). By implication GHQ was negatively related to religiosity. But for gender females (code 2) was more related to religiosity than males (code 1)

Disscussion and Conclusion

This study investigated general health status and gender as correlates of religiosity among Christians in Awka. The first hypothesis which stated that there will be a significant relationship between general health and religiosity was accepted. This finding is consistent with previous research (Ismail & Desmukh, 2012) which reported that religious involvements are associated with positive

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mental health outcomes. Religious activities help to develop, sustain and reinforce certain explanations that some use it to comprehend the world. Anxiety and fear often drive people toward religion as a way to cope with the anxiety. As a result, they become psychologically stable and in good health because of consistent exposure to messages and lessons in religious activities. Furthermore, this is in line with the rational choice theory which states that religion is essentially a rational response to human needs and that there is a constant potential human demand for religious goods (compensators). This is an indicator that being religious serves as a form of social support that buffer stress (anxiety, depression, insomnia).

The findings of the second hypothesis revealed a significant relationship between gender and religiosity with female being highly religious from the mean score. The finding is consistent with previous studY (Bryant, 2007). Miller and Hoffmann (1995) explained the risk aversion theory and concluded that women are less likely to be involved in risk taking and as result are more inclined to religion than men who are more likely to be risk takers. Being unsatisfied with this, Miller and Stark (2002: 1401) reluctantly concluded that physiological differences related to risk preference appear to offer the only viable explanation of gender differences in religiousness. However, women are more religious than men because women are raised to be nurturing and submissive and these qualities make religious acceptance and commitment. Furthermore, their belief that being religious brings a form of consolation to their mind makes them to be solely involved in religious activities to see if there will be an intervention in their problems of living especially when it comes to their husbands and children. Women are ready to pay any price and do all it takes to protect their families. Similarly, motherhood is believed to subsume religiousness since it entails teaching the children morality and caring for the physical and spiritual wellbeing of other family members. On the contrarily, this finding is not inconsistent with the work of Simpson, Cloud, Newman, and Fuqa (2008) who reported that there are no significant difference between male and female in active participation of religious activities.

Conclusion

In conclusion, the researcher therfore recommends that all psychologists and other health professionals to think towards the development of a cross-culturally relevant psycho-religious or Christ-centered therapy(for Christians) that will take care of the people. It will not be out of place also for psychological bodies to give recognition of some religious centers by organizing seminars, conferences

and training for them in order to equip them with requisite skills for the services they are required to render to the people. Since the health and wellbeing of the clients and satisfaction is at stake, clinicians should be experienced in delivering care that addresses the whole person—body, mind, and spirit.

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