

Depression, Stress Differential and Social Support among Catholic Religious in Nigeria

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ABSTRACT

This study explored the relationship between depression, stress differential and social support among Catholic Religious. To carry out this study a sample of 186 Catholic Religious from different Congregations (religious institute) as well as different states were examined using the DASS (Depression, Anxiety and Stress Scale) and MOSS (Medical Outcome Study Social Support) scales. It was hypothesized that both gender and social support will have significant effect on depression and stress and also that there would be an interaction effect of gender and social support on depression and stress. Results using the analysis of variance (ANOVA) indicated that gender was not statistically significant on stress and depression, while social support was marginally significant on depression with $f(1,178) = 2.771, p < 0.05$ the mean for male was 11.283 while the mean for female was 12.690. But social support was not significant on stress. An interaction effect also indicated that both gender and social support were statistically not significant on depression and stress. The results have important implications of the effects of social support on psychological wellbeing.

Keywords: *depression, stress differential, social support, Catholic Religious*

INTRODUCTION

A genuine religious community can be a “heaven on earth” where every member experiences joy and happiness, peace and harmony, love and understanding, acceptance and recognition. All the members together have to build up this “heaven”. Fraternal life, share in love, is an eloquent sign of ecclesial communion. In an ideal religious community every member feels free to think and to work, and enjoys the love and support of other members. Selfishness and unhealthy competition have no place there. In such a community all the members can live in unity and generosity. There is always mutual love, understanding and prayerful support (Kaitholil (2002)). Many religious are seen to suffer from signs of depression and stress as a result of this lack of social support that is gotten from an ideal community life. Knox, Virginia and Lombardo (2002) in research to find out vocational satisfaction reported a high level of emotional exhaustion, depression and anxiety among Roman Catholic secular clergy. Olisah (2006) finds out that Nigerian religious are suffering from several kinds of psychological disorders such as anxiety, eating disorder, depression, mood stress, personality disorder, anti-social, schizophrenia etc which are caused by the unhealthy life situation in which they find themselves in the religious life.

Ihariss (2010) makes it clear that clergy are as susceptible to burnout and depression as are their congregants. Whether low social supports are associated with depression and stress have hardly been studied among catholic religious. This study is focused on looking at the relationship between social support, stress differential and depression among Catholic religious. Here social support which is defined as emotional support received by religious in individual different catholic religious community is seen as a factor that can help in the reduction of negative symptoms of individual stress and depressive symptoms. Catholic Religious in the society are supposed to be a sign of love, peace and joy touching the lives of others and reaching out to them through their different apostolate (works). They are to live a life of oneness and support thereby living happily together. Nowadays, one of the researchers has observed that though living in common as mentioned above, has noticed that some are not happy and show a lot of depressive symptoms, stress and lack of social support. Depression is an affective, or mood disorder. It is an illness that immunes its sufferers in a world of self-blame, confusion and hopelessness. It is an illness of mind and body; some could argue that depression is a way of coping with life's pressures (Schwartz A. and Schwartz R., 1993). Clinical depression is a serious illness that affects most, if not all facets of a depressive' life. The major component of depression is a loss of interest in activities once found pleasurable. In fact, in order for a person to be diagnosed with having depression, a loss of interest in activities once found pleasurable must be present (Schwartz A. and Schwartz R., 1993).

For some depressive there is even a loss of interest in life itself. Each year an average of 5,000 Americans take their lives. How many of these people are suffering from depression is not known, but it is believed a vast majority of them were depressed. Depression can only be disabling to the point where the depressive can no longer function in the daily rigors of life. Absence from work or school is common, for the severely depressed individual does not have enough energy or motivation to get out of bed. Many a depressive will describe his or her illness to having a large and heavy weight on his or her back. Often that weight is an accumulation of stressors, and sometimes the weight is unexplainable.

Physically a depressive is sluggish. His or her speech is noticeably slow, and motor skills are retarded (Comer, 1992). The depressive may complain of headaches or other ailment that have no explanation (Schwartz A. and Schwartz R., 1993). Cognitively, depressives exhibit confusion and find it difficult to make even what many people seem to be the simplest of decisions (Schwartz A. and Schwartz R., 1993). Memory is also impaired. Depressives are often agitated and irritable. They may perform repetitive motor tasks, like pacing or rubbing their hands together. They may exert a poor disposition and become "aggressively hostile" to others (Wetzel, 1984). Life can be a lonely experience for the depressives. Their sense of humor is lost and they are seldom seen smiling. They are often tired from either too little or too much sleep. Intense feeling of shame and guilt because they believe that everything that goes wrong is their fault are often harbored (Schwartz A. and Schwartz R., 1993). Feelings of inadequacy may lead a depressive to attempt to withdraw from family and friends. Feelings of inferiority may eventually lead to feelings of

hopelessness. Nothing will ever improve, they believe. Often times feelings of inferiority are as a result of the depressive's demanding expectations of him or herself (Schwartz A. and Schwartz R., 1993). While some depressives may shy away from family and friends, some display an overdependence on others. When they are shunned by those they depend on, they become even more depressed. Their world becomes that much more lonely and hopeless. In this research, participants who score above average in the DASS scale would be said to have depressive symptoms.

Although researchers disagree over particulars of stress, they agree that stress is the reaction of the organism to a perception of threat (McGrath, 1970; Derogatis, 1982). Lazarus (1966) has developed a convincing conceptual model involving both stressors and coping abilities of the person. He defines stress as any situation in which "Environmental demands tax or exceed the resources of the person" (Lazarus and Launier, 1978). 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. The sensitivity of the individual to specific stimulus affects the level of stress felt from them. One person may experience stress from work overload, while a second does not; the second may feel stress from role ambiguity, while the first does not (Kasl 1978 and Pearlin, 1982).

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. Past research indicates that chronic stressors are more consequential, in general, than episodic events (Beehr and Bhagat, 1985). Another recurrent research finding is that individuals can learn to cope with stressors through training and experience. In this study, participant would be suffering from stress when they score above average in the DASS scale

Social support is the function and quality of social relationship, such as perceived availability of help or support actually received. It occurs through an interactive process and can be related to altruism, a sense of obligation, and the perception of reciprocity. Social support refers to the infrastructure that must be in place for individuals and families. Social services, community events and basic fellowship that is essential to a happy and well adjusted life. It has become increasingly clear that isolation from these community pillars can lead to deep alienation, depression and even psychosis in the long term. Appraisal support (Quantifiable forms of support) is important in that it can measure the effect that community programs have on the development of recovery and the process of reintegration into society. This is a case where professionals can provide support for their ongoing treatment. Informational support makes it possible for the isolated community member (such as the ill, the elderly or a recent parolee) to understand and realize what is going on around them that can be of assistance in any manner.

Instrumental support is the more typical, tangible form of community support. It includes monetary assistance, transportation help and other forms of assistance that can be measured in naira and it is a purely quantitative measure of support. Emotional support (Non-Quantifiable Forms of Support) refers to the intangible aspects of community life that maintain a strong sense of belonging, and seeks to bring isolated person into the mainline of community life. This form of support is the focus of this study.

Integration is the final goal of all social support approaches. In this case, it is not a matter of linking up the client to the proper programmes or events, but rather the constant interplay of clients, events, programmes and the community that support the individual. This is the individual judgment. Additionally as with personal coping skills, the mere perception of an adequate support system has sometimes been shown to have more beneficial effects than the actual receipt of support (Vaux 1988; Wethington and Kessler 1986; Ross and Mirowsky 1989). Social support is, therefore, a critical determinant of psychological well-being. In this research, participants who have a low score in the MOS social support scale would be said to have less social support.

Religious life, as a consecration of the whole person manifests in the church the marvelous marriage established by God as a sign of the world to come. Religious thus consummates a full gift of themselves as offered to God, so that their whole existence becomes a continuous worship of God in charity. Among these disciples, those gathered together in religious communities, women and men “from every nation, from all tribes and peoples and tongue “(Rev. 7: 9), have been and still are a particularly eloquent expression of this sublime and boundless love. Born out “of the will of the flesh” nor from personal attraction, nor from motives, but “from God” (John 1: 13), from a divine vocation and a divine attraction, religious communities are a living sign of the primacy of the love of God who works wonders, and of the love for God and for one’ brothers and sisters as manifested and practiced by Jesus Christ. This study was designed to test the following hypotheses:

1. There is no significant gender main effect on stress among catholic religious with female religious experiencing significantly more stress than the males.
2. There is no significant gender main effect on depression among catholic religious with female religious experiencing significantly more depression than the males.
3. There is no significant social support main effect on stress among catholic religious.
4. There is no significant social support main effect on depression among catholic religious.
5. There is no significant interaction effect between gender and social support on stress among catholic religious.
6. There is no significant interaction effect between gender and social support on depression among catholic religious.

PARTICIPANTS AND PROCEDURE

Participants were 200 Roman Catholic male and female religious residing in Abuja, Benue, Cross River, Enugu and Plateau States randomly selected from different congregations (Religious institutes). A total of 186 copies of questionnaire were returned filled including

those that were not properly filled (98 females and 88 males). This consisted of seventeen congregations comprising of twelve females and five males congregation. In all 200 copies of questionnaire were sent out, 187 were responded to comprising of 89 for males and 98 for females including 8 copies that were not properly filled. 7 were returned unfilled and 8 were never returned. Participants both male and female were within the age range of 20-30, 30-40, 40-50, 50-60 and above coming from different ethnic groups in the country. The design used in this study was a 2 by 2 factorial design. The variables are gender (male and female) and social support (high and low). The dependent variables were depression and stress.

The instruments that were used for the study are four questionnaires, they are the ZUNG depression scale, the 14 PSM stress scale, the DASS 21 scale, and the MOS social support scale. For the purpose of this study the DASS 21 and the MOS social support scales were be used in the analysis of the data. Depression, Anxiety & Stress Scale (DASS-21) is a self-report 4-point Likert scale and composed of three subscales: Depression (DASS-D), Anxiety (DASS-A), and Stress (DASS-S). The DASS-21 measures each of the three mental health conditions, over the past week, through seven items. Responses on each item range was from 0 (*did not apply to me at all*) to 3 (*applied to me very much*) (see appendix). The intensity of any of the three conditions is determined by the sum scores of responses to its 7-item subscale.

The instrument was developed and used by Lovibond and Lovibond (1995). The original 42 items were developed using a non-clinical sample of 2914. The Depression scale measures hopelessness, low self-esteem, and low positive affect. The Anxiety scale assesses autonomic arousal, physiological hyper-arousal, and the subjective feeling of fear. The Stress scale items measure tension, agitation, and negative affect. The DASS demonstrates excellent internal consistency in both the 42- and 21-item (DASS-21) versions: Depression (range=.91 to .97); Anxiety (range=.81 to .92); and Stress (range=.88 to .95). A three-factor solution reflecting the three scales has been found consistently across samples and factor-analytic techniques with only minor variations. Inter-scale correlations range as follows: Depression – Anxiety (.45 – .71; .50, Anxiety – Stress (.65 – .73), and Depression – Stress (.57 – .79).

At first the questionnaires packet, addressed by hand, was mailed to some of the participants especially those in Benue State and Cross River. The researcher took the questionnaire to those who reside in Abuja as well as those who reside in Plateau State. When about 40 copies of the questionnaire came back unattended to, the researcher then took them to those who reside in Enugu State. The packet contained a heading describing the study on the questionnaire and explaining the individuals' right to refuse participation, withdrawal at will as well as confidentiality of all information provided. The statistical analysis of the data obtained through the use of questionnaires administered to the 200 participants was analyzed using the sample percentage and frequency analysis, descriptive statistics as well as two-way analysis of variance. The sample percentage and frequency analysis was performed on the demographic data of the participants while the descriptive statistics and the two-way analysis of variance (ANOVA) was employed to test the various

hypotheses of the research. Furthermore, in order to ease the computation and the generation of result, a statistical package commonly referred to as SPSS (statistical package for social science) was used to enhance data analysis.

RESULTS AND DISCUSSION

Based on the frequencies observed, 44.7% of the participants were males and 49.2% were females

Hypothesis One: There is no significant gender main effect on stress among catholic religious with female religious experiencing significantly more stress than the males. The $f(1,178) = .812$, $p > 0.05$, with marginal means of 13.067 and 13.879 for females and male respectively was not statistically significant. Hence, the hypothesis was rejected.

Hypothesis Two: There is no significant gender main effect on depression among catholic religious with female religious experiencing significantly more depression than the males. The $f(1,178) = 2.771$, $p > 0.05$.and means values of 11.283 and 12.629 for females and males repectively was not significant and was also rejected..

Hypothesis Three: It was also hypothesized there is no significant social support effect on stress among catholic religious. The result $f(1,178) = 1.522$, $p > 0.05$ was not significant. The mean for males was 12.917, while the mean for female was 14.029. The hypothesis was thus rejected.

Hypothesis Four: There is no significant social support effect on depression among catholic religious. The ANOVA result, $f(1,178) = 2.771$, $p < 0.05$ and the mean for male was 11.283 while the mean for female was 12.690. This was significant and was accepted.

Hypothesis Five: There is no significant interaction effect between gender and social support on stress among catholic religious. Analysis using the two-way ANOVA was performed to test this hypothesis and the results $f(1,178) = 1.55$, $p > 0.05$. A low mean for gender and social support on stress was 13.500 and 12.333 for males and females respectively, while a high mean was 14.258 for males and 13.800 for females. The result obtained was statistically not significant.

Hypothesis Six: There is no significant interaction effect of gender and social support on depression among catholic religious The $f(1,178) = 1.569$; $p > 0.05$, the marginal means for low social support were 12.455 and 10.111 for males and females respectively, while mean for male and females are 12.803 and 12.576 for high social support respectively. The result obtained was not statistically significant.

At the end of the analysis, results were obtained as discussed extensively based on each hypothesis. The hypotheses were statistically not significant. Gender was not a significant factor among catholic religious on stress as well as on depression. The findings were that gender would not affect stress among catholic religious. Gentry, Chung, Aung, Keller, Heinrich and Maddock (2007) conducted a study on how understanding sex differences in stress regulation has important implications for understanding basic physiological differences. Although find out that women reported higher overall perceived stress but there was no difference on the experienced social stressors and health stressors between genders. Men perceived stress from personal factors. There was no gender

difference in the perceived ability to cope with stress. Also social support was found to be statistically not significant among catholic religious on stress but was marginally significant on depression. The findings were that social support was not statistically significant, that is, it does not have effect on stress but have little effect on depression. This may support the finding of Stansfeld and Sprooton (2002); Alarie (1996) on their different stress observed that close relationship may be stressful as well as stress relieving and high levels of negative interaction within relationship increase the risk of mental health. Gender and social support did not have significant effect on stress and depression. The findings were that gender and social support was not statistically significant on stress and depression. Bryan (1997) suggested that a shared immunological defect may link many disorders, whereas other studies suggest that the inappropriateness of the stress response in dealing with modern treats-which are largely psychological rather than physical, is to blame. While Akinboye, Akinboye and Adeyemo (2002) 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. In order to investigate the interaction effect, two ways ANOVA was used and the data obtained showed that the outcome was statistically not significant therefore we reject the null hypothesis.

CONCLUSION AND RECOMMENDATIONS

At the beginning of this project work the objectives were set for the study and during the literature review it was found that some literature did not support the findings that gender and social support have no statistically significant effect on depression and stress while others have supported the findings. On gender and social support effect on stress and depression it was found that there was no effect on the dependent variables and that the effect seems to be even among both genders. This was in line with the findings of the data collected during my research because my study found that the result was statistically not significant. The findings highlight the importance of examining the relationship between social network context and psychological well-being.

Further research should explore areas of stress among catholic religious and find out how these specific stresses affect the religious. Also they should research in to other areas of health to see how these various health problems could be the cause of depression and stress on psychological wellbeing. Future studies should find out whether other aspects of social support also affect the religious and ask how and why. This thesis provides empirical evidence that some other aspects of support could be too demanding on the individual psychological wellbeing. Therefore, future studies should explore possible mechanisms for effects of social support on psychological wellbeing among catholic religious. By exploring the relationships between stress, depression and social support my analysis provides empirical evidence that supports the premises of crowded social support. This perspective argues that when structure of social support is crowded it constrains members in ways that importantly influence outcomes.

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