

The impact of praying and fasting on the mental health of students attending the Bandar Abbas Branch of Islamic Azad University in Iran in 2012

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Abstract: Introduction: Mental health issues are common in Iran. This study examined the impact of praying and fasting on the mental health of students attending the Bandar Abbas Branch of Islamic Azad University in Iran in 2012. **Methods:** A total of 200 undergraduate students (85 girls and 115 boys) at the Bandar Abbas Branch of Islamic Azad University were selected as the sample using a multi-stage cluster random sampling process. The GHQ-28 mental health questionnaire was administered to them 2 weeks before Ramadan as a pre-test and 2 weeks after Ramadan as a post-test. **Results:** After analyzing data using a one-way ANOVA test and t-test, it was revealed that people who fasted the whole month of Ramadan or most of it, even they did so just for amusement, received more favorable scores on all the mental health subscales; meanwhile, reduced scores were evident after Ramadan among those who did not fast at all or, due to religious or medical reasons, could not fast. In addition, people who always or usually prayed also received higher scores on the mental health subscales. **Conclusion:** The results of this study indicate that fasting, even for amusement purposes, enhances individuals' mental health. In addition, people who always or usually pray have higher mental health scores than those who never or rarely pray.

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1. Introduction

Religion has been one of the most discussed topics among theorists. Some theorists consider religion to be a form of mental illness and religious practices to cause deviant and obsessive neurosis; other theorists disagree and have deeply examined the role of religion in achieving mental health (Spilka et al., 2003; Wolf, 1997). A similar conflict exists in the context of experimental studies: Some studies have reported negative consequences of religion on mental health, noting a direct relationship between neurosis and strict piety (stifoss-hanssen) and inflexibility, while others have highlighted the positive impact of religion on mental health (Spilka et al., 2003). In an attempt to understand these conflicts better, the current study examined various factors (e.g., quality or type of religiosity and religiosity elements) from 115 studies and found that, generally speaking, mental health has a positive relationship with internal religion but a negative relationship with external religion (Argyle, 2000). Azerbaijani (2002) categorized various elements of religion into five dimensions: rituals, religious knowledge, religious feelings, ideology, and consequences (i.e., the application of religion in life). Praying and fasting are two religious rituals. According to Doorkim (1898), practices and rituals exist in all religions and are considered the common

core of every religion. Several studies have highlighted the positive and significant effects of religious practices and customs on mental health and anxiety reduction. For example, YusefiLooyeh and Hassanpour (1998) examined the effect of intimacy with the Koran on mental health. Jalilvandvajehei (1998) studied the relationship between praying and anxiety, focusing on verse 14 "Pray to God if you want to have it in your mind" in the Koran's Sura Taha and verse 28 "Only by praying to God your heart will rest assured" in Sura Raad. Finally, Sadeghi and Mazaheri (2006) studied the effect of fasting on mental health. Bayani et al. (2006) focused on the relationship between religious orientation and anxiety and depression in students; their results demonstrated that strengthening and internalizing religious values can lead to enhanced mental health among students. In the Koran, the Sura Baqara says "Seek help in patience and prayer"; fasting teaches us patience as a kind of feeling and belief are formed during the fasting process when the individual puts aside the basic physiological needs using faith, social supports, mental images, abilities, and talents. In this way, the individual can cope with various situations, developing the skill to use knowledge is self-efficacy (Ghadiri, 2010).

To explain the relationship between religion and health, three mechanisms can be imagined. First,

religion encourages the person to adopt a set of virtuous personality traits that affect health. Second, organized religion brings social supports into practice that affects health. Third, religion prepares a person to deal more efficiently with stress (Karami et al., 2007). Numerous cross-sectional studies have demonstrated that people turn to spirituality to gain support and cope with their pains (Rippentrop, 2005). Christopher et al. (1995) found a positive correlation between frequency of church attendance and mental health, a weak negative correlation between praying and mental health, and a positive correlation between the belief in immortality and general health. In response to the need to determine which aspects of religion play a more major role in mental health, Ball (2003) found that adolescents of religion-oriented families enjoyed higher self-esteem, but in terms of psychological performance and sexual activities, there was no significant difference between adolescents from different families (in terms of religious orientation).

Praying is a spiritual performance that creates a relationship with the higher entity; it is a fundamental act in most major religions of the world, including Islam, Christianity, Judaism, and Buddhism. Praying can strengthen the sense of control and stimulate the internal power of the person. Praying facilitates relaxation and leads to a better mood, mental health, and tranquility (KarimAlahi et al., 2008). Praying leads to comfort, joy, and motivation, which elevate mood and increase motivation and sense of purposefulness (KarimAlahi et al., 2008). Although many studies on spirituality, religion, and health are of the correlation type, meaning the cause-and-effect relationship cannot be proved directly, evidence suggests a strong relationship between religious participation and good health as well as between awareness of spiritual commitment and good health (KarimAlahi et al., 2008). BahramiEhsan et al. (2008) found that participation in religious ceremonies and worship (such as praying and fasting) is followed by consequences such as formal psychotherapy. Emotional discharge and participation in collective religious ceremonies result in reduced stress and the elimination of emotional distress.

As communities expand and further development is promoted, people face increased, more diverse stress. Different strategies are used to mitigate such stress. The aim of this study is to investigate the effect of fasting and praying on the mental health of students attending Iran's Islamic Azad University in Bandar Abbas in 2012. The specific objectives of this research are as follows:

1. To evaluate the effectiveness of fasting on the mental health of students attending the Islamic Azad University in Bandar Abbas, Iran, in 2012 and
2. To evaluate the effectiveness of praying on the mental health of students attending the Islamic Azad University in Bandar Abbas, Iran, in 2012.

2. Material and Methods

This is a descriptive study. The statistical population of this study consists of all undergraduate students from Islamic Azad University in Bandar Abbas, from which 210 individuals were selected in the pre-test stage. After performing the post-test 50 days later and as a result of sample loss, 200 persons were selected for the multi-stage cluster random sampling and analyzed. A general health questionnaire was administered in two stages with a 50-day interval—two weeks before Ramadan and two weeks after Ramadan. The following tools were used in the present study.

A. GHQ-28 mental health questionnaire:

This self-reported diagnostic questionnaire was developed by Goldberg and Hill (1979). Its main purpose is to distinguish between mental illnesses and health. Its 28 items fall within 4 subscales: physical symptoms, anxiety and insomnia, social dysfunction, and depression. A score of 14 or higher in any subscale indicates the participant's deterioration in that factor. Summing the scores of the four subscales results in an overall score in terms of general health. The questionnaire has been evaluated in different cultures in terms of validity. KhodaPanahi and Heydari (2005) examined the validity of the general health questionnaire through the three methods of re-assessment, description, and Cronbach's alpha, obtaining validity coefficients of 0.72, 0.93, and 0.90, respectively.

B. Researcher-developed questionnaire:

This questionnaire consists of two parts. The first part is a personal profile and includes items such as age, sex, and marital status of participants. The second part includes questions about how much individuals fulfilled their religious obligations during Ramadan. This section contains four options; participants are divided into four groups based on the option they select: the first group (I fast all or most days in Ramadan); the second group (I couldn't fast due to religious or medical reasons); the third group (I didn't fast during Ramadan at all); and finally the fourth group (I fasted a few days in Ramadan for amusement). The second section includes questions about praying to divide participants into four groups: those who always pray, those who often pray, those who sometimes pray, and finally those who never

pray. Participants completed the questionnaire during the post-test period and after the implementation of the general health questionnaire.

3. Results

According to the data summarized in Table 1, most participants were between the ages of 20 and 25, were male, and were unmarried.

Table 1. Demographic status of the experimental group

Variable		n (%)
Age	18-20	30 (15)
	20-25	145 (72.5)
	25-30	20 (10)
	>30	5 (2.5)
Sex	Male	115 (57.5)
	Female	85 (42.5)
Marital status	Single	109 (54.4)
	Married	91 (45.6)

Table 2. Data obtained in regard with praying

		Female n (%)	Male n (%)
To pray	never	19 (16.5)	12 (14.1)
	Some when	21 (18.2)	12 (14.1)
	often	35 (30.4)	21 (24.7)
	always	40 (34.7)	49 (47.7)

Table 2 presents the data on participants' praying. According to Table 2, most people (i.e., 47.7

percent) always pray while 14.1 percent often and sometimes pray. In Table 3, the mean and standard deviation of mental health subscales of participants who do not pray (Group 1), sometimes pray (Group 2), often pray (Group 3), and always pray (Group 4) are listed. In Table 3, the mean, standard deviation and one-way ANOVA of mental health subscales of people who do not pray, sometimes pray, often pray, and always pray are listed; the results indicate that those who often or always pray have higher mental health scores. Finally, Table 4 lists the mean, standard deviation, and comparison of before and after Ramadan in terms of mental health subscales of people who fast almost always during Ramadan, did not fast at all during Ramadan, fasted some day during Ramadan for amusement, and did not fast during Ramadan due to religious or medical reasons. The results indicate that people who did not fast at all or did not fast due to religious or medical reasons scored lower on the mental health subscales after Ramadan.

Given that the number of people in the groups is not equal, a Scheffé post hoc test was used to determine the difference between means. The results in each of the mental health subscales were as follows: A significant difference emerged in the depression subscale among the means of groups praying 1, 3, and 4; in the anxiety and insomnia subscale among the means of groups 1, 2, 3, and 4; in the somatization subscale between groups 1 and 4; and in the social dysfunction subscale among groups 1, 3, and 4.

Table 3. Mean, standard deviation, and variance analysis of general health subscales of people with various conditions of praying

variables	Groups	Mean	Std.Deviation	df	F	Sig
somatization	Group 1	13.4	3.8	208	5.9	0002.
	Group2	12.4	3.8			
	Group3	11.5	3.6			
	Group4	10	3.3			
anxiety & insomnia	Group1	16.1	2.1	208	80.2	000.
	Group2	14.4	3			
	Group3	11.4	2			
	Group4	10.1	2.1			
depression	Group1	16.6	2.2	208	53.3	000.
	Group2	15.3	2			
	Group3	12.7	2.5			
	Group4	10.6	1.7			
social dysfunction	Group1	17	1.9	208	62.8	000.
	Group2	15	2.2			
	Group3	14.4	1.9			
	Group4	12	3.8			

Table 4. Mean and standard deviation of subscales, and the overall score of the general health questionnaire, and the four groups fasting in pre-test and post-test

variables	Group*	number	Mean	Std.Deviation	df	t-test	Sig
somatization	Post test Group1	78	9.6	1.7	77	11.9	0.000
	Pre test Group 1		11.8	1.8			
	Post test Group 2	38	15.2	2.2	37	-7.7	0.000
	Pre test Group2		14.1	2.5			
Anxiety & insomnia	Post test Group 3	35	10.1	2.1	34	10	0.000
	Pre test Group3		11	2			
	Post test Group 4	49	13.9	2.2	48	-9.1	0.000
	Pre test Group4		12	2.1			
Social dysfunction	Post test Group1	78	10.1	1.4	77	8.8	0.000
	Pre test Group 1		12.4	1.9			
	Post test Group 2	38	15.7	2.3	37	-5.3	0.000
	Pre test Group2		14.4	2.5			
depression	Post test Group 3	35	11.2	2	34	6.1	0.000
	Pre test Group3		11.8	1.9			
	Post test Group 4	49	12.9	2	48	-5.8	0.000
	Pre test Group4		13	2.1			
Social dysfunction	Post test Group1	78	1.7	1.2	77	10.59	0.000
	Pre test Group 1		11.4	1.9			
	Post test Group 2	38	14.6	2.5	7	-13.3	0.000
	Pre test Group2		13.3	2.5			
depression	Post test Group 3	35	13.9	1.8	34	11.2	0.000
	Pre test Group3		12.8	2			
	Post test Group 4	49	12.8	2.3	48	-12.2	0.000
	Pre test Group4		13	2.1			
depression	Post test Group1	78	7.1	1.8	77	12.3	0.000
	Pre test Group 1		10.1	1.4			
	Post test Group 2	38	15.4	2.3	37	-4.1	0.000
	Pre test Group2		14.3	2.6			
depression	Post test Group 3	35	9	1.9	34	11.8	0.000
	Pre test Group3		11.2	2			
	Post test Group 4	49	13.2	2.1	48	-5.2	0.000
	Pre test Group4		12.9	2.3			

*The first group: Fast always during Ramadan; The second group: Did not fast at all during Ramadan; The third group: Fast some days during Ramadan for amusement; The fourth group: Did not fast during Ramadan due to religious or medical reasons

4. Discussions

The purpose of the present study is to investigate the effect of fasting and praying on people's mental health. The data demonstrated that fasting and praying have a positive impact on mental health promotion. This finding is consistent with the findings of YusefiLooyeh and Hasanpour (1998), Galehdar and Saki (2002), JalilvandVajeheie (1998), Sadeghi and Mazareie (2006), Bayani et al. (2008), Azarbayejani (2002), and Karami et al. (2007), although it is not consistent with the results of Froid (1964) and Ellis (1980). The different results are likely due to the quality or type of religiosity and the elements of religiosity considered.

Religion as an operational model of behavior is able to provide instructing principles for dealing with phenomena, enabling the religious person to achieve an efficient model for dealing with events and incidents by practicing and repeating these principles. According to Pargamen et al. (2000), through the acquisition and internalization process, religion can lead to healthier and better personality constructs. In the religious framework, a model is presented that leads to the formation of more modified personality traits or features; religious teachings also provide the possibility to form a more evolved personality model (BahramiEhsan et al., 2008).

Religion as a social phenomenon is the oldest social network of support. Religious teachings offer efficient and authentic models regarding devotion, affection, aid, and assistance. From this perspective, religion can play a role as a protective group. In such circumstances, receiving support from religious reference groups would be quite natural when facing problems. Thus, it seems that the effect of religion and religious rituals (such as praying and fasting) on mental health is the product of six different, yet complementary processes:

1. Religion can create sense; therefore, religion gives sense to good living and dying (BahramiEhsan et al., 2008).
2. Religion causes hope and increases people's optimism (BahramiEhsan et al., 2008).
3. Religion gives a sense of control and efficiency to people that is rooted in God and can compensate for the loss of personal control (BahramiEhsan et al., 2008).
4. Religion prescribes a healthier life for people that have a more positive impact on mental health (BahramiEhsan et al., 2008).
5. Religion is a set of positive social norms; obeying them leads to support and acceptance from others (BahramiEhsan et al., 2008).
6. Religion gives sense of the supernatural that undoubtedly has psychological effects (BahramiEhsan et al., 2008).

Based on Pargamen et al.'s (2000) theory, religion can intervene in the early assessment stages of life-threatening issues, acting as a mediator variable. It can also play a decisive role in the re-evaluation stage and, after the problem occurs, create more hopefulness and meaningfulness. In addition, religion can have a positive impact on the results and consequences of stressful factors during interpretation of the events. Those who have an internal religious orientation can better modify stressful factors when performing religious affairs such as praying and fasting, resulting in better mental health. In this regard, the role of religious attitude is stronger than merely performing religious practices. According to Bergin (1991), religion has a positive impact on the mental health of individuals with an internal religious orientation, whereas individuals with an external religious orientation not only do not benefit from the religion, but will also be plagued with negative consequences due to the lifestyle of people with an internal religious orientation (Karami et al., 2007).

In light of these findings, sincere attitudes toward religion should be protected from the negative impact of society. Internal religious orientation is far more important than the tendency to engage in religious rituals. This does not mean that this

tendency to engage in rituals does not affect mental health; on the contrary, it does affect mental health. By examining simple correlations between dimensions of religious orientation and dimensions of mental health, it can be observed that adherence to beliefs and rituals is also related to all mental health dimensions. According to the theory of cognitive inconsistency (Festinger, 1957), another possible justification in this context is based on why externally religious people have lower mental health in performing religious affairs such as praying and fasting. When a person performs religious rituals in front of others, he or she will face external reinforcement and rewards. As a result, the individual's internal attitude about these rituals is weakened, and people will attribute these practices more often to consequences (external reinforcement and reward) than to their own attitudes (Karami et al., 2007).

The obtained results of the study show that fasting and praying are effective for enhancing students' mental health as well as reducing their depression, anxiety, and physical symptoms while promoting their social functioning. One limitation of the current study is the interval between tests, which caused the loss of some participants. The same study should be performed in other cultures and with people of different religions and ages; the results should be compared with the current study's results. If similar results are obtained, a suitable practical strategy can be developed to enhance people's mental health.

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