International Journal of Islamic Psychology
2020, Vol. 3, No. 1 P-ISSN: 2655-531X. E-ISSN: 2721-2262

Spirituality and Health in Relation to Religious Internalization and Collective Religious Practices

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Abstract: The present investigation is aimed at studying the spirituality and health of senior citizens belonging to Muslim community in relation to types of religious internalization and participation in collective religious practices. For this purpose, two types of religious internalization (identification and introjection) have been worked by the investigator that were presumed to vary in their relative autonomy. Identification represents adoption of beliefs as personal values and is characterized by greater volition and introjection represents a partial internalization of beliefs as characterized by self and other approval-based pressures. In order to identify identification and introjection internalization subjects Muslim Religious Internalization Scale was administered upon 160 senior citizens (age ranging from 60 to 75 years) belonging to belonging to Muslim religious community, On the basis of their scores 24 subjects were identified as introjection internalization and 26 subjects were identified as identification internalization subjects. Spirituality Questionnaire and General Health Questionnaire were administered upon them. In order to find out the significance of difference between the two comparisons groups, t-test was used. Identification internalized subjects were found to be significantly more spiritual than introjection internalized subjects. This finding suggested that religion and spirituality does not oppose to each other, rather it is matter of how does a person internalize his religious faith and practice. In fact, many characteristics that are common to religiousness may also be found in spirituality (Jones, 2004; Idler, 2003). In addition, other social researchers espoused that a search for the sacred can be deemed as the common ground between religion and spirituality. The results further revealed subjects whose religious identification was taken place on identification basis and participating in collective religious practices five times daily exhibited lesser somatoform symptoms, experienced less anxiety and depression and have had less social dysfunction in comparison to those subjects whose religious identification was done on introjection basis and participating in collective religious prayers five times daily. Thus the relationship between religious practices and health of the subjects was found to be the function of how their religious internalization has taken place.

Keywords: Collective religious practices, Salah, Spirituality, Religious internalization, Identification, Introjection, Depression, Anxiety, Social dysfunction

Introduction

Within the last decade, the connection between religiosity/spirituality and health has become a subject of increasing interest particularly within the field of health care (Klein, Berth, and Balck, 2011, Plante and Sherman, 2001). A considerable number of quantitative studies have so far found religious/spiritual variables to be modestly but meaningfully associated with mental or even physical health and psychosocial adjustment (Koenig, McCullough, and Larson, 2001; Miller and Kelley, 2005; Chida, Steptoe, and Powell,2009). However, the research results are not entirely consistent; null findings and even negative associations were shown as well. This may be due to variations in subjects, stressors, or contextual characteristics and may indicate that religiosity/ spirituality, especially religious/spiritual struggle and feelings of shame and guilt (Exline ,2002; Exline and Rose, 2005), can also be part of psychosocial problems. Furthermore, varying results may also reflect the breadth of indicators and questionnaires used for measuring religiosity/ spirituality.

In recent years many pathways through which religiosity/spirituality may cause (better) health have been discussed. Among the first, Peterson and Roy (1985) suggested three major pathways: Religiosity/spirituality enables the individual to experience positive emotions like hope, optimism, and solace. Religiosity/ spirituality also offers many opportunities to find a meaning in one’s life. Furthermore, religious communities can provide social support. As further pathways, Argyle (1999, 2000) added religious behavior which fosters a healthy lifestyle and a close relationship with God as a source of comfort and self-esteem. Park (2005, 2007) highlighted in particular the importance of religiosity/spirituality as a meaning system and frame of reference, while Dörr (2001) viewed also alternative value orientations (e.g., humility, abstinence, social engagement) as a salutary

resource of religiosity/spirituality. Among others, Oman and Thoresen (2005) further included the concept of religious coping in the list of possible pathways. Finally, Koenig, McCullough, and Larson (2001) distinguished factors on an individual level (such as self-esteem or meaning-making) and social resources (such as religious communities) from coping strategies which directly try to improve one's health. Additionally, their model includes the occurrence of critical life events and predispositions.

One of the most important questions in the psychology of religion is how religious practices relate to mental health. Psychological theories have sometimes assumed that religion is a regressive or delusionary phenomenon (e.g., Ellis, 1985: Freud, 1927), while others have construed it as a positive striving often conducive to psychological integration (Fowler, 1981; James, 1958; Jung, 1960). The study of religious orientation has suggested that religiosity per se cannot be meaningfully related to psychological health or pathology without considering how a person is religious. Bergin (1991), reviewing the literature, concluded that, in general, there is "no correlation between religion and mental health" (p. 399). However, he also suggested that overall null relationship is a function of the fact that divergent orientations to the religion are differentially correlated with psychological outcomes. For example, in a study of Mormon students, Bergin, Masters, and Richards (1987) found Allport and Ross's (1967) intrinsic religious orientation to be positively associated with a number of indices of mental health, whereas extrinsic religious orientation, when related to such variables, tended to be negatively correlated. Such research underscores the point that religiosity is multidimensional and that different ways of being religious have different consequences.

In large part, specific religious beliefs are maintained through cultural transmission, in that they have continuity only through being passed on to new generation, the individual members of which must in turn adopt the transmitted beliefs and practices as their own. Put differently, religions must be internalized by cultural members both to survive and to provide any functional value to adherents.

Internalization refers to the process which an individual transforms a formally externally prescribed regulation or value into an internal one. In internalization, one "takes on" the value or regulation as one's own. Numerous theories, from psychoanalytic (e.g. Schafer, 1968) to social psychologists (e.g. Kelman, 1958; Perry, 1970) to sociological (Berger, 1969; Parsons, 1951) have emphasized the importance of internalization process for the transmission and stability of culture. Different styles of internalization are nowhere more evident than in the case of religious beliefs and practices. Religious beliefs can be rigidly and unreflectively adopted or can be flexible, leaving open to the consideration and assimilation of open ideas (Fromm, 1950). In addition, religious systems can be adopted because of fear, guilt, or social pressure or because of their compelling contents and meanings. Thus, the manner in which the religious beliefs are internalized may vary considerably, and functional impacts of religion may differ accordingly.

Ryan, Rigby, and King (1993) postulated two types of religious internalization, which they labeled as introjection and identification, based on self determination theory. Deci and Ryan, (1985, 1991) argued that the process of internalization reflects people's intrinsic tendencies to assimilate and integrate external regulations into more self-determined ones and to move away from heteronomy toward autonomy when possible. According to this model, the more fully internalized a regulation, the more the behaviors it entails are characterized by an internal perceived locus of causality (deCharms, 1968; Deci and Ryan, 1985), that is, the more one experiences behavior as volitional or self-determined. An external regulation that has been assimilated to the self in the form of identification is therefore likely to be experienced as a personal value and as something one carries out autonomously (Ryan, 1991, 1993). Put differently, regulations or beliefs associated with identification are those that the individual feels are personally chosen and valued. However, a regulation can also be internalized in form of introjection. In introjected regulation behaviors are performed because one "should" do them, or because not doing so might engender anxiety, guilt, or loss of esteem. Thus even though internalized, introjected styles of regulation connote considerably less experience of volition and a greater sense of internal pressure and conflict than those more fully assimilated to the self. Deci and Ryan (1985) have described introjection as an internally controlling state in which affective and self-esteem contingencies are applied to enforce or motivate an adopted value or set of actions.

The theoretical framework of Deci and Ryan (1985) was used by O'Connor and Vallerand (1990) to assess a continuum of internalization with regard to religious practices in an elderly population. Their findings revealed that less self-determined styles of internalization were positively associated with depression and negatively associated with life satisfaction, self-esteem, and sense of meaning of life, whereas the opposite pattern was found for internalization styles characterized by greater self-determination.

In line with self-determination theory it might be expected that introjection versus identification with respect to the religion will be differentially associated with well-being and mental health. Deci and Ryan argued (1985) that introjection, in which there is only a partial assimilation of beliefs or behavioral prescriptions, is an internally controlling system of regulation characterized by experiences of conflict and pressure. It thus should be associated with a number of negative psychological outcomes, including self-esteem vulnerabilities (Ryan, 1982), anxiety (Ryan and Connell, 1989), and Lack of self-cohesion and integration (Deci and Ryan, 1991; Ryan, 1991, 1993). Identification on the other hand should conduce toward greater identity stability, self-esteem, and a relative absence of mental health difficulties. Although these theoretical predictions have been widely explicated, they still need to be empirically examined. The study of religious internalization is very important, because religion is both a central value and one that appears to be functionally implicated in the studies of mental health. Accordingly, it was expected that the two types of internalization to show divergent and largely opposing relations to mental health, with identification associated with more positive and introjections with more negative outcomes.

Since most of the studied reviewed are conducted on followers of Christian religion where the congregational religious practices are held mostly once in a week. Daily religious congregations are rarely held in Christianity. But in Islam performing religious practices are very frequent. In Islam it is obligatory for its followers to offer *salah* (prayer) collectively five times daily in an organized manner. For this purpose, believers of Islam gather in the mosque five times each day and offer their prayer in congregation under a religious head called Imam. The timings of these prayers are spaced fairly evenly throughout the day, so that one is constantly reminded of God and given opportunities to seek His guidance and forgiveness. Collective prayers are offered at the following times:

Fajr (pre-dawn): This prayer starts off the day with the remembrance of God; it is performed before sunrise.

Dhuhr (noon): After the day's work has begun, one breaks shortly after noon to again remember God and seek His guidance.

'Asr (afternoon): In the late afternoon, people are usually busy wrapping up the day's work, getting kids home from school, etc. It is an important time to take a few minutes to remember God and the greater meaning of their lives.

Maghrib (sunset): Just after the sun goes down, Muslims remember God again as the day begins to come to a close.

'Isha (evening): Before retiring for the night, Muslims again take time to remember God's presence, guidance, mercy, and forgiveness.

In Muslim communities, people are reminded of the daily prayer times through the calling of the *adhan*. In order to offer the prayer, it is obligatory to make sure that the body and place of prayer are clean. The prayer is offered in the following manner:

First of all, they make the intention to perform their obligatory prayer and raise hands up and say "Allahu Akbar" (God is Most Great) and then folded their hand over chest, they recite the first chapter of the Qur'an in Arabic. Then recite any other verses of the Qur'an that they would like. Now they raise hands up, saying "Allahu Akbar." Bow, reciting three times, "Subhana rabbiyal adheem" (Glory be to my Lord Almighty). After completing it they rise to standing while reciting "Sam'i Allahu liman hamidah, Rabbana wa lakal hamd" (God hears those who call upon Him; Our Lord, praise be to You). After reciting it, saying "Allahu Akbar." they prostrate on the ground, reciting three times "Subhana Rabbiyal A'ala" (Glory be to my Lord, the Most High). After doing this they rise to a sitting position, saying "Allahu Akbar." Prostrate again in the same manner. Then they rise to a standing position, saying "Allahu Akbar." This concludes one "rak'a" (cycle or unit of prayer). Folding their hands over chest, the second rak'a is completed in the same manner as that of first rak'a. After completing two rak'as, one remains sitting after the prostrations and recites the first part of the Tashahhud in Arabic. If the prayer is to be longer than these two rak'as, one now stands up and begins again to complete the prayer, sitting again after all rak'as have been completed. Recite the second part of the Tashahhud in Arabic. Turn

to the right and say "Assalamu alaikum wa rahmatullah" (Peace be upon you and God's blessings). Turn to the left and repeat the greeting. Concentration and meditation are two essential elements of salah. Believers are required to concentrate their attention only on Almighty. Besides the concentration and meditation, praying during the salah requires to stand straight, to bend, to prostrate, and to sit keeping the left hip on the folded left leg, and to turn the head in the right and left side to ninety degree angles.

Methods

Sample

Initially 160 young male subjects belonging to Muslim Community who were regular in offering the prayers five times daily were selected and Muslim Religious Internalization Scale (MRIS) was administered in order to identify the subjects whose religious internalization is based on identification and the subjects whose religious internalization is based on introjection. On the basis of the scores on MRIS 24 subjects were identified as introjection internalized and 26 subjects were identified as identification internalized. Thus a final sample of the study consisted of 50 subjects.

Tools

Spirituality Questionnaire developed by Nasrin Parsian and Trisha Dunning (2009) was used to measure spirituality. The questionnaire consists of 29 items and covering four factors: self-awareness, the importance of spiritual beliefs, spiritual practices, and spiritual needs. The specific validation processes used were: content and face validity, construct validity using factor analysis, reliability and internal consistency using test-retest reliability and Cronbach's alpha correlation coefficient. The items on the Spirituality Questionnaire (SQ) revealed factor loading = 0.5. Reliability processes indicated that the SQ is reliable: Cronbach's alpha 0.94 for the global SQ and between 0.80 0.91 for the four subscales. Test-retest statistic examination revealed stability of the responses at two time points 10 weeks apart.

Muslim Religious Internalization Scale: The Muslim Religious Internalization Scale (MRIS) is a 10 items measure designed to assess the degree of self-determination for Muslim beliefs and practices. The scale has a format adapted from a similar scale developed by Ryan, Rigby, and King (1993) for measuring degree of self-determination for Christian beliefs and practices. Respondents indicate the degree to which various motives will be salient to them if they were to perform a religious behavior. Responses are made on a 4-point scale (1= not at all true and 4= true at all). Sample items on this scale include "Pray because I find it satisfying" (identified item) and "Pray to God because God will disapprove if I didn't" (introjected item).

General Health Questionnaire (GHQ): The GHQ developed by Goldberg and Hillier (1979) is a 4-point Likert type scale consisting of 28 items. The scale contains four 7-item subscales; somatic symptoms, anxiety, depression, and social dysfunction. Concurrent validity for GHQ subscales has been established through their significant associations with independent psychiatric assessments using the clinical interview schedule.

Results

The mean scores on Spirituality Questionnaire of two groups of subjects were obtained and t-values were calculated in order to find out the significance of difference between their means.

As evident from the above table that the mean spirituality score of subjects whose religious internalization was based on introjection and were participating in religious prayers regularly five times a day was 73.47 and the mean spirituality score of subjects who were also regular in the participation of religious prayers but their religious internalization was taken place on identification was 89.56. The difference between the two means was significant beyond 0.01 level of confidence ($t = 2.23$; <0.05).

Table 1

Mean SD and t-value for spirituality scores of identification and introjection groups.

Groups	N	M	SD	t-value
Introjection	24	73.47	13.82	3.97**
Identification	26	89.56	14.23	
**p<0.01				

Table 2

Mean SD and t-value of identification and introjection groups on general health questionnaire.

Measures	Introjection			Identification			t-values
	N	M	SD	N	M	SD	
Somatic symptoms	24	11.36	3.07	26	9.53	2.74	2.23*
Anxiety	24	10.86	2.58	26	8.37	2.12	3.56**
Depression	24	15.92	4.21	26	12.64	4.02	2.80**
Social dysfunction	24	14.34	5.10	26	11.08	4.19	2.43*

*p<0.05 **p<0.01

On the basis of scores obtained on the scale, 24 subjects were identified as having the religious internalization based on introjection, and 26 subjects as having religious internalization based on identification. All the selected subjects were contacted individually and their responses were taken on Spirituality Questionnaire and General Health Questionnaire.

As evident from the above table that the mean score on somatic symptoms dimension of GHQ of subjects whose religious internalization was based on introjection and were participating in religious prayers regularly five times a day was 11.36 and the mean score on somatic symptoms dimension of GHQ of subjects who were also regular in the participation of religious prayers but their religious internalization was taken place on identification was 9.53. The difference between the two means was significant beyond 0.05 level of confidence (t = 2.23; <0.05).

It may also be inferred from the above table that the mean depression score of subjects of introjections internalization was 15.92 and the mean depression score of subjects of identification internalization was 12.64. The difference between the two means was significant at 0.01 level of confidence (t = 2.80; <0.01).

Similarly, the mean score on social dysfunction dimension of GHQ of subjects of introjection internalization was 14.34 and the mean score on social dysfunction dimension of GHQ of subjects of identification internalization was 11.08. The difference between the two means was significant beyond 0.05 level of confidence (t = 2.43; <0.05).

Discussion

Result presented in table-1 reveals the significant difference between subjects who internalized religious faith and practices on identification basis and subjects who internalizes religious faith and practices on introjection basis on spirituality. The higher mean score of identification internalized subjects in comparison to introjection internalized subjects suggests that religion and spirituality does not oppose to each other, it depends on the fact that how does a person internalize his religious faith and practices. If a person internalizes his religious faith and practices because he finds it enjoying and satisfying rather than internalizing the religion because if he does not perform

religious practices God as well as other people will disapprove of him, his religion and spirituality do not contradict or oppose each other rather hey can complement each other, in the search for inner peace.

Religion can be seen as a pathway that leads to God. The pathway is not God, but in the best and highest intentions it would lead people closer to God. All true religious paths and teachings came into existence through divine inspiration and revelation, the spark of God's love and light that opens a pathway for God's presence to be seen and felt more directly. Spirituality is a more general term that includes religion but that also encompasses the general human impulse to reach out towards the greater whole of which we all are a part. The difference between religion and spirituality is simply that most religions offer a specific set of beliefs and structures to help people to attune to their innate spirituality. In fact, many characteristics that are common to religiousness may also be found in spirituality (Jones, 2004; Idler, 2003). In addition, other social researchers espoused that a search for the sacred can be deemed as the common ground between religion and spirituality (Gall & Grant, 2005; Idler et al., 2003; Koenig et al., 2001; Muller et al., 2001). Hence, spirituality and religion have been often used interchangeably in prior research and less is known about spirituality outside the context of religion. It is apparent that at its core spirituality is related to all the value orientations, beliefs, actions and behaviors or activities by which adherents attempt to link their lives to God, the Divinity, or a higher power.

The result shown in the table-2 reveals that people having the religious internalization on introjection basis and were regular in performing the religious prayers five times a day exhibited significantly more somatic symptoms as compared to those people who were also regular in the participation of the religious prayers but their religious internalization was based on identification. Similarly, the results presented in the same table also reveal that the people of introjection internalization experienced greater amount of anxiety in comparison to people having introjection identification. In the same manner the t-value for the difference between the mean depression score of people having the introjection internalization and attending the prayers regularly and the mean depression score of people having identification internalization and also appearing in such prayers was statistically significant at 0.01 level of confidence. The mean depression score of introjection internalization subjects was greater than the subjects of identification internalization. It should be noted that both groups of subjects were similar in so far as their participation in religious prayers is concerned but they differ in their religious internalization. Similarly, the results presented in the same table also reveal that the people of introjection internalization experienced greater amount of social dysfunction in comparison to people having introjection identification. The mean somatic symptoms, anxiety, depression and social dysfunction scores of introjection internalization subjects were greater than the subjects of identification internalization. Thus the types of religious internalization emerged as a factor which determines that whether the participation in religious prayers will cause to enhance the physical and mental health. The religious practices will be more effective for spending a healthy life free from physical and mental illness for those people whose religious internalization is done on the basis of identification.

Internalization refers to the process by which cultural beliefs and practices are adopted by the individual and then enacted in the absence on immediate external contingencies or constraints (Ryan, Connell, and Deci, 1985). Two types of internalization were derived from self-determination theory (Deci and Ryan, 1985; Ryan, 1993), which describes internalization in terms of an underlying continuum of autonomy. In this conception introjection represents a form of internalization in which beliefs and practices are maintained through contingent self-approval, guilt, and esteem related anxieties. As a result, introjection is theorized to be associated with conflict and pressure. Identification represents a form of internalization, in which there is a more internal perceived locus of causality (deCharms, 1968) or sense of volition with regard to the adopted practices and beliefs. In identification, the individual experiences more personal value for the activities and see them as emanating from himself or herself to

a greater extent than in introjection. This pattern of the findings supports the arguments of Bergin (1991), who suggested that religiosity per se is unrelated to psychological well-being but the different types of religiosity can either facilitate or inhibit mental health. So it can be concluded that if one is religious, it matters how one in religious.

Introjection and identification were systematically related to the other measures of religious orientation, namely those of Allport and Ross (1967) and Batson and Ventis (1982). Ryan, Rigby, and King (1993) provided evidence that identification was closely associated with Allport and Ross's dimension of intrinsic religiosity and with what Batson and Ventis called the Religion as an End orientation. Introjection was moderately related to extrinsic religiosity and religion as a Means. In their study, these two forms of internalization were also found to be linked with mental health and well-being. Identification was tended to be positively associated with psychological adjustment, whereas introjection related negatively to these factors.

If the religious identification of a person is done on the basis identification and if the person is engaged in performing the religious practices, the religious practices facilitates his/her physical and mental health. Devotional activities such as prayer may be experienced as direct communication to the Divine, and may be practiced as part of an ongoing dialogue or relationship with God. Believers seek to engage God regularly through prayer for insight, guidance and solace. Moreover, prayer and other religious practices may assist individuals in cultivating a spiritual narrative and meaning system, via which may gain a sense of coherence and orderliness (Idler and George, 1998). Religious frameworks may be helpful for individuals in interpreting and assigning significance of the events of their lives - daily affairs, personal challenges, and major traumas alike (Pargament, Smith, Koenig, and Perez, 1998, 2000). Further, these religious practices may involve (indeed, may require) establishing routine of discipline, e.g. setting aside regular times of the day and night for prayer and recitation of Qur'an. In pursuing these activities, believers may seek quiet solitude, without distractions, and they may experience states of physiological and mental calm. These factors may also contribute to enhance their physical and mental health. In addition to this, through prayer (perhaps augmented by recitation of Qur'anic verses or other devotional acts) individual may perceive that they enjoy a unique relationship with the most powerful Entity of the universe, who loves and cares for them and intervenes directly in their lives. This perspective may confer to spend a healthy life.

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