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The Relationship between Religious Orientation with The Focus of Chastity and Hijab and Women's Mental Health

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Abstract

Mental health is one of the indicators of developing countries and is one of the aspects of the overall concept of health and religious beliefs are one of the factors affecting mental health. Despite this internal and external religious orientation, it can have different effects on people's lives. Therefore, the purpose of this study was to determine the correlation between religious orientation and mental health of women referring to mental health unit of Mashhad Health Center. The present study was a descriptive study which was done by correlation method. The statistical population of this study included all women referred to the mental health unit of Samen Health Center in Mashhad in 1395, 180 subjects were selected as the sample. A random method was used to select the sample size. Data collection was done by standard General Health Questionnaire and Allport religious orientation. Data were analyzed by Pearson correlation test using SPSS software. Based on the findings, there is a positive correlation between the external religious orientation and mental health components (P = 1) and between the religious orientation and the mental health components (P = 1). This means that women surveyed in this study have a better general health with internal religious orientation. Regarding the effect of religious orientation on the quality of mental health in individuals, it seems that in developing programs for the promotion and promotion of religious and religious culture and paved the way for a spiritual and healthy society, one can emphasize the spiritual aspects of religion.

Keywords: Religious Orientation, Mental Health, Chastity and Veil

Introduction:

The role of religion in relation to health and healing has been known since the ages. Over the course of thousands of years, religion and medicine have been partners in treating and reducing human suffering (suchman, 1999). One of the pillars of health assessment in different societies is the mental health of that community, and mental health is considered by the World Health Organization as one of the basic principles of mental health (Ehsanmanesh, 2000). The mental health of generations of the community depends on securing the mental health of the family as a hotbed of affection and tranquility for the development of talent, that any damage to it will not protect the future generation from its own work and will bring many social organizations He will engage himself (Samadi, 1395).

In this context, women play a major role as the central core of the family, as lack of mental health as well as mood disorders can affect all family members and their mental health. Women's awareness of the consequences of chastity and veil and its role in maintaining security and mental health as well as physical security is very important because women with a pedagogical role in the family will translate religious beliefs and beliefs into the next generation.

Chastity in the word means to refrain from what is not lawful. Hijab means curtains. God says in the Qur'an that women should wear their adornments and headdresses. "But I want to admire Ali Giobhan". Khmer means scarf and pocket means roundabout. The effects and consequences of veil contain two individual and social components. In the individual, it includes respect for the personality of the woman, spirituality of communication, preservation of chastity and prevention of corruption, and in the social type includes the health of the new generation of society, prevention of moral corruption and the maintenance of the same society (Motahari, 76). Other consequences of the veil and The chastity of calm and maintaining the mental health of women.

According to the World Organization reports, out of every four people, 1 person suffers from one or more mental disorders during their life (samadi, 2016). Mental health is one of the most important components of a healthy life, with countless factors involved in its proper or unhealthy formulation. This concept seeks to diminish negative feelings such as anxiety, depression and despair and prevent symptoms from occurring in people (Sadock, 2007).

The World Health Organization has three dimensions of health, namely physical, psychological, and social health, all of which are necessary and necessary for each other. In this definition, mental health is the ability to communicate in a coordinated manner with others, to modify the individual and social environment and to solve conflicts and personal preferences fairly and appropriately (Mirkohi, 2010). In other words, mental health refers to the sense of goodness and the assurance of self-efficacy, self-reliance, competitive capacity, intergenerational membership, and self-actualization of potential intellectual, emotional and other potential abilities (Haddadi, 2007).

The other concept discussed in this study is the religious orientation component. According to Allport and Ross (1967), religious orientation means tendency to perform religious practices and thoughts. Historically, scientifically, for the first time, Allport divided religious orientation into two internal and external trends. The religious orientation is internal, comprehensive, and has internal and internal principles, while external religious orientation is an external and instrumental tool that is used to satisfy

individual needs such as authority and security. The purpose of Alport's intrinsic religious orientation is to provide a comprehensive motivational commitment that is ultimate goal and not a means to achieve individual goals. In other words, internal religious orientation can be considered to be religious or religious (Allport, 1967).

From the perspective of Allport, individuals with an inner orientation include those who reflect their religious beliefs at all times of life and in all their behaviors and deeds. While individuals with external religious orientation who have a more unformed form of religious beliefs and beliefs, prefer their own personal interests and put their religious beliefs at the forefront of their desires (Maltby, 2003).

Regarding the effect of religious orientation on mental health status, there have been some studies in this regard, including Maltby and Dee, who in a study showed that internal religious orientation has a positive relationship with mental health and external religious orientation has a relationship Negative is mental health (Maltby, 2003). Also, Dezter, Sennanese and Hatzbot found that internal and external orientation had a significant relationship with mental health and explained higher and lower levels of well-being and mental health (Dezutter, 2006).

In a futuristic study, the role of religion and spirituality on the symptoms of depression in adolescent teenagers with mental disorders was identified. Losing faith and religious beliefs after 6 months results in no improvement in depressive symptoms. In some of these studies It has been reported that those with a higher religious orientation and participating in religious activities suffer from less depression (Koeng, 1997) (Parker, 2003).

A research on the factors affecting anxiety in 760 urban women revealed that the Catholic women's scores in anxiety were significantly higher than others (Shreve, 2004). A study in Brazil also found that there is a relationship between psychoactive reactions and prolonged hospitalization with religious affiliation (Dalgulaooindo, 1999).

Many studies show that religious principles have a meaningful relationship with the physical and mental health of individuals (Alves, 2010). In another study, a group of subjects who used prayer and prayer had better physical performance than the control group and had better performance in solving their problems (Palmar, 2004). Saber Studies in Iran also showed a positive effect of religious orientation on the mental health of individuals (Baniyy, 2008; Kojibf, 2008). Considering the researches carried out in this field as well as the need of the women's society to observe the consequences of chastity and veil and the effect of religious orientation on women's mental health, the present study aims to investigate the relationship between religious orientation with a focus on chastity and veil and mental health. Women referring to the mental health unit of Samen Health Center in Mashhad.

Research method:

The present study was descriptive and correlational. The statistical population of this study included all the women referred to the mental health unit of Samen Health Center in Mashhad. The number of samples in this study is based on the Georgian table. Morgan was estimated to be 180. The criteria for entry and exit of the study are to have at least a cycle of evidence and above, lack of serious medical and

psychiatric disorder, and willingness and willingness of the participants to participate in the research. Also, due to the relationship between age development with increasing beliefs and religious beliefs as an interventional factor in the study, participants aged between 18 and 45 years old were used.

The data gathering tool in this study included two parts: religious orientation questionnaire and mental health questionnaire. A religious orientation questionnaire was developed by Allport in 20 articles with a five-item accountability scale (from "very low" to "very high"), of which 11 were related to the external orientation and 9 materials related to the inner orientation (Alpirt, 1967). According to the Allport study, the correlation between internal religious orientation materials and external religious orientation materials was estimated at 21 hundredths (Nasabe, 2005).

In a number of other studies, the correlation between internal and external religious orientation was estimated at 20 hundredths (Donahue, 1985). The validity of the questionnaire has been reported by Mokhtari et al. Using the alpha of Cronbach's 71-hundredth degree (Mokhtar, 2001). To assess the general health of women referred to the mental health unit, the general health questionnaire provided by Goldberg, which had 28 questions (Goldberg, 1979), was used. Each question based on Likert scale has four options from 0 to 3 grades It has 4 scales and each scale has 7 questions.

These scales include: 1. Physical symptoms; 2. Signs of anxiety and sleep disturbances; 3. Disorders of social functioning; 4. Depression. Grades from 84-0 were based on quadratic scores of excellent, good, moderate and poorly ranked (0-21), excellent (22-42), medium (64-43) and 64 Upper, poorly categorized. Chan reported the internal consistency of this questionnaire using the Cronbach's alpha of 93 hundredth (Chan, 1985) and in the study of Keys, the alpha coefficient of this questionnaire was 93 hundredth (Keyes, 1989).

Noorbala et al. Obtained the sensitivity and specificity of this questionnaire at its best cutting point, respectively, 97.3 and 70.5 (Noorbala, 2009). The reliability of this questionnaire was tested in two ways The Cronbach's alpha, respectively, was 93.7 and 90.10, respectively (Taghavi, 2002). Correlation coefficient for questionnaire of religious orientation was 74 hundredth and general health questionnaire was 76 hundred. Then, the score of people in both instruments was calculated. For statistical analysis of the collected data, descriptive statistics and then Pearson correlation coefficient were used. Then all stages were calculated by SPSS software.

Findings:

Table 1: Mean and standard deviation for dimensions Religious orientation

Standard deviation	Average	Variable
7/41	**27/71**	Internal religious orientation
6/84	**34/72**	The external religious orientation

Table 2: Mean and standard deviation of mental health components

Standard deviation	Average	ئد Average Variable
4/52	**6/47**	Physical signs
5/35	**7/35**	Anxiety and sleep disturbance
4/29	**12/30**	Disruption of social function
5/17	**8/62**	Depression
13/12	**34/47**	Mental healtl

Table 3: Correlation coefficient of orientation Religious with mental health

Significance level	The correlation coefficient	variable
1 thousandth	**-**473 thousandth	Internal religious orientation
1 thousandth	395 thousandth	External religious orientation

In Table 1 and 2, the mean and standard deviation of the variables of religious orientation and mental health and their components are included. As it can be seen, there is a negative and significant correlation between internal religious orientation scores and mental health (P = 1.000, r = 437,000). But the correlation between external religious orientation and mental health is positive and significant (P = 1.000, r = 395). In this way, women with an internal religious orientation have a better mental health than women with external religious orientation. (Table 3).

Discussion and conclusion:

The findings of the study indicated a significant correlation between religious orientation and mental health in women referred to the mental health unit. Thus, the internal religious orientation is associated with a more favorable mental health status in women and in contrast to the external religious orientation, there is a lower level of psychological quality. This finding is in line with the results of the Nowruz and Gholami studies, Maltibi and Dei (Maltby, 2003) (Expression, 2008).

Nowrooz and Gholami, in studying the relationship between religious orientation and mental health of students, concluded that there is a positive relationship between internal religious orientation and mental health, and external religious orientation has a negative relationship with Mental health is in the students (Nozari, 2010). Maltby and Dee in their numerous studies confirmed that external orientation has a positive relationship with neuroticism and internal orientation, which has a negative relationship with psychosis. Therefore, the religious orientation of individuals is more intrinsic, they are more likely to have better mental health (Parker, 2003, Maltby, 2004).

To better understand the findings, we look at the nature of the religious orientation dimensions from the perspective of Allport and Ross. Researchers believe that individuals whose religious activities are externally uses religion as a tool for personal and social purposes, selfish approach, and a tool that brings benefits to the individual. These people may come to see others by increasing their credibility in society or meeting the expectations of the community in religious ceremonies. In contrast to the inner orientation, regardless of the social interest that one can achieve for a person, it is a style of religion to gain a sense of meaning and purpose. Without taking into account the social benefits that it derives from religion. According to Allport, only internal orientation is positively related to mental health (Alport, 1967).

Since our society has an Islamic Iranian culture and our values and traditions have a close relationship with religious variables, religious beliefs and their orientation have a significant impact on mental health and Quality of life. Because the foundations of our personality and ethical values are shaped by the religious community and many of our moral needs and desires are rooted in our religious and religious teachings (Hobby, 2005). On the other hand, this close relationship, if not explicitly interpreted and interpreted, the religious variable and its orientation can have a destructive role in women's mental health. Therefore, the findings of this research can be the source of many of our problems regarding the quality of women's religiosity and their mental health status. Because spirituality and religiosity are and will be part of the historical heritage of mankind, man has always been able to find a way in the crisis of his life so that he can look for a place of hope against the difficulties and difficulties of life (Tan siang, 2001).

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