

RELIGIOSITY, PARANORMAL BELIEFS, AND PSYCHOPATHOLOGICAL SYMPTOMS IN TWO ETHNIC SAMPLES

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ABSTRACT

This study was carried out to determine the influence of religiosity and paranormal beliefs on the development of psychopathological symptoms among groups of people from two different ethnic origin. A survey research was adopted using a purposive sampling method to draw the sample from Igbo and Yoruba ethnic groups. The sample consisted of two hundred and four respondents with the age range of 14 and 65 years. 101 were females and 103 were males; 6 traditional, 66 Islamic and 132 Christian religious adherents. 98 Igbo and 106 Yoruba all with minimum educational qualification of Junior Secondary School Certificate responded to Religious Affiliation Scale (Omoluabi, 1995) Revised Paranormal Belief Scale (Tobacyk, 1988) and General Health Questionnaire (Goldberg, 1978). Analysis of Variance, Independent t-test, and Multiple Regression were used to analyse the data and results indicated that paranormal beliefs significantly influenced only anxiety dimension of psychopathology but do not influence other dimension. No significant effect of religiosity was discovered on any dimension of psychopathology. There was a significant difference between Igbo and Yoruba on Paranormal Beliefs, depression and anxiety dimensions of psychopathology but no significant difference was discovered on religiosity. It was concluded that paranormal beliefs partially influence psychopathology but religious beliefs do not have any influence on psychopathology in this study.

Keywords: Religiosity, Paranormal, Beliefs, Psychopathology.

Contribution/ Originality

It originates new formula which stipulates that therapeutic attempt on health should consider the beliefs and norms of the people since these variables are interwoven.

1. INTRODUCTION

Paranormal beliefs are phenomena that are associated with myths and rituals and those unusual events which people perceive to go contrary to the laws and principles of science

(Tobacyk, 1988). Paranormal also refers to hypothesized process that in principle are physically impossible or outside the realm of human capabilities (Thalbourne, 1994). Events such as witchcraft, spiritualism, precognition, PSI and traditional religion are classified under paranormal. By paranormal beliefs, people tend to search for desires to find logical meaning to some chaotic ways. If they are suddenly aware of a distant event they should not neglect, it might be credited to psychic powers of clairvoyance and many others.

Paranormal beliefs is most often assumed to be associated with the consequences of religious dogma whereby the individual concerned becomes rigidly sensitive to the religious principle of which he becomes absolutely affiliated. Such individual tends to see the world only and exclusively in line with his religious philosophy. Since most religions outline certain principles as laws that must not be violated (such as abuse of sacred objects, blaspheming the sacred names, disregard for the injunctions of the leaders and many others with the consequences of punishment due to sins committed), it is assumed that the violation of sacred order is capable of inflicting mental illness on the sinner.

The common elements in African belief system is that physical and mental illness is the consequence of distortions or disturbance in the harmony between an individual and the cosmos, which may mean his family, religion, society, ancestors, peers, or a deity. Africans perceive ill-health to have material, moral and supernatural causes which can only be determined both by physical observation and divination (Ezeabasili, 1977). Also, Pearce (1989) argued that it is too simplistic to see diseases as something physical, which attacks the body. According to him, disease causation can be due to things we see and things we do not see. Many of the things we do not see and which can therefore not be scientifically explained (called paranormal beliefs) are included in African belief systems.

African belief systems recognized the links between conflict/stress and breakdown in indigenous theories of causation which Nzewi (1989) has documented as good/moral behavior and social harmony in the etiology of health among the Igbo of Nigeria. Also, African society, including Yoruba and Igbo in Nigeria, and others around the continent belief that disruptive behavior, blaspheming and sacrilege, as well as breaking of taboos are punishable through misfortune and ill-health.

Religiosity or religious belief refers to a mental state in which faith is placed in a creed related to the supernatural, sacred or divine. Such a state may relate to the existence, characteristics, and worship of a deity or deities, divine intervention in the universe, and a human life, or values and practices centered on the teaching of a spiritual leader. In contrast to other belief systems, religious beliefs are usually codified. While the term religious beliefs are often considered to have the same meaning as religiosity, religiosity usually deals with both ideas and practices whereas religious belief can be seen as focusing exclusively on ideas.

In examining religious beliefs, Spirituality, which deals in a matter of the spirit is usually considered a part of religion, and can be distinguished from religion. The practitioners and

believers in a religion are known as religious adherents who often distinguish belief from superstition.

Both superstition and traditional religions are believed to be non-materialistic, that is, do not see the world as being subject to laws of cause and effect and presume that there are immaterial forces influencing the lives of human beings. Religion involves rituals at a particular period of the year with an intention to purify the lives of the adherent and also attract miraculous benefits (Murdock *et al.*, 1971).

The development of psychopathological events have been traced to various religious orientation most especially in Nigeria, where abnormal behaviors were usually attributed to supernatural causes, such as, evil spirits, witchcraft, blasphemy, offending sacred or spiritual forces and many others. The treatment of these, usually include special religious practices in form of praying, fasting, cleaning with holy water and anointed with oil.

Sometimes the burning of incense was used in churches while Alfas of the Islamic religion also treated patients by writing extracts of the Holy Qur'an on a slate with washable ink which the patient is made to drink as a therapy Lee and David (1990). It is imperative to investigate the extent to which the violation of these religious tenets are capable of eliciting symptoms of psychopathology in an individual who are strongly affiliated to them.

Many previous studies have tried to investigate paranormal phenomena in relation to religion and personality Chris and Tim (2005). Attempts were made to identify the relationship between specific dimensions of paranormal such as spiritualism, supernatural or extra-ordinary life forms and many other variables like personality and religion. Unfortunately some of the previous research in this area have been plagued by several methodological problems including semantic ambiguity regarding the dimensions of paranormal belief, imprecise operational definition that blur the constructs of belief and experience, and measurement inconsistencies of the construct themselves (French, 1992; Irwin, 1993).

None, however, have investigated the variables in relation with psychopathological symptoms. This study intends to fill this gap by investigating two different ethnic groups with regard to their religious orientation, paranormal occurrences and possible consequences on their mental health.

Studies that tried to correlate religion to paranormal beliefs ended with varied results. For instance, one study concluded that there is a strong chance that belief in the paranormal is a substitute for religious beliefs and that both religious belief and paranormal belief serve to lower dead anxiety (Persinger and Makarec, 1990).

Other researchers found that paranormal belief was commonly not associated to religiosity and that there were some events and specific beliefs such as Extra Sensory Perception (E.S.P) and astrology that had a minor opposite relationship with religiosity. The study concluded that belief in the paranormal may substitute for traditional religious beliefs. However, traditional religion is in decline among secular countries, the psychological underpinnings of the secularization thesis

are debatable. Orthogonal research on paranormal belief finds that people in secular society maintain a variety of paranormal beliefs and that these are found among those who adhere to classical religious faith and those who do not (Irwin, 1997; Aarnio and Lindeman, 2007).

It was also discovered that the practice of religion appears to be associated with greater trust for religious cohorts: people who participate in religious communities are often entrusted by fellow members of the community (Berggren and Bjornskov, 2011; Maselko *et al.*, 2011; Todd and Allen, 2011). Other studies also found that religious people appear to experience higher levels of social belonging (Sibley and Bulbulia, 2012b).

This is supportive of what a French sociologist Emile Durkheim 1897 observed in more than a century ago that the transition to industrial life, which produced the demographic shift to urbanization, concurrently increased feelings of isolation and alienation, a condition that Durkheim called *anomie*. Durkheim guessed that strong religious community buffers their members against anomie. Other studies have also supported Durkheim postulation when it was discovered that religious practice was associated with strong social ties, which predict overall higher levels of personal well-being (Koeig *et al.*, 1997; Salsman *et al.*, 2005).

The objective of this study is to explore how Africans attribute and perceive etiological factors of illness based on their paranormal beliefs and religious orientation. According to American Psychiatric Association (1994) much attention was paid to the relationship that exists between paranormal belief and psychopathology, and in particular 'magical thinking' (as seen among the defined symptoms of some psychiatric disorders like schizotypal personality disorder in the DSM-IV).

It was found that those who score highest on magical thinking showed a predisposition to psychosis (Eckblad and Chapman, 1983). One of the past researches also showed correlation between paranormal and religious beliefs: Tobacyk and Milford (1983) found traditional religious beliefs to correlate positively with belief in witchcraft and precognition, but negatively with belief in spiritualism and non-significantly with belief in PSI, superstition and extra ordinary life-forms. Clarke (1991) found slightly different result-with religiosity correlating positively with belief in psychic healing and negatively with Unidentified Flying Object (UFO) belief.

However, whether religiosity and paranormal beliefs have similar or varied attributes, both are part of the beliefs system of many people in various culture. It is obvious that both share common perception of what seems to be extra-ordinary (i.e. having paranormal and spiritual essence) and which seems to be capable of influencing the behavior of individuals concerned. Therefore, the extent to which these attributes of paranormal and religious beliefs are capable of eliciting symptoms of psychopathology is what this study tries to unravel. This study intend to: empirically investigate whether people of different cultural origin will differ in their susceptibility to psychopathological symptoms as the consequence of their religious affiliation and paranormal tendencies. It also tries to determine whether individual that score high in religiosity and

paranormal belief scale will also score high in psychopathological scale as well as whether those who score low in religious belief and paranormal will score low in psychopathology scale.

Result of these would enable social psychologist, psychologist, psychotherapist, psychiatrist, and other related agents of mental health consider the ethnic differences and religious orientation of clients when designing any therapeutic programs.

2. METHODS

Participants: 300 participants were sampled out of which 204 responded fully to the instruments. They comprise of the Igbo and Yoruba ethnic groups resident in Ado-Ekiti, the capital city of Ekiti State, Nigeria. They were 101 females and 103 males between the ages of 14 to 65 years. The anonymity of the respondents were adequately protected. They had minimum educational qualification of Junior Secondary School, are literate enough to comprehend the instrument used, and they include 132 Christians, 66 Muslims and 6 Traditional religious adherents, 106 were Yoruba while 98 were from Igbo ethnic origin.

2.1. Instrument

A questionnaire comprising of three psychological instruments was administered on each participant. The first of the psychological instruments is the Religious Affiliation Scale (RAS) developed by [Omoluabi \(1995\)](#) to measure how devoted a respondent is to his/her religion. The instrument contains 21 items in form of religious statements which the respondents only has two options of either True or False by shading only one that applies to him/her. A score of 2 is assigned to "True" and 1 for "False".

The total scores are added while the mean score serve as the basis for interpreting the score for each participant. Score that is higher than the norm (mean) is considered high religiously. The second instrument used is the Revised Paranormal Belief Scale (RPBS) developed by [Tobacyk and Milford \(1988\)](#) which contains 26 items. It is a self report scale that provides a measure of degree of beliefs in each of the seven dimensions involving traditional religious beliefs, Psi, witchcrafts, superstitions, spiritualism, extraordinary life forms, and precognition.

Participants were asked to respond to all questions regarding their beliefs adjacent to paranormal belief in relation to the items on the questionnaire by putting a number next to each item to indicate how much they agree or disagree with that item starting with 1 = Strongly disagree 2 = Moderately disagree 3 = Slightly disagree 4 = Slightly agree 5 = Moderately agree and 6 = Strongly agree. Each item is scored on a seven point Likert scale with a higher rating indicating stronger endorsement of paranormal beliefs. The internal consistencies of the RPBS were adequate with Cronbach alpha of .91, and .83 for global paranormal beliefs and subscales respectively.

The third instrument used is the General Health Questionnaire (GHQ) developed by Goldberg (1978). It is a screening instrument aimed at detecting non-psychotic psychiatric disorders regardless of diagnosis in the community.

It is a 28 items instrument which measures scale on somatic symptoms, anxiety, insomnia, social dysfunction and severe depression. It has a cronbach alpha coefficient reliability of the subscales which vary around 0.82 and the internal consistency of the total scale of 0.92.

Participants were instructed to answer all questions by simply underlying the answer they think nearly applies to them as at the time of responding to the questionnaire. A score of 1, 2, 3, and 4 are assigned to each of the four responses respectively. A choice of either the third or fourth response is considered "Positive" and what looks like a four way response scale which represent, Yes or No scale. The total scores are added to give the global score for analysis.

2.2. Procedure for Data Collection

The questionnaires were administered to the participants in their places of works, houses, and business offices and at their religious institutions. Necessary materials such as pencil, sharpener and eraser to be used in responding to the instruments were attached. Permission of the religious leaders (Priests and Imams) were sought. The questionnaire was given to their leaders to read after which necessary rapport was established.

They were enjoined to help introduce the research instrument to their members through announcement on worship days and urge them to simply participate since no adverse intention was found associated with it. Many members with specified credential accepted the questionnaire. Participants were also asked to submit them back to their religious leaders for collection. Participants at schools were given through their class teachers while some staff of such schools also participated. Those in the markets and shops were given directly but were asked to submit them back to a designated place within their location.

Nobody was visited at home by the researcher but many extra copies were collected by those who accepted for the purpose of given them to their relatives at home. All participants were asked to return the questionnaire within one week. It was easier to collect those at the religious houses and that of the schools. The collections at the market places and shops were more difficult either.

A total number of three hundred questionnaires were administered, but only 276 were returned. Out of the 276, only 204 were correctly responded to. 72 questionnaires were disqualified based on errors ranging from non-completion of items, incomplete pages of instrument and outright non compliance with instructions given.

2.3. Research Design and Statistics

Factorial design was used for this study while analysis of variance (ANOVA), multiple regression and independent t-test were used for the analysis.

3. RESULTS

Table-1. Multiple regression summary table showing the effect of paranormal beliefs and religiosity on psychopathological symptoms.

	Variable	β	t	p	R	R ²	F	P
General Psychopathology	Paranormal beliefs	-.035	-.50	> .05	.047	.002	.22	≥ .05
	Religiosity	-.031	-.44	> .05				
Anxiety	P. Belief	-.171	-2.47	< .05	.172	.03	3.07	< .05
	Religiosity	.016	.224	> .05				
Insomnia	P. Belief	.035	.49	> .05	.051	.003	.26	> .05
	Religiosity	-.037	-.53	> .05				
Social dysfunction	P. Belief	-.094	-1.34	> .05	.126	.016	1.62	> .05
	Religiosity	-.084	-1.199	> .05				
Depression	P. Belief	.112	1.599	> .05	.112	.013	1.28	> .05
	Religiosity	-.005	-.078	> .05				

Table-2. Independent t-test table, showing the difference between the Yoruba and Igbo in the Paranormal Beliefs, Religiosity and Psychopathological symptoms.

Variable		N	\bar{X}	SD	SE	df	t	p
PB	Yoruba	107	90.68	13.53	1.31	202	2.75	< .05
	Igbo	97	96.07	14.48	1.47			
General Psychopathology	Yoruba	107	40.77	17.86	1.47	202	1.29	> .05
	Igbo	97	38.75	10.37	1.05			
Anxiety	Yoruba	107	10.77	3.63	.35	202	3.05	< .05
	Igbo	97	9.32	3.09	.31			
Insomnia	Yoruba	107	10.09	3.60	.35	202	.66	> .05
	Igbo	97	9.76	3.63	.36			
Social dysfunction	Yoruba	107	10.43	3.19	.31	202	-.63	> .05
	Igbo	97	10.70	2.92	.29			
Depression	Yoruba	107	9.89	3.73	.36	202	1.99	< .05
	Igbo	97	8.92	3.29	.33			
Religiosity								

There is a significant difference between the Yoruba and Igbo on Paranormal Beliefs. ($t(202) = 2.75 P < .05$). Also there is a significant difference between the Yoruba and Igbo on anxiety symptoms ($t(202) = 3.05 P < .05$) and on depression ($t(202) = 1.99, p < .05$). However, there are no significant differences on other dimensions of psychopathology. There is also no significant difference between the Yoruba and Igbo on Religiosity.

4. DISCUSSION

This research was carried out to find out the implication of religiosity and paranormal beliefs on the development of psychopathological symptoms. Findings showed that paranormal beliefs significantly influence anxiety dimension of psychopathology but religiosity does not predict any sub-dimension and global psychopathological symptom. When analyzing a study (Taylor and Mc Donald, 1999; Kosek, 1999; 2000; Saroglou, 2002) on whether religiousness is positively related to agreeableness and consciousness, it revealed low correlation between psychotism and religion in the three factor model of personality. However, in most studies conducted, no significant relation between religion and other factors of the five factor model of personality (Saroglou, 2002) was found. Other studies suggest that religious people should be situated high on some of the other factors (Taylor and Mc Donald, 1999; Duriez, 2000). The fact that religiosity does not significantly predict psychopathological symptoms may mean that people have come to realization of the fact that religiosity has no correlation with psychopathology. Thus, the practice within religious institutions where incidence of psychopathology were treated through special religious prayers, fasting, cleansing with holy water and anointing with oil or preparing extracts from the Holy Qur'an (Lee and David, 1990) as therapies for the patients, and various religious methodology of handling their affected adherence may perhaps be responsible for low rate of susceptibility to the negative influence of religious dogmatism. Also, one of the previous studies concluded that there is a strong chance that religious beliefs and paranormal beliefs serve to lower dead anxiety. (Persinger and Makarec, 1990). This also may be responsible for partial influence paranormal beliefs had and negative correlation religiosity had on psychopathology as discovered in this study. Findings from previous researches as reported above may have justified the reason why religiosity did not predict incidents of psychopathology in this study due to the higher levels of social ties and sense of belongingness enjoyed by religious adherents which inhibit their susceptibility to any dimensions of psychopathology.

The assumption that there will be a significant difference in paranormal beliefs, and psychopathological symptoms among people of different ethnic origin was confirmed. Finding showed a significant difference between the Igbo and Yoruba ethnic groups on paranormal beliefs. Studies by Ebigbo and Ihezue (1982) showed that the characteristics of different societal values can reflect on the symptom report. That is, symptoms or descriptions of them can be very dissimilar in different societies. For example, Ebigbo and Ihezue (1982) reported that Nigerians who are depressed complained of heaviness or heat in the head, crawling sensation in the body and a feeling that their belly is bloated with water. Also, people in the United States of America report feelings of worthless and being unable to start or finish any activities , losing interest in usual activities and thinking of suicide. Whereas, natives of China do not report loss of pleasure, the helplessness or hopelessness, guilt or suicidal thought seen in depressed North Americans (Kleinmen, 1980). These finding above indicates that people of different ethnic origin may differ in

their reportage of symptoms. Therefore, applying a standard definition of depression across different culture may result in vastly different outcomes.

In a study to find out what happened when people seek psychotherapeutic help, Sue and Zane (1987) noted that seeking such help is related to one ethnic background (By implication, including one's religious orientation and social values). Sue and Zane (1987) cited Statistics indicating that Black Native Americans, Asian-American, and Hispanic tend to terminate psychotherapeutic treatment earlier and also average fewer sessions than the Whites. The single most important reason may be that therapists do not provide responsive forms of therapy that is based on the social values and religious orientation of those concerned. This thus lends credence to the findings from current study that paranormal beliefs and perceived incidence of psychopathological symptoms differ across ethnic groups.

5. CONCLUSION AND RECOMMENDATION

This study has been able to show the extent of relationship that exist between religiosity and paranormal beliefs and their individual and joint impact on the development of psychopathological symptoms. While paranormal beliefs have partial influence on psychopathology, religiosity does not show any influence. It also indicated that people from different ethnic origin may differ in their perspective of paranormal occurrence without showing the same on their religious philosophy. Therefore, therapeutic attempt on health should take into consideration the religious beliefs, social values and norms in the society since these variables seem to be interwoven. For instance, in China, the concept of health, based on Chinese religion and philosophy, focuses on the principle of Yin and Yang, which represent negative and positive energies respectively. The Chinese believe that our bodies are made up of elements of Yin and Yang while balance between these two forces results in good health; and imbalance in too much Yang leads to poor health. It is therefore recommended that any psychological approach to the treatment of mental illness or incidence of psychopathology should adopt holistic assessment of the client socio-cultural and religious orientation in order to have overall view of the problem.

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