THE INTERNATIONAL JOURNAL OF HUMANITIES & SOCIAL STUDIES

Severity of Depression and Its Association with Spiritual Coping among Consecrated Religious in the Catholic Diocese of Mtwara, Tanzania

William J. Tumaini
Student, Department of Clergy, Catholic Diocese of Mtwara, Tanzania
Dr. Lucy M. Njiru
Lecturer, Department of Counselling & amp; Psychotherapy
Amref International University, Kenya
Dr. Daniel Kitonga
Lecturer, Department of Directorate of Postgraduate Studies & Research
Tangaza University College, Kenya

Abstract:
The World Health Organization considers depression as one of the leading causes of disability in the world. Even though studies in many parts of the world have reported an association between depression and spiritual coping, limited studies have been conducted among consecrated religious. The present cross-sectional study aimed to analyze the severity of depression and its association with spiritual coping among consecrated religious in the Catholic Diocese of Mtwara, Tanzania. Convenience sampling was used to obtain 192 participants. Self-report questionnaires which included Brief Religious/Spiritual Coping scale and Becks Depression Inventory-II scale were used to measure spiritual coping and depression respectively. Data was analyzed using descriptive and inferential statistics. The findings revealed that 48.5% of the participants had clinical. Also, the results shown an association between depression and negative spiritual coping (p=0.051).

Keywords*: Depression, spiritual coping, consecrated religious*

1. Introduction

Depression is 'a common mental disorder that presents with depressed mood, loss of interest or pleasure, decreased energy, feelings of guilt or low self-worth, disturbed sleep or appetite, and poor concentration' (Marcus, Yasamy, Van Ommeren, Chisholm, & Saxena,2012, 6). Depression is global issue that leads to disability and it affects the normal functioning of people (Marcus et al., 2012). Moreover,depression can become serious and lead to a considerable damage of the ability of a person to pay attention to daily responsibilities, and sometimes a person may end his/her life (APA, 2013). Over the years, the burden of depression has increased globally (Lancet, 2016). For instance, between 2005 and 2015 depression had increased by 18.4%, and over 322 million people worldwide were suffering from depression (Friedrich, 2017). Furthermore, Friedrich reported that even though depression can affect any person in the society, more females are affected in comparison to males.

The National Health and Nutrition Examination Survey, 2013 to 2016 revealed that 8.1% of American adults aged 20 and above had depression in a given 2-week period (Brody, Pratt, & Hughes, 2018). Mental health statistics for England estimated 1 in 6 people experienced depression in the past week (Baker, 2018). Moreover, in other parts of the world depression was estimated to be: Germany 5.2%, India 4,5%, Kuwait 5.0%, Nigeria 3.9%, South Africa 4.6%, Uganda 4.6%, Kenya 4.4% and United Republic of Tanzania 4,1% (WHO, 2017). Further, studies on prevalence of depression have also been carried out in specific populations across Africa. For instance, the cross-sectional study that was conducted among HIV infected women in Machakos County, Kenya, showed the overall prevalence of major depressive disorder to be 35.5% (Njiru, Munene, & Ojuade, 2018). Similarly, a study that was conducted in rural Tanzania among HIV-positive outpatients revealed that 15.5% of subjects had depression (Marwick & Kaaya, 2010). Moreover, a cross-sectional study among Asians who live in Dar es Salaam found out that 6.5% of that population had depression (Moledina, Bhimji, & Manji, 2018).

The seriousness of depression necessitated WHO to suggest to the member countries to have an action plan for reducing the impacts of depression in the society (WHO, 2012). Koenig (2012) suggestedspirituality to be one of the coping mechanisms that individuals use to address depression. Spirituality is human relational experience arising within the inner subjective awareness of individuals, communities, social groups and traditions, transcendent and beyond self that is related with the searching for the meaning in life (Cook, 2004). Blackburn and Owens (2015) showed that the meaning in life as part of spirituality that minimizes depressive symptoms. The transcendent part of spirituality is considered as searching for the sacred (God), and the way a person copes with a stressor in life in relation to the sacred can either be a

positive or negative (Koenig, 2010). Callahan (2015) and Pargament (1997) defined religious/spiritual coping as attempts to comprehend and cope with life stressors in connection with God.

It has been revealed that a positive spiritual coping in relation toGod contributes to the spiritual and mental wellbeing of individuals (Vieten, et al., 2013). The positive spiritual coping is concerned with a right relationship with God that considers life to be meaningful (Pargament, et al., 2001). Further, Pargament suggested seven positive spiritual copings that can help consecrated religious to cope with stressors:a sense spiritual connection with God when a consecrated religious is facing a stressor; assurance of God's love and care when facing a stressor; asking for God's grace in order to control or get rid of anger; involving God in dealing with stressors in life ; considering stressors as an opportunity to grow into mature relationship with God; seeking religious purification by asking forgiveness of sins; and engaging in spiritual activities in order to stop worrying about stressors (Pargament, Koenig & Perez, 2000).

Studies have revealed thatpositive spirituality has got a negative relationship with depression. For instance, a study conducted by Brown, Carney, Parrish and Klem (2013) among university students in USA revealed that high level of spirituality was associated with low level of depression. Further, a study conducted among depressive disorder patients in India showed that participants with mild depression scored significantly higher on the spirituality scale in comparison with those in moderate and severe depression (Bonelli, Dew, Koenig, Rosmarin, & Vesegh, 2012). Similarly, Mahwati (2017) found that spirituality had a negative significant relationship with the rates of depression among the elderly in Indonesia. Moreover, a study conducted in South Africa among medical students also found that low level of spirituality was associated with the history of depression (Pillay, Ramlall, & Burns, 2016).

In contrary, some scholars have argued that spirituality can relate positively to depression. For instance, Corey, Corey and Callanan (2011) suggested that negative spiritual copings may result to guilt, anger, sadness and other mental disorders. The negative spiritual coping reflects insecure relationship with God where a consecrated religious finds the life to be meaningless because of doubtful and questionable view of God, self, others and the world (Pargament, et al., 2001).Further Pargament suggested seven negative spiritual copings when encountering stressors: not being satisfied and a feeling of being abandoned with God when facing a stressor; considering a stressor as a punishment from God for being unfaithful; wondering as to why God as allowed the stressor/punishment to happen; facing a stressor and questioning about God's love; being dissatisfied and confused with spiritual supporters or other members of the Church when one faces a stressor; blaming the devil for causing a stressor; and doubting about the power of God when one faces a stressor (Pargament, et al., 2000).

Studies have revealed that there is an association between spirituality and depression. For instance, Diaz, et al. (2011) in their study among inpatient substance abusers in USA they found that the experiences of closeness to God was positively related to depression.Further, a survey among 134 family members of Hospice patients in the Great Lakes region of the United States who were spiritually struggling with anger towards God found a positive relationship between spirituality and depression (Exline, Prince-Paul, Root & Peereboom, 2013). Moreover, Gallagher, Phillips, and Lee (2015) examined the association between spirituality and depression among 32 parents caring for children with developmental disability in United Kingdom and found that spirituality was positively related with depression.

From general experience, it is common for a consecrated religious to pass through a difficult spiritual moments or situations in life known as 'Dark Night of the Soul'. The 'Dark Night of the Soul' is a metaphor used to describe the experience of loneliness and desolation with regard to relationship with God (Dura` -Vila` & Dein, 2009). A moment of loneliness and desolation in spiritual journey may lead a consecrated religious into depression. However, some consecrated religious consider the period of 'Dark Night of the Soul' as important moment for growth and maturity of faith (Dura` -Vila` & Dein, 2009).

Steglitz, Mosha and Kershaw (2012) in their study among HIV-positive adults in Iringa, Tanzania revealed that spirituality was considered as a way of coping with stressors in life. Despite this, limited studieshave been carried out to establish the association between spiritual coping and depression among consecrated religiouspopulations in Mtwara Diocese. This underscores the importance of the present study.

2. Methods

This research was approved Tanzania Commission for Science and Technology. A cross-sectional study was conducted among the consecrated religious in the Catholic Diocese of Mtwara. Tanzania. Informed consent was sought from the participants. Incomplete questionnaires were excluded from final analysis. Convenience sampling was used to include only the participants who were willing and ready to participate in the study. The sample size for the study was 192 consecrated religious people.

The study used the following research instruments to collect data: demographic questionnaire to get the background information of the participants; brief religious/spiritual coping (Brief RCOPE) to assess spirituality; andBecks depression inventory II (BDI-II) to assess clinical depression.The Brief RCOPE is a 14-item measure of religious coping with major life stressors that was developed by Kenneth Pargament in 1997 (Pargament, Feuille & Burdzy, 2011). Among the 14-items measure of religious coping, seven are for positive religious/spiritual coping (PRC) and the other seven are for negative religious/spiritual coping (NRC). A four-point Likert scale with scores range from 7 (minimum) to 28 (maximum) in PRC and NRC respectively. A study conducted among patients undergoing cardiac surgery Clinic at the Cardiac Surgery Clinic of the University of Michigan found the Brief RCOPE reported Cronbach's alpha scores at .93 and .83 for positive and negative religious/spiritual respectively (Ai, Seymour, Tice, Kronfol & Bolling, 2009).

Depressive symptoms were measured by using Becks depression inventory-II (BDI-II) developed in 1996 by Aaron T. Beck in 1996 (Beck, Steer & Brown, 1996). The BDI-II is a 21-item self-report measure that taps major depression

symptoms. The participants whose scored between 20 to 63 were considered to have clinical depression.A comprehensive review of psychometric properties of the BDI-II where 118 relevant studies were retrieved through a search of electronic databases found Cronbach's alpha score to be around 0.9 (Wang & Gorenstein, 2013). A Kenyan study among HIV infected populations reported BDI-II Cronbach's alpha of 0.81.

Pearson's correlation (r) was used to test the correlation between spiritual coping and depression while Chi-square test was used for analyses of the severity of depressive symptoms.

3. Results

Table 1 presents the background distribution of socio-demographic characteristics of 192 consecrated religious who participated in the study. Among the participant's gender, the frequency of female participants was higher (128, 66.7%) as opposed to male participants (64, 33.3%). As regards participant's age, the variable was grouped into four age groups: 24-29, 30-39, 40-49 and 50-59 respectively. The frequency of participants aged 24-29 was higher (33.3%) compared with participants aged 30-39 (15.1%), 40-49 (26.6%), and 50-59 (25%).

As regards to participants' religious status, participants who are Nuns were higher 128 (66.7%) compared to Brother 47(24.5%) and Priest 17(8.9%). Whereas, distribution of participant's priestly/religious years shows that frequency of participants whose priestly years was within 1-5 years has higher frequency at 74(38.5%) compared to 6-10 years at 27(14.1%), 11-25 years at 66(34.4%) and 26-50 years at 25(13%). As for the level of education, majority of participants completed their Form IV/VI education with 100(52.1%) followed by Certificate/ Diploma 53(27.6%), Bachelor degree 27(14.1%), Post-graduate Diploma/Master 11(5.7%) and PhD 1(0.5%).

Variable	Frequency	Percent
Male	64	33.3
Female	128	66.7
Total	192	100
24-29	64	33.3
30-39	29	15.1
40-49	51	26.6
50-59	48	25.0
Total	192	100
Priest	17	8.9
Brother	47	24.5
Nun	128	66.7
Total	192`	100
1-5 Years	74	38.5
6-10 Years	27	14.1
11-25 Years	66	34.4
26-50 Years	25	13.0
Total	192	100
Form IV/VI	100	52.1
Certificate/Diploma	53	27.6
Bachelor Degree	27	14.1
Post-Graduate Diploma/ Masters	11	5.7
PhD	1	.5
Total	192	100

Table 1: Descriptive Statistics of the Key Socio-demographic Characteristics of the Participants

Table 2 presents the bivariate statistics analysis showing the distribution of participant's scores on severity of depressive and the socio-demographic characteristics. The severity of depression ranges from normal, mild, borderline, moderate, severe and extreme depression. In terms of participant's gender, depression symptom seems to be more severe among female participants (17.7%) as opposed to male counterparts (4.7%). The frequency of borderline clinical depression indicated that female participants scored higher at 8.9% compared to male at 4.2%. In addition, frequency of moderate depression was higher among female participants (15.1%) as opposed to male counterpart (5.7%). The frequency of severe depression was also seen to be higher among female participants at 7.8% compared to male participants at 3.1%. Chi-Square statistics indicated that the distribution of depression severity among the participants' gender was significant (p=0.033).

As for participant's age, frequency of mild depression was higher among those aged between 24-29 (7.3%) as compared to 30-39 (2.1%), 40-49 (6.8%) and 50-59 (6.3%). The frequency of borderline clinical depression was higher among those aged between 50-59 (8.2%) as compared to 40-49 (3.1%), 30-39 (2.6) and 24-29 (3.1%). In addition, frequency of moderate depression was higher at those aged between 50-59 (6.8%) as compared to 40-49 (5.2%), 30-39 (2.6%) and 24-29(6.3%). The frequency of severe depression was higher among participants aged between 40-49 (4.2%)

as compared to 24-29 (3.6%), 30-39 (2.6) and 50-59 (0.5%). Chi-Square statistics indicated that the distribution of depression severity among participants' age was insignificant (p=0.093).

As for participant's religious status, frequency of mild depression was higher among the nuns (17.7 %) as compared to brothers (3.1%) and priests (1.6%). The frequency of borderline clinical depression was higher among the nuns (17.7%) as compared to brothers (3.1%) and priests (1%). In addition, frequency of moderate depression was higher among the nuns (15.1%) in comparison to brothers (5.2%) and priests (0.5%). The frequency of severe depression was higher among the nuns (5.8%) as compared to brothers (1.6%) and priests (1.6%). However, the frequency of extreme depression was lower among the brothers (1.0%). Chi-Square statistics indicated that the distribution of depression severity among participants' religious status was insignificant (p=0.066).

With regards to participant's priestly/religious years, frequency of mild depression was higher among those aged between 11-25 (9.4%) as compared to 1-5 (8.3%), 6-10 (2.6%) and 26-50 (2.1%). The frequency of borderline clinical depression was higher between the years 11-25 (4.7%) as compared to 1-5 (3.6%), 6-10 (2.1%) and 26-50 (2.6%). In addition, frequency of moderate depression was higher between the years 11-25 (8.9%) as compared to 1-5 (5.7%), 6-10 (3.6%) and 26-50 (2.6%). The frequency of severe depression was higher between the years 1-5 (4.2%) as compared to 6-10 (3.1%), 11-25 (3.1%) and 26-50 (0.5%). Moreover, the frequency of extreme depression was insignificantly between years of 1-5 (1%). Chi-Square statistics indicated that the distribution of depression severity among participants' priestly/religious years was insignificant (p=0.257).

As for participant's educational level, frequency of mild depression was higher among Form IV/VI leavers (11.5 %) as compared to Certificate/Diploma (8.3%), Bachelor degree (1.6%), Post-Graduate Diploma/Masters (0.5%) and PhD (0.5%). The frequency of borderline clinical depression was higher among among Form IV/VI leavers (5.7%) as compared to Certificate/Diploma (4.7%), Bachelor degree (1.6%), Post-Graduate Diploma/Masters (1.6%) and PhD (0.0%). The frequency of moderate depression was higher among among Form IV leavers (11.5%%) as compared to Certificate/Diploma (6.3%), Bachelor degree (2.1%), Post-Graduate Diploma/Masters (1%) and PhD (0.0%). The frequency of severe depression was higher among among Form IV/VI leavers (7.8%) as compared to Certificate/Diploma (1.0%), Bachelor degree (2.1%), Post-Graduate Diploma/Masters (0.0%) and PhD (0%). However, the frequency of extreme depression was insignificantly among Form IV/VI leavers (1.0%). Chi-Square statistics indicated that the distribution of depression severity among participants' educational level was insignificant (p=0.361).

Variables	Total %	Depression Scores						Chi-Square Test		
		Normal	Mild	Borderline	Moderate	Severe	Extreme	Value	df	Sig
Participant's Gender										
Male	64(33.3)	28(14.6)	9(4.7)	8 (4.2)	11(5.7)	6(3.1)	2(1.0)	12.160	1	.033
Female	128(66.7)	33(17.2	34(17.7)	17(8.9)	29(15.1)	15(7.8)	0(0.0)			
Participant's Age										
24-29	64(33.3)	25(13.0)	14(7.3)	6(3.1)	12(6.3)	7(3.6)	0(0.0)	22.601	3	.093
30-39	29(15.1)	8(4.2)	4(2.1)	5(2.6)	5(2.6)	5(2.6)	2(1.0)			
40-49	51(26.6)	14(7.3)	13(6.8)	6(3.1)	10(5.2)	8(4.2)	0(0.0)			
50-59	48(25.0)	14(7.3)	12(6.3)	8(4.2)	13(6.8)	1(0.5)	0(0.0)			
Participant's Religious Status										
Priest	17(8.9)	8(4.2)	3(1.6)	2(1.0)	1(0.5)	3(1.6)	0(0.0)	17.420	2	.066
Brother	47(24.5)	20(10.4)	6(3.1)	6(3.1)	10(5.2)	3(1.6)	2(1.0)			
Nun	128(66.7)	33(17.2)	34(17.7)	17(8.9)	29(15.1)	15(7.8)	0(0.0)			
Participant's Priestly/ Religious Years										
1-5 Years	74(38.5)	30(15.6)	16(8.3)	7(3.6)	11(5.7)	8(4.2)	2(1.0)	18.112	3	.257
6-10 Years	27(14.1)	5(2.6)	5(2.6)	4(2.1)	7(3.6)	6(3.1)	0(0.0)			
11-25 Years	66(34.4)	16(8.3)	18(9.4)	9(4.7)	17(8.9)	6(3.1)	0(0.0)			
26-75 Years	25(13.0)	10(5.2)	4(2.1)	5(2.6)	5(2.6)	1(0.5)	0(0.0)			
Participant's Educational Level										
Form IV/VI	100(52.1)	28(14.6)	22(11.5)	11(5.7)	22(11.5)	15(7.8)	2(1.0)	21.623	4	.361
Certificate/Diploma	53(27.6)	14(7.3)	16(8.3)	9(4.7)	12(6.3)	2(1.0)	0(0.0)			
Bachelor Degree	27(14.1)	13(6.8)	3(1.6)	3(1.6)	4(2.1)	4(2.1)	0(0.0)			
Post-Graduate Diploma/ Masters	11(5.7)	6(3.1)	1(0.5)	2(1.0)	2(1.0)	0(0.0)	0(0.0)			
PhD	1(0.5)	0(0.0)	1(0.5)	0(0.0)	0(0.0)	0(0.0)	0(0.0)			

Table 2: Distribution of Demographic Characteristics of the Participants and Depressive symptoms

Table 3 presents the severity of depression among the participants. The Table shows that 31.8% of the participants did not present with depressive symptoms. However, frequency of mild mood disturbance was higher at 43 (22.4%) while borderline clinical depression was 25 (13%), moderate depression 40 (20.8%), severe depression21(10.9%) and extreme depression 2 (1.0%).

Severity Classification	Frequency	Percent
Minimal	61	31.8
Mild mood Disturbance	43	22.4
Borderline Clinical Depression	25	13.0
Moderate Depression	40	20.8
Severe Depression	21	10.9
Extreme Depression	2	1.0
Total	192	100

Table 3: Severity of Depression among the Participants

Table 4 presents participants with clinical depression and the socio-demographic characteristics. Participants who scored below borderline clinical depression were considered to be non-clinical depression and participant who scored from borderline clinical depression and above were considered to be presenting with clinical depression. As indicated on the Table, frequency of clinical depression was higher among female participants (61, 31.8%) as opposed to male counterpart (27, 14.1%). Statistical analysis shows that distribution of clinical depression across gender distribution was insignificant (p=0.473). As regards to the participant's age, frequency of clinical depression was higher between the age of 24-29(13%) as compared to 30-39 (8.9%), 40-49 (12.5%) and 50-60 (11.5%).Chi-Square statistics indicated that the distribution of clinical depression across age distribution was insignificant (p=0.373). In addition, frequency of clinical depression was higher among the nuns (31.8%) as compared to brothers (10.9%) and priests (3.1%). Statistical analysis shows that distribution of clinical depression across religious status was insignificant (p=0.620). With regards to participant's priestly/religious years, frequency of clinical depression was higher among participants aged between the years 11-25(16.7%) as compared to 1-5(14.6%), 6-10(8.9%) and 26-50(5.7%). Chi-Square statistics indicated that the distribution of clinical depression across priestly/religious life was insignificant (p=0.150). As regards to participant's educational level, frequency of clinical depression was higher among Form IV leavers (26.0%) as compared to Certificate/Diploma (12.0%), Bachelor degree (5.7%), Post-Graduate Diploma/Masters (2.1%) and PhD (0.0%).Statistical analysis shows that distribution of clinical depression across level of education distribution was insignificant (p=0.671).

Variable	Total %	Participant's Clinical Depression		Chi-Square Test		
		Non-Clinical	Clinical	Value	df	Sig.
Participant's Gender						
Male	64 (33.3)	37 (19.3)	27 (14.1)	.514	1	.473
Female	128 (66.7)	67 (34.9)	61 (31.8)			
Participant's Age						
24-29	64(33.3)	39 (20.3)	25 (13.0)	3.123	3	.373
30-39	29(15.1)	12 (6.3)	17 (8.9)			
40-49	51(26.6)	27 (14.1)	24 (12.5)			
50-59	48(25.0)	26 (13.5)	22 (11.5)			
Participant's Religious Status						
Priest	17(8.9)	11 (5.7)	6 (3.1)	.957	2	.620
Brother	47(24.5)	26 (13.5)	21 (10.9)			
Nun	128(66.7)	67 (34.9)	61 (31.8)			
Participant's Priestly/Religious Years						
1-5 Years	74(38.5)	46 (24.0)	28 (14.6)	5.317	3	.150
6-10 Years	27(14.1)	10 (5.2)	17 (8.9)			
11-25 Years	66(34.4)	34 (17.7)	32 (16.7)			
26-75 Years	25(13.0)	14 (7.3)	11 (5.7)			
Participant's Level of Education						
Form IV/VI	100(52.1)	50 (26.0)	50 (26.0)	2.352	4	.671
Certificate/Diploma	53(27.6)	30 (15.6)	23 (12.0)			
Bachelor Degree	27(14.1)	16 (8.3)	11 (5.7)			
Post-Graduate Diploma/ Masters	11(5.7)	7 (3.6)	4 (2.1)			
PhD	1(0.5)	1 (0.5)	0 (0.0)			

Table 4: Distribution of Participant's Clinical Depressive Symptoms and Demographic Characteristics

Table 5 presents severity of clinical depression among the participants. Frequency of non-clinical depression was slightly higher at 54.2% as opposed clinical depression at 45.8%.

Variable	Frequency	Percent
Non-Clinical Depression	104	54.2
Clinical Depression	88	45.8
Total	192	100

Table 5: Severity of Clinical Depression among the Participants

Table 6 presents the descriptive mean statistics of participant's spiritual coping and depressive symptoms. The mean clinical depression was .4583 ± (SD: .49956), the mean positive spiritual coping was .0677 ± (SD: .25190) while the mean of negative spiritual coping was .9323 ± (SD: .25190).

	Mean	Std. Deviation	N
Participants Depression Classification	.4583	.49956	192
Participant's diagnosed with Positive Religious/Spiritual Coping	.0677	.25190	192
Participant's diagnosed with Negative Religious/Spiritual Coping	.9323	.25190	192

Table 6: The Descriptive Mean Statistics of Participant's Spiritual Coping and Depressive Symptoms

Table 7 examines the degree of association between clinical depression and negative, positive spiritual coping.Pearson's correlation coefficient is the statistics used to measure the statistical relationship between two continuous variables and it is based on the method of covariance. It gives information about the magnitude of the association or correlation between X and Y. Clinical depression as a continuous variable was tested with positive spiritual coping, the result shows that the correlation matrix was insignificant (p=0.551). However, clinical depression and negative spiritual coping scores were significantly correlated (p=0.051).

		Participant's Depression Classification	Participant's diagnosed with Positive Religious/Spiritual Coping	Participant diagnosed with Negative Religious/Spiritual Coping
Participant's Depression Classification	Pearson Correlation	1	.043	-.043
	Sig. (2-tailed)		.551	.051
	Sum of Squares and Cross-products	47.667	1.042	-1.042
	Covariance	.250	.005	-.005
	N	192	192	192
Participant's diagnosed with Positive Religious/Spiritual Coping	Pearson Correlation	.043	1	-1.000**
	Sig. (2-tailed)	.150		.100
	Sum of Squares and Cross-products	1.042	12.120	-12.120
	Covariance	.005	.063	-.063
	N	192	192	192
Participant diagnosed with Negative Religious/Spiritual Coping	Pearson Correlation	-.043	-1.000**	1
	Sig. (2-tailed)	.051	.100	
	Sum of Squares and Cross-products	-1.042	-12.120	12.120
	Covariance	-.005	-.063	.063
	N	192	192	192
**. Correlation is significant at the 0.01 level (2-tailed).				

Table 7: Pearson Correlations Statistics Analyzing Similarities in Mean of Depression, Positive and Negative Spiritual Coping

4. Discussion

The severity of depressive symptoms among consecrated religious in Mtwara diocese, Tanzania was investigated in the present study. The severity of depression ranged from normal (31.8%), mild (22.4%), borderline clinical (13.0%), moderate depression (20.8%), severe depression (10.9%) and extreme depression (1.0%). The findings revealed that clinical depression among consecrated religious was high (45.8%). The results suggest that depression also prevails among consecrated religious in Mtwara diocese. These findings are congruent with other studies conducted in different parts of the world that seem to indicate that depression is high (WHO, 2017; Friedrich, 2017). The finding also concurs with some studies conducted in Tanzania which found the prevalence of depression to be high among different populations (Fawzia et al, 2019; Moledina, Bhimji, & Manji, 2018; Hill, Maman, Kilonzo, & Kajula, 2017; Marwick & Kaaya, 2010).

In terms of participant's gender, depression symptom seemed to be more severe among female participants as opposed to male counterpart. However, the frequency of extreme depression was lower among male participants as opposed to female participants. Chi-Square statistics indicated that the distribution of depression severity among the participants' gender was significant (p=0.033). The findings suggest that consecrated religious females are more vulnerable to depressive symptoms as compared to consecrated religious males. The results align with other studies which have suggested that even though depression can affect any person in the society but women are more affected than men (Friedrich, 2017; Ferrari, et al, 2013).

As for participant's age, Chi-Square statistics indicated that the distribution of depression severity among participants' age was insignificant (p=0.093). That suggests that depression can affect consecrated religious of different ages regardless of age group. However, the findings differ with those found by Miletic, et al. (2015) that suggested that symptoms of depression were more visible on the younger students as compared to the older students. Further, as for participant's religious status, Chi-Square statistics indicated that the distribution of depression severity among participants' religious status was insignificant (p=0.066). The findings suggest that depression can affect all consecrated religious regardless of religious status.

As regards to participant's priestly/religious years, Chi-Square statistics indicated that the distribution of depression severity among participants' priestly/religious years was insignificant (p=0.257). The findings suggest that depression can affect any consecrated religious regardless of the years spent in priestly/religious life. Moreover, as for participant's educational level, Chi-Square statistics indicated that the distribution of depression severity among participants' educational level was insignificant (p=0.361). This suggest that depression can affect consecrated religious regardless of education level.

Another objective aimed to test the correlation of positive and negative spiritual coping and clinical depression. The result revealed that the correlation between positive spiritual coping and clinical depression was insignificant (p=0.551). This suggests that participants who scored high on positive spiritual coping were unlikely to exhibit clinical depression.The finding are in agreement with previous studies which suggested a negative association between spirituality and depression (Rentala, Hi Po Laub & Chan, 2017; Mahwati, 2017; Pillay, Ramlall & Burns, 2016; Luna & MacMillab, 2015; Van Rensburg, Myburgh, Szabo, & Poggenpoel, 2013).

This study shown there is a significant correlation between negative spiritual coping and clinical depression (p=0.051). This implies that participants who scored high on negative spiritual coping were likely to have clinical depression.The findings concur with other studies which have shown that there is a positive relationship between spirituality and depressive symptoms (Gallagher, Phillips, & Lee, 2015; Exline, Prince-Paul, Root, & Peerboom, 2013; Diaz, et al, 2011).

5. Conclusions

The findings in the current study have corresponded with previous studies on severity of depression in the world and its association with spirituality. The high prevalence of depression among consecrated religious in the Catholic Diocese of Mtwara, Tanzania is a clear indication that depression affects different populations in the world regardless of a status of a person. Further, the results have also revealed that there is a significant association between negative spiritual coping and depressive symptoms.

6. Recommendations

With the high prevalence of depression reported among participants in Mtwara Catholic in Tanzania, it is suggested that the Catholic bishops and religious superiors in Tanzania should start sensitization programs/seminars about spiritual coping and depression targeting consecrated religious. Further, mental health programs should be integrated in the programs of consecrated religious formation in order to create an awareness about the importance of mental health in connection with spirituality.

The present study was a quantitative study that could not explore the experience of participants. Therefore, qualitative studies are recommended in order to examine the experience and feelings of the participants with regard to the research problem. Further, as the current study was a cross-sectional study, the researcher suggests more experimental and longitudinal studies on association between spirituality and depression in order to establish a causal relationship.

7. References

i. Ai, A. L., Seymour, E. M., Tice, T. N., Kronfol, Z., & Bolling, S. (2009). Spiritual struggle related to plasma interleukin-6 prior to cardiac surgery. *Psychology of Religion and Spirituality, 1*(2), 112-128.

ii. American Psychiatric Association (2013). *Diagnostic and Statistical Manual of Mental Disorders (DSM-5) 5th ed*. Washington, DC, APA.

iii. Baker, C. (2018). Mental health statistics for England: prevalence, services and funding. *Briefing Paper, 6988,* 1-32.

iv. Beck, A. T., Steer, R. A., & Brown, G. K. (1996). *Beck Depression Inventory-Second Edition Manual*. San Antonio, TX: The Psychological Corporation. doi:10.1037/t00742-000.

v. Blackburn, L., & Owens, G. P. (2015). The effect of self-efficacy and meaning in life on posttraumatic stress disorder and depression severity among veterans. *Journal of Clinical Psychology, 71*, 2019-228.

vi. Bonelli, R., Dew, H. R., Koenig, G. H., Rosmarin, H. D., & Vesegh, S. (2012). Religious and spiritual factors in depression: Review and integration of the research. *Depression Research and Treatment, 1*(2), 1–8. doi:10.1155/2012/962860.

vii. Brody D.J, Pratt L.A, Hughes J. (2018). Prevalence of depression among adults aged 20 and over: United States, 2013–2016. *NCHS Data Brief, 303.*

viii. Brown, D. R., Carney, J. S., Parrish, M. S., & Klem, J. L. (2013). *Assessing Spiritualty in Mental Health, 15*(2), 107-122.

ix. Callahan, A. M. (2015). Key concepts in spiritual care for hospice social workers: How an interdisciplinary perspective can inform spiritual competence. *Social Work and Christianity, 42*, 43-62. Retrieved from http://www.nacsw.org/samplesswc.html

x. Cook, C.C.H. (2004). Addiction and spirituality. *Addiction, 99,* 539–551.

xi. Corey, G., Corey, M.S., & Callanan, P. (2011). *Issues and Ethics in the Helping Professions, 8th ed*. Canada: Brooks/Cole, Cengage Learning.

xii. Daniel, K. (2013). Loneliness and depression among university students in Kenya. *Global Journal of Human Sciences (A), X111*(1V)*,* 1-18.

xiii. Diaz, N., Horton, E.G., Mcllveen, J., Weiner, M., & William, L.B. (2011). Spirituality, Religiosity and depressive symptoms among inpatients substance abusers. *Journal of Religion and Spirituality in Social Work: Social Thought, 30*(1), 71-87.

xiv. Dura` -Vila`, G. & Dein, S. (2009). The Dark Night of the Soul: spiritual distress and its psychiatric implications. *Mental Health, Religion and Culture, 12*(6), 543-559.

xv. Exline, J., Prince-Paul, M., Root, B.L., & Peereboom, K.S. (2013). The Spiritual Struggle of Anger toward God: A Study with Family Members of Hospice Patients. *Journal of Palliative Medicine, 16*(4), 369-375.

xvi. Fawzi, M. C., Ngakongwa, F., Liu, Y., Rutayuga, F., T., Siril, H., Somba, M. & Kaaya, S.F. (2019). Validating the Patient Health Questionnaire-9 (PHQ-9) for screening of depression in Tanzania. *Neurology, Psychiatry and Brain Research 31*, 9–14.

xvii. Ferrari, A. J., Charlson, F. J., Norman, R. E., Flaxman, A. D., Patten, S. B., Vos, T., & Whiteford, H. A. (2013). The Epidemiological Modelling of Major Depressive Disorder: Application for the Global Burden of Disease Study 2010. *PloS ONE, 8*(7), 1-14.

xviii. Friedrich, M. J. (2017). Depression Is the Leading Cause of Disability Around the World. *JAMA*, *317*(15), 1517.

xix. Gallagher, S., Phillips, A. C., & Lee, H. (2015). The association between spirituality and depression in parents caring for children with developmental disabilities: social support and/or last resort. *Journal of Religion and Health*, *54*(1), 358–370.

xx. Hill, L. M., Maman, S., Kilonzo, M. N., & Kajula, L. J. (2017). Anxiety and depression strongly associated with sexual risk behaviors among networks of young men in Dar es Salaam, Tanzania. *AIDS Care, 29*(2), 252-258.

xxi. Koenig, H. G. (2012). Religion, spirituality and health: The research and clinical implications. *International Scholarly Research Network*, 1-33.

xxii. Koenig, H.G. (2010). Spirituality and Mental Health. *International Journalof Applied Psychoanalytic Studies, 7*(2),116–122.

xxiii. Lancet (2016). GBD 2015 Disease and Injury Incidence and Prevalence Collaborators: Global, regional, and national incidence, prevalence, and years lived with disability for 310 diseases and injuries, 1990-2015: a systematic analysis for the global burden of disease study 2015. *www.thelancet.com, 388*, 1545-602. 10.1016/S0140-6736(16)31678-6.

xxiv. Luna, N. & MacMillanb, T. (2015). The relationship between spirituality and depressive symptoms severity, psychosocial functioning impairment, and quality of life: examining the impact of age, gender and ethnic differences. *Mental Health, Religion & Culture,18* (6), 513–525.

xxv. Mahwati, Y. (2017). The Relationship between Spirituality and Depression Among the Elderly in Indonesia.*Makara J. Health Res., 21(1)*, 13-19.

xxvi. Marcus, M, Yasamy, M. T., Van Ommeren, M., Chisholm, D., & Saxena, S. (2012). Depression: A global public health concern. *World Health Organization Paper on Depression,* 6-8.

xxvii. Marwick, K. & Kaaya, S. (2010). Prevalence of depression and anxiety disorders in HIV-positive outpatients in rural Tanzania. *AIDS care, 22,* 415-419.

xxviii. Miletic, V., Lukovic, J., Ratkovic, N., Aleksic, D., & Grgurevic, A. (2015). Demographic risk factors for suicide and depression among Serbian medical school students. *Social Psychiatry & Psychiatric Epidemiology*, *50*(4), 633–638.

xxix. Moledina, S. M., Bhimji, K. M., & Manji, K. P. (2018). Prevalence and Associated Factors of Depression in an Asian Community in Dar es Salaam, Tanzania. *Psychiatry Journal, 9548471.*

xxx. Njiru, L.M, Munene, A. & Ojuade, S.O. (2018). Prevalence and Associated Risk Factors for Major Disorder among Women Living with Human Immunodeficiency Virus. *The International Journal of Humanities and Social Studies, 6*(10), 469-478.

xxxi. Pargament, K.I. (1997). *The psychology of religion and coping: Theory, research, practice*. New York: Guilford.

xxxii. Pargament, K.I., Feuille, M. & Burdzy, D. (2011). The brief RCOPE: Current psychometric status of a short measure of religious coping. *Religions*, 21, 51-76.

xxxiii. Pargament, K.I., Koenig, H.G., & Perez, L.M. (2000). The many methods of religious coping: Development and initial validation of the RCOPE. *Journal of Clinical Psychology, 56(4)*, 519-543.

xxxiv. Pargament, K.I., Tarakeshwar, N., Ellison, C.G. & Wulff, K.M. (2001). Religious Coping Among the Religious: The Relationship Between Religious Coping and Well-Being in a National Sample of Presbyterian Clergy, Elders and Members. *Journal of the Scientific Study of Religion, 40*(3), 497-513.

xxxv. Pillay, N., Ramlall, S., & Burns, J. K. (2016). Spirituality, depression and quality of life in medical students in KwaZulu-Natal. *South African Journal of Psychiatry*, *22*(1), 1–6.

xxxvi. Rentala, S., Lau, B. & Chan, C. (2017): Association Between Spirituality and Depression Among Depressive Disorder Patients in India. *Journal of Spirituality in Mental Health,19 (45)*, 1-13.
xxxvii. Steglitz J., Ng R., Mosha J.S., Kershaw T. (2012). Divinity and distress: the impact of religion and spirituality on the mental health of HIV-positive adults in Tanzania. *AIDS Behav, 16(8),*2392–2398.
xxxviii. Van Rensburg, A. J., Myburgh, C., Szabo, C. P., & Poggenpoel, M. (2013). The role of spirituality in specialist psychiatry: A review of the medical literature. *African Journal of Psychiatry, 16(4)*, 247–255.
xxxix. Vieten, C., Pilato, R., Pargament, K. I., Scammell, S., Ammondson, I., & Lukoff, D. (2013). Spiritual and religious competencies for psychologists. *Psychology of Religion and Spirituality, 5*(3), 129-144.
xl. Wang, Y. & Gorenstein, C. (2013). Psychometric properties of the Beck Depression Inventory-II: A comprehensive review. *Revista brasileira de psiquiatria, 35,* 416-431.
xli. World Health Organization, (2012). *World suicide prevention* day. http://www. who.int/mediacentre/events/annual/world_suicide_prevention_day/en/ [Accessed 16.6.2012].
xlii. World Health Organization, (2017). *Depression and Other Common Mental Disorders: Global Health Estimates*. Geneva: Switzerland.