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INFLUENCE OF RELIGIOUS COMMITMENT AND LOCUS OF CONTROL ON MENTAL HEALTH AMONG PARISHIONERS OF CHURCH OF THE ASSUMPTION ASOKORO, ABUJA, NIGERIA

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ABSTRACT
The study examined the influence of religious commitment and locus of control on mental health among Parishioners of the Church of the Assumption, Asokoro, Abuja, Nigeria. The conceptualisation of the different variables was sufficiently given, underscoring the propelling factor(s) behind the research. A sample of two hundred and seventy (270) participants took part in the study. Three instruments were used to collect data from participants, namely: the Religious Commitment Scale, Rotter's Locus of Control Scale, and the Self-Reporting Questionnaire. Three hypotheses were tested, and the collected data were analysed using inferential and descriptive statistics. Accordingly, Pearson's correlation was used to examine the relationship between the independent variables and dependent variables, while hierarchical multiple regression was conducted to test the prediction of mental health by religious commitment and locus of control. The between-subject effects of religious commitment and locus of control on mental health were determined using the Analysis of Variance (ANOVA). After testing the study hypotheses, the study findings are: there was a significant negative association between religious commitment and mental health; there was a significant positive association between locus of control and mental health; and religious commitment and locus of control had significant independent and joint effects on mental health among Parishioners of the Church of the Assumption Asokoro, Abuja. Based on the findings, it is recommended that mental health professionals should endeavour to create an appropriate therapeutic environment that allows the involvement of religious experts or the clergy in the care of clients with strong religious inclinations.

Keywords: *religious commitment, locus of control, mental health and parishioners*

INTRODUCTION
The impact of religious commitment and locus of control on mental health has been debated for centuries, especially among clinical psychologists and other scientists around the world. Accordingly, history shows that religious organisations were often the first to offer compassionate care to vulnerable groups, including the medically ill, the elderly, and the disabled (Amedome and Bedi, 2018). The first hospitals for patients with mental health problems established in the fourteenth century were sponsored by the church and priest-managed (Alexander and Selesnick, 1966). In Western civilization, religious organisations provided some of the first and best care for the mentally ill. Since the beginning of the Middle Ages up to the past century, religious orders have built and maintained many hospitals. The establishment of large hospitals as an act of charity is a Christian idea. As already noted, the first hospital designed specifically to care for the mentally ill was established in Spain in 1409 under the guidance of priests. Religious groups have founded or supported many psychiatric hospitals in the United States and Brazil (Moreira-Almeida, 2005).

Within the framework of psychology, mental health is seen as an essential aspect of the general wellbeing of an individual. Recognition and understanding of mental health conditions have changed over time across cultures, and there are still variations in the definition, assessment, and

classification of mental disorders despite the availability of standard guideline criteria (Insel and Wang, 2010).

Mental health and mental illness are conceptualised as distinct constructs. There are two main perspectives explaining the distinction between the two constructs, namely, the continuum and categorical approaches (Scheid and Brown, 2010). The continuum approach posits that mental illness and mental health are two opposite poles of a continuum, with most people falling in between the two poles. The categorical approach, on the other hand, represents mental health and mental illness as a dichotomy, with people who exhibit symptoms of mental illness belonging to that category and those without symptoms of mental illness considered mentally healthy (Scheid and Brown, 2010). It is important to note that there is no generally agreed definition of mental health, as the term has often been used as a euphemism for mental illness (Maxwell et al., 2015). However, the World Health Organisation (WHO) defined mental health as a state of well-being in which every individual realises his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community (WHO, 2021). In the context of the present study, mental health represents the relative absence of symptoms of mental illness.

Most notions of mental health derive from western contexts (Gopalkrishnan, 2018). Cultural values and traditions are known to shape how mental health and illness are conceptualised as well as how people manifest symptoms and cope with psychological challenges (Vaillant, 2012), so it has been argued that issues related to the “mind” are often interpreted differently in non-western cultures (Fernando, 2019). Though theistic and religiously-based beliefs and behaviours have been demonstrated to consistently predict both physical and mental health (Ryan and Francis, 2012), the psychological processes underlying these relationships are unclear.

Religious commitment reflects a degree or level of religiosity. It attempts to capture how internally committed the person is to his religion. One of the best indicators of religious commitment is the estimation of intrinsic religious motivation, or intrinsic religiosity. Persons described as having an intrinsic orientation to religion have been described as living their religious beliefs, the influence of which is evident in every aspect of their lives (Joshi and Kumari, 2011). Worthington et al. (2003) defined religious commitment as “the degree to which a person adheres to his or her religious values, beliefs, and practises and uses them in daily living”. In other words, religious commitment indicates the amount of time spent in private religious involvement, religious affiliation, the activities of religious organisations, and the importance of religious beliefs, which are practised in intrapersonal and interpersonal daily living (Worthington et al., 2003). Worthington (1988) used a religious commitment model to look more closely at how religion affects individuals both positively and negatively, and under what conditions. He hypothesised the extent to which individuals were positively affected by religion; those who enjoyed good mental health were those who were the most committed to their religion (Worthington, 1988; Alaedein-Zawawi, 2015).

More so, several reviews have been published concerning the relationship between religiosity and mental health. Some have been general in nature, while others have focused on one specific type of religiosity. To this end, numerous research studies reveal positive health outcomes among those who frequently attend religious services. For example, religion has been found to aid in stress reduction through coping and allow individuals to engage in healthier lifestyles (Georg et al., 1998). Studies also indicate a positive association between religiosity and mental health, including well-being, self-esteem, and decreased stress levels (Krause et al., 2016).

On the other hand, locus of control is also considered in this study; it refers to an individual's perception of the underlying causes of events in his or her life. It is the extent to which individuals believe that they can control events that affect them. The locus of Control is considered an important aspect of personality and a person's perception of the source of his or her fate (Robins, 2000). People who are externals believe that external forces and events dictate their actions, decisions, and behaviours. Internals, on the other hand, take responsibility for their actions (Grable et al., 2009). For example, if a parishioner is externalising personal emotional problems by spiritualizing them, he may avoid seeking professional psychological help because he believes that 'powerful forces' beyond his control are responsible for the problems. In addition, a parishioner with an internal locus of control feels he is personally responsible for his problems and does not blame others for whatever experience he is having. Although the extent to which people expect events to be controlled by themselves or by external factors may vary between situations and events, people tend to display a more generalised locus of control when interpreting events in their lives (Rotter, 1966).

Statement of the Problem

There are indeed many works done in the areas of religious commitment, locus of control, and mental health in western societies, but there are just a few studies that examine the independent role of religiosity (Ifeagwazi and Chukwuorji, 2015) and locus of control in mental health within the Nigerian context. Notably, none, to the researcher's knowledge, particularly examined the combined influence of the two independent variables (i.e., religious commitment and locus of control) on mental health among Catholic members in Nigeria. Therefore, it is expected that this research work will bridge the existing knowledge gap on the subject of religious commitment, locus of control, and mental health in Nigeria. Furthermore, this research work will create more awareness among Catholics and Christians in general, as well as other religious faiths, on the potential impacts of religious commitment and locus of control on mental health. This study's findings may also provide the basis for clinicians and other mental health professionals to recognise the salience of religion in clients' lives and its relevance to mental health and wellbeing. Additionally, clinicians will be prompted by the results of this study to modify existing intervention strategies and embed elements of religiosity and healthy attribution in their therapy interventions for better outcomes.

Objectives of the Study

The main aim of the study is to investigate the influence of religiosity and locus of control on mental health among Parishioners of the Church of the Assumption Asokoro in Abuja. The following are the specific objectives of the study:

1. To examine the influence of religious commitment on mental health among Catholic Parishioners of the Church of the Assumption Asokoro in Abuja.
2. To examine the influence of locus of control on mental health among Catholic Parishioners of the Church of the Assumption Asokoro in Abuja.
3. To examine the joint influence of religious commitment and locus of control among Catholic Parishioners of the Church of the Assumption Asokoro in Abuja.

THEORETICAL FRAMEWORK

Theory of Religious Commitment

Scholars in psychology and sociology of religion have long been concerned with how best to explain and measure religious commitment (Roof, 1979), given that one's position towards the supernatural being and its manifestations involves a multi-dimensional process such as attitude, beliefs, emotions, experience, and rituals (Finney, 1978). Arguably, religion means different things to different people, depending on social and cultural contexts as well as people's mindsets. Recognising that the concept denotes a variety of experiences and expressions, most scholars seem to perceive religion as a multidimensional belief system rather than a monolithic system. Thus, most popular models and theoretical frameworks have adopted dimensionality in the analysis of religious belief, attitude, and behaviour. Finney (1978) presented a five-dimension theory of religious commitment comprising ideological, ritualistic, experiential, intellectual, and consequential dimensions. The ideological dimension involves the beliefs that religious adherents are expected to maintain. The ritualistic dimension encompasses various ways in which religious adherents are expected to practise their religion. The experiential dimension pertains to the intimate and emotional relationship that religious adherents are expected to have with a supernatural being. The intellectual dimension refers to the expectation that the religious person will be informed and knowledgeable about the basic tenets of his faith and its sacred scripture. Finally, the consequential dimension includes the secular effects of religious belief, practise, experience, and knowledge. Thus, arguably, the multi-dimensional conceptualisation of religious commitment appears to occupy a dominant position in the literature, having been supported by notable theorists in the field.

Social Learning Theory of Locus of Control

The theory is defined in terms of individuals' goals, expectations, and social reinforcements. According to social learning theory, a man's behaviour is determined by his goals. Behaviour is always directional. An individual responds with those behaviours that he has learned will lead to the greatest satisfaction in a given situation (Rotter, 1971). According to Strain (1993), Rotter's social learning theory proposes that the probability of a behaviour occurring is related to the individual's expectation that the behaviour will gain reinforcement and that the reinforcement has value to the individual. Rotter chose the label "Social Learning" because the theory stressed the fact that the majority of basic modes of behaviour are learned in social situations and are inextricably fused with need, requiring for their satisfaction the mediation of another person (Naila, 2001). Bandura's (1997) social learning theory posits that people learn from one another via observation, imitation, and modelling. People learn through observing others behaviours, attitudes, and outcomes of those behaviours. "Most human behaviour is learned observationally through modelling: from observing others, one forms an idea of how new behaviours are performed, and on later occasions, this coded information serves as a guide for action". Social learning theory explains human behaviour in terms of the continuous reciprocal interaction between cognitive, behavioural, and environmental influences. According to Morris (1993), the main idea of social learning theory remains the same: there is always an interaction among three factors: the person, the situation, and the evaluation of expectancies obtained by that person from that person's experiences.

Biological Theory of Mental Health

This is a medical model for treating mental disorders. The idea is that something physical is the cause of the mental illness. Symptoms are "outward signs of the inner physical disorder" (McLeod, 2018). Charles Darwin first introduced the idea that evolution and genetics play a role in human

behaviour. Furthermore, Selye's (1956) theory and research on the physiological responses to stress and the description of the adaptation responses of the individual, including at the cellular level as well as at the system level, have received much attention. Selye described the fight-or-flight mechanism within the general adaptation syndrome. He noted three stages within adaptation: the alarm reaction, resistance, and exhaustion.

Hypotheses

1. There will be a significant positive association between religious commitment and mental health among Parishioners of the Church of the Assumption, Asokoro, Abuja.
2. Hypothesis two states that there will be a significant positive association between locus of control and mental health among Parishioners of the Church of the Assumption, Asokoro, Abuja.
3. Religious commitment and locus of control will have significant independent and joint effect on mental health among Parishioners of the Church of the Assumption, Asokoro, Abuja.

LITERATURE REVIEW

Spiritual Commitment

In describing religious commitment, Cornwall and Albrecht (1986) focused on two dimensions, namely, spiritual commitment and church commitment. The spiritual aspect encompasses the believers' relationship with the transcendent and the members' affective orientation towards deity, while the church aspect relates to the affective orientation of the individual towards the religious organisation or community.

The above views seem to agree with Takamizawa's (1999) view that religious commitment involves three phenomenological dimensions, namely, ideational, communal, and experiential/spiritual. The ideational dimension refers to the content of the belief; the communal dimension denotes human relationships within the religious group; and the experiential or spiritual dimension refers to members' subjective experiences that connect them to the Deity. According to Takamizawa (1999), the commitment of members of a religion to the Deity intensifies through these three phenomenological dimensions, or at least a part of them. Commitment to the Deity can be partial because some members may terminate their affiliation with the religious or spiritual group without forsaking their doctrinal beliefs, or others may doubt the religious doctrine without leaving their communal affiliation with the group. Therefore, religious commitment has been described as a volitional linkage between a religious group and its members, which facilitates the willingness of the members to contribute towards maintaining the group with their doctrinal, communal, experiential, or spiritual assent and participation (Takamizawa, 1999).

In view of the above, therefore, the present study conceptualised religious commitment as the degree to which a person adheres to his or her religious values, beliefs, and practices and uses them in daily living (Worthington, 1988). In this sense, religious commitment is viewed as encompassing both religious and spiritual practices, behaviours, and experiences manifested across the full range of both individual and institutional domains.

Locus of Control

Locus of control is the degree to which people believe that they, as opposed to external forces (beyond their influence), have control over the outcome of events in their lives. The concept was developed by Rotter (1954) and has since become an aspect of personality psychology. A person's "locus"(plural "loci", Latin for "place" or "location") is conceptualised as internal (a belief that one can control one's own life) or external (a belief that life is controlled by outside factors which the person cannot influence, or that chance or fate controls their lives) (Rotter, 1966). Individuals with a strong internal locus of control believe events in their lives are primarily the result of their own actions. For example, when receiving exam results, people with a high internal locus of control tend to praise or blame themselves and their abilities, whereas those with a high external locus of control are likely to praise or blame external factors such as the teacher or the examination for the outcome (Carlson, Buskist, Michael, & Donald, 2007). Locus of control has generated much research in a variety of areas in psychology. The construct is applicable to such fields as educational psychology, health psychology, and clinical psychology. Locus of control is one of the four dimensions of core self-evaluations—the fundamental appraisal of oneself—along with neuroticism, self-efficacy, and self-esteem (Judge, Locke, & Durham, 1997; Judge, Timothy, Amir, Bono, & Carl, 2002).

Mental Health

Mental health refers to a satisfactory state of psychological functioning and adjustment or the absence of mental disorders. According to the WHO, mental health includes "subjective wellbeing, perceived self-efficacy, autonomy, competence, inter-generational dependence, and self-actualisation of one's intellectual and emotional potential, among others". This encompasses the realisation of individuals' abilities, coping with the normal stresses of life, productive work, and contributing to the community. Mental health, also known as eudemonic wellbeing, is defined as the successful performance of mental functions resulting in the capacity to adjust to changes and cope with adversity (Johal and Pooja, 2016). It is not merely the absence of mental disorders but a state of mind characterised by emotional well-being, the capacity to establish and maintain fulfilling relationships, and the ability to cope with the stresses of daily living (Goldman, 1984). Generally, mental health encompasses psychological and social wellbeing and relates to how we think, feel, and act. These, in turn, determine how we relate to other people, deal with life's stresses, and make choices.

Religious Commitment and Locus of Control

Researchers often equate external control with relying on fate or God. However, dependence on fate and dependence on God are not synonymous if the latter involves some degree of mutuality (Jackson and Coursey, 1988). Unlike fatalism, for which an external locus of control is the clearest underlying psychological mechanism, religion has a more nuanced relationship with the locus of control. Religion may increase external control, but at the same time, a reliance on God may actually improve one's sense of internal control and thereby improve psychological outcomes (Pargament and Hahn, 1986). In a qualitative study examining religious turning points in a sample of 30 older adults, Fiori et al. (2004) noted an interesting comment made by one of the participants, recalling his fight with prostate cancer: ''I asked the good Lord to give me strength to accept my fate.'' Thus, this participant interpreted his cancer as caused by fate and the ''good Lord,'' his means of strength to accept it and cope with the disease. This combination of internal and external loci of control exemplifies the complicated relationship between religiosity and loci of control.

The idea of ‘‘collaborative control’’ encapsulates this balance between internal and external loci of control; with this type of control, individuals work together with others (Krause, 2002) or, more specifically, with God (Pargament et al., 1988; Schieman, 2003) to jointly influence their problems. How can belief in God be related to internal control? Two areas of research in particular may offer some insight into this question: research on religious coping and research on attribution theory. According to Pargament et al. (1988), when an individual sees God as a partner in the process of coping, control is achieved through the relationship between the individual and God. This collaborative approach has been associated with better outcomes than other religious coping approaches, such as the deferring approach, in which the individual relinquishes personal responsibility to God.

Religious Commitment and Mental Health

One of the few studies that investigated the influence of R/S on health outcomes during the COVID-19 pandemic (Weinberger-Litman et al., 2020) included 303 members of North American religious communities and found no association between religious commitment and distress or anxiety. According to the authors, the lack of association is because this population is very religious and composed of members of specific religious traditions, which may lead to a low variability of responses and minimise the statistical power. Another study (Pirutinsky et al., 2020) has investigated 419 American Orthodox Jews and found that positive religious coping, intrinsic religiosity, and trust in God strongly correlated with less stress and more positive impact, while negative religious coping and mistrust in God correlated with the inverse.

Hodapp and Zwingmann (2019) investigate the relationship between religiosity and spirituality (R/S) and mental health based on 67 studies from the German-speaking area (Germany, Austria, and Switzerland). The weighted average correlation is.03 (95% CI [.01,.05]), indicating that a greater R/S is minimally but significantly associated with better mental health. The results are moderated by the type of R/S measure: negative R/S types correlate − .20 with mental health, whereas other R/S measures exhibit small positive associations. In comparison with US-American meta-analyses, the average effect size is lower, and the associations between negative R/S types and lower mental health are particularly strong.

Locus of Control and Mental Health

Kurtovi et al. (2018) examined the effect of locus of control on university students’ mental health and examine possible mediational roles of self-esteem and coping. A total of 418 university students completed the Rotters I-E Scale, the Self-liking/self-competence Scale, the Endlers Coping with Stressful Situations Scale, and the Depression, Anxiety, and Stress Scale. The results showed that external loci of control, lower self-liking and self-competence, as well as less problem-focused and more emotion-focused coping, predict more symptoms of depression, anxiety, and stress in university students. However, mediational analysis revealed that the effect of locus of control was fully mediated by self-esteem and coping, with self-liking and emotion-focused coping being the strongest mediators. Results suggest that beliefs about control affect beliefs about one’s self-worth and coping strategies, which in turn can affect one’s mental health.

Churchill et al. (2020) examine whether gender differences in locus of control (LoC) explain gender gaps in mental health using longitudinal data from the Household, Income, and Labour Dynamics in Australia (HILDA) survey. Findings revealed that gender differences in LoC are an important factor contributing to the well-recognised gender gap in mental health in favour of males. The preferred estimates, which take into account differences in the distribution of

characteristics between males and females, suggest that at the mean, a unit increase in internal LoC for females would narrow the mental health gender gap by 2.2%, and if the LoC of women were the same as that of men, it could close the gender gap in mental health by as much as 18.8%. This general conclusion is generally robust to evaluating the gender gap at the 10th and 90th quantiles and a suite of sensitivity checks, including different ways of measuring key variables and alternative approaches to the Blinder-Oaxaca decomposition.

Shojae and French (2014) pioneered a study to explore the association between LOC and the mental health of the respondents. The study revealed that there was a close and significant association between locus of control and the mental health of young adults.

Sidola et al. (2020) examined the relationship between locus of control and mental health among college students. The sample for the study comprised 400 undergraduate students (aged 17–21 years) from four constituent colleges of Punjab Agricultural University, Ludhiana, Punjab. A self-structured Locus of Control Questionnaire adapted from Rotter's Locus of Control Scale (1966) and Levenson's Multidimensional Locus of Control Scale (1992) was used to assess the Locus of control, and the mental health battery by Singh and Gupta (2000) was used to investigate the mental health of the selected students. Results indicated statistically significant differences in the type of locus of control among the students from various colleges, with respondents from the College of Agricultural Engineering and Technology leading in internal LOC and those from the College of Agriculture as well as the College of Community Science superseding in external LOC. Further, a major proportion of the respondents had a medium level of mental health, but a significant positive contribution of the internal locus of control was observed towards the overall adjustment dimension and overall mental health of the respondents.

METHODS

Research Design

Based on the fact that the researcher does not intend to manipulate the independent variables so as to measure mental health, cross-sectional survey design was used for the study.

Setting

The study's field work was conducted in the Catholic Church of the Assumption, Asokoro, Abuja. The Catholic Church of the Assumption, as the name implies, is one of the Catholic Churches in the Catholic Archdiocese of Abuja, located at 2 Kwame Nkrumah Crescent in Asokoro district. This Church has been in existence for about 20 years and has a population of about 1,000 parishioners who are largely educated.

Population, Sample, and Sampling Technique

The target population for this study comprised adult males and females who were recruited from Catholics in Church of the Assumption Asokoro, Abuja. Purposive sampling, also known as non-probability sampling, was used to select participants. This is because the items in the samples were deliberately chosen by the researcher. Purposive sampling allows for particular units of the universe to be chosen to constitute a sample on the basis that the small mass selected out of a huge one will be typical or representative of the whole. Here, the study adopted the Raosoft Sample Size calculator in determining the Sample Size of the study. Raosoft sample size calculator is computer software that is used to generate the size of a research sample from a

study population. It is used as follows: Margin of error = 5%**,** Confidence Level = 95%**,** Population = 270, and Response Distribution =50%

Methods of Data Collection

This study basically considered the primary source of data by using a survey questionnaire. The questionnaire definitely captured the demographic information of the respondents, like their age, marital status, educational qualifications, religion, sex, and occupation. The study research instruments used for data collection include the Religious Commitment Inventory (RCI-10), Rotter's Locus of Control scale, and the Self-Reporting Questionnaire.

Instruments

Religious Commitment Inventory

The Religious Commitment Inventory (RCI-1O) by Worthington et al. (2003) measures an individual's level of religious adherence in daily life and the extent to which he or she interprets life events based on his or her religious views. The scale was scored on a 5-point Likert scale: not at all true of me = 1, somewhat true of me = 2, moderately true of me = 3, mostly true of me = 4, and totally true of me = 5. Scores on the RCI-1O have strong estimated internal consistency, with Cronbach's alpha ranging from.93 to.96. In addition, Cronbach's alpha of the subscales was.92 (intrapersonal religious commitment) and.87 (interpersonal religious commitment). The full scale has a test-retest reliability of.87.

Locus of Control Scale

This scale was developed b**y** Rotter (1966) to measure the direction and strength of locus and control. It was constructed within the context of social learning theory. The scale consists of 29 paired items. Eyetsemitan (1996) validated the instrument for use on the Nigerian population, which yielded a validity index of.61. The scale has been validated and used by many researchers in Nigeria (e.g., Nduanya et al., 2018).

Self-reporting Questionnaire-20

The Self-reporting Questionnaire-20 (SRQ-20) was developed as part of a collaborative study coordinated by the World Health Organisation (WHO) (Beusenberg and Orley, 1994) on strategies for extending mental health care. It consists of 20 yes-or-no questions with a reference period of the previous 30 days. It has acceptable levels of reliability and validity in many settings and is recommended by the WHO as a screening tool for psychiatric morbidity. It has previously been used to screen for maternal illness in developing countries (including Ethiopia) with similar socio-cultural settings, and a cut-off score of 7/8 was used to separate probable non-cases from cases of common mental disorders.

Procedure for the Administration of the Instrument

Approval was obtained from the research ethical committee of the Department of Psychology through a seminar presentation and the Catholic Archdiocese of Abuja. Participants were interacted with, and their consent was sought. Questionnaires were administered to them directly, and they were instructed to freely give their choice of answers to the items of the questionnaires as their responses would only be used for research purposes.

Techniques for Data Analysis

Data obtained in this study were analysed using Pearson's Product Moment Correlation and Hierarchical Multiple Regression Analysis to measure the extent to which pairs of related variables tend to co-vary or change together positively or negatively (Coolican, 2009; Strauss, 2000). ANOVA was also used to establish the extent to which religiosity and locus of control independently or jointly predict mental health. Also, descriptive statistics such as percentage mean and standard deviation were used to explore the demographic characteristics of the respondents. The analyses were performed using Statistical Package for Social Science (SPSS), version 21.

RESULTS

Test of Hypotheses

This section presents and interprets the stated hypotheses in the study.

Hypothesis One

Hypothesis One stated that there will be a significant positive association between religious commitment and mental health among Parishioners of the Church of the Assumption, Asokoro, Abuja. To address this hypothesis, Pearson's correlation (*r*) was conducted.

Table 1: Summary of Correlations of religious commitment, locus of control and mental health

Variables		1	2	3	4	5
1	Age	-				
2	Gender	-.23***	-			
3	Employment status	.15*	-.06	-		
4	Religious commitment	.19**	-.03	.08	-	
5	Locus of Control	-.08	.06	-.07	-.13*	-
6	Mental Health	-.26***	.20**	-.21**	-.29***	.18**

Note: ***p.001; **p.01; *p.05. Gender coded: 0 = Male, 1 = Female. Employment

Results of the correlations in Table 1 showed that religious commitment was negatively associated with locus of control (*r* = -.13, *p.05*) and mental health status (*r* = -.29, *p.001).* In other words, being more committed to religion was associated with fewer symptoms of mental illness. Locus of control was positively associated with mental health (*r* = .18, *p.01).* Thus, those with an external locus of control reported more symptoms of mental illness. The findings imply that there was a significant negative association between religious commitment and mental health among Parishioners of the Church of the Assumption, Asokoro, Abuja, thus confirming the first study hypothesis.

Hypothesis Two

Hypothesis Two stated that there will be a significant positive association between locus of control and mental health among Parishioners of the Church of the Assumption, Asokoro, Abuja. This hypothesis was confirmed as shown in Table 2, where it was shown that locus of control was positively associated with mental health.

Table 2: Hierarchical multiple regression predicting mental health of Parishioners of Church of the Assumption Asokoro, Abuja by religious commitment and locus of control.

Predictors	Step 1			Step 2		
	B	***B***	***T***	***B***	***β***	***t***
Religious commitment	-.16	-.29	-4.93***	-.15	-.27	-4.61***
Locus of control				.23	.15	2.52*
R^2		.08			.10	
ΔR^2		.08			.02	
F		24.27 (1, 268)			15.55 (2, 267)	
ΔF		24.27 (1, 268)			6.35 (1, 267)	

Note. ***p<.001; *p<.05; Δ = Change

A hierarchical multiple regression analysis was carried out, and the results are as shown in Table 2. Step 1 of the regression model showed that religious commitment was a negatively significant predictor of mental health, *β* = -.29, *t* (270) = -4.93, *p.001.* The Unstandardised regression coefficient (*B*) showed that for every one unit rise in religious commitment, mental illness symptoms decrease by -.16 units. The contribution of religious commitment in explaining the variance in mental health was 8% (R^2 =.08), and the overall model was significant, *F* (1, 268) = 24.27. Step 2 of the regression model showed that locus of control was a positively significant predictor of mental health, *β* =.15, *t* (270) = 2.52, *p.05.* The Unstandardised regression coefficient (*B*) showed that for every one unit rise in locus of control scores (indicating external locus of control), mental illness symptoms decrease by.23 units. The contribution of the locus of control in explaining the variance in mental health was 2% (R^2 change =.02), and the overall model was significant (*F* change (1, 267) = 6.35).

Hypothesis Three

Hypothesis Three stated that religious commitment and locus of control will have significant independent and joint effect on mental health among Parishioners of the Church of the Assumption, Asokoro, Abuja. In order to test the third hypothesis, ANOVA was conducted. The results are shown in Table 3.

Table 3: Summary of ANOVA results for between subject effects of religious commitment and locus of control on mental health

Source	Type III Sum of Squares	Df	Mean Square	*F*	Sig.
Religious Commitment (RC)	109.01	1	109.01	5.87	.016
Locus of control	70.07	1	70.07	3.77	.048
RC * Locus of control	76.60	1	76.60	4.13	.040
Error	4939.24	266	18.57		
Total	11137.00	270			
Corrected Total	5266.33	269			

Table 3 showed a significant main effect of religious commitment on mental health: *F* (1, 266) = 5.87, *p.001.* Participants with higher religious commitment had lower symptoms of mental illness (*M* = 3.95, *SD* = 3.47) than those with low religious commitment (*M* = 5.74, *SD* = 5.42). Also, there was a significant main effect of locus of control on mental health, *F* (1, 266) = 3.77, *p.05.* Participants with an external locus of control (high scores on the locus of control) had higher symptoms of mental illness (*M* = 4.98, *SD* = 4.80) than those who had low locus of control scores (internal locus of control) (*M* = 4.06, *SD* = 3.54). Similarly, the two-way interaction effect of

religious commitment and locus of control on mental health was found to be significant, *F* (1, 266) = 4.13, *p.05.* The graphical representation in Figure 1 showing the slope of the interaction indicated that those with low religious commitment who had an internal locus of control reported low symptoms of mental illness (*M* = 4.21, *SD* = 3.76) compared to those who had an external locus of control (*M* = 6.47, *SD* = 5.92). Similarly, those with high religious commitment who had an internal locus of control reported fewer symptoms of mental illness (*M* = 3.93, *SD* = 3.50) compared to those who had an external locus of control (*M* = 3.98, *SD* = 3.44).

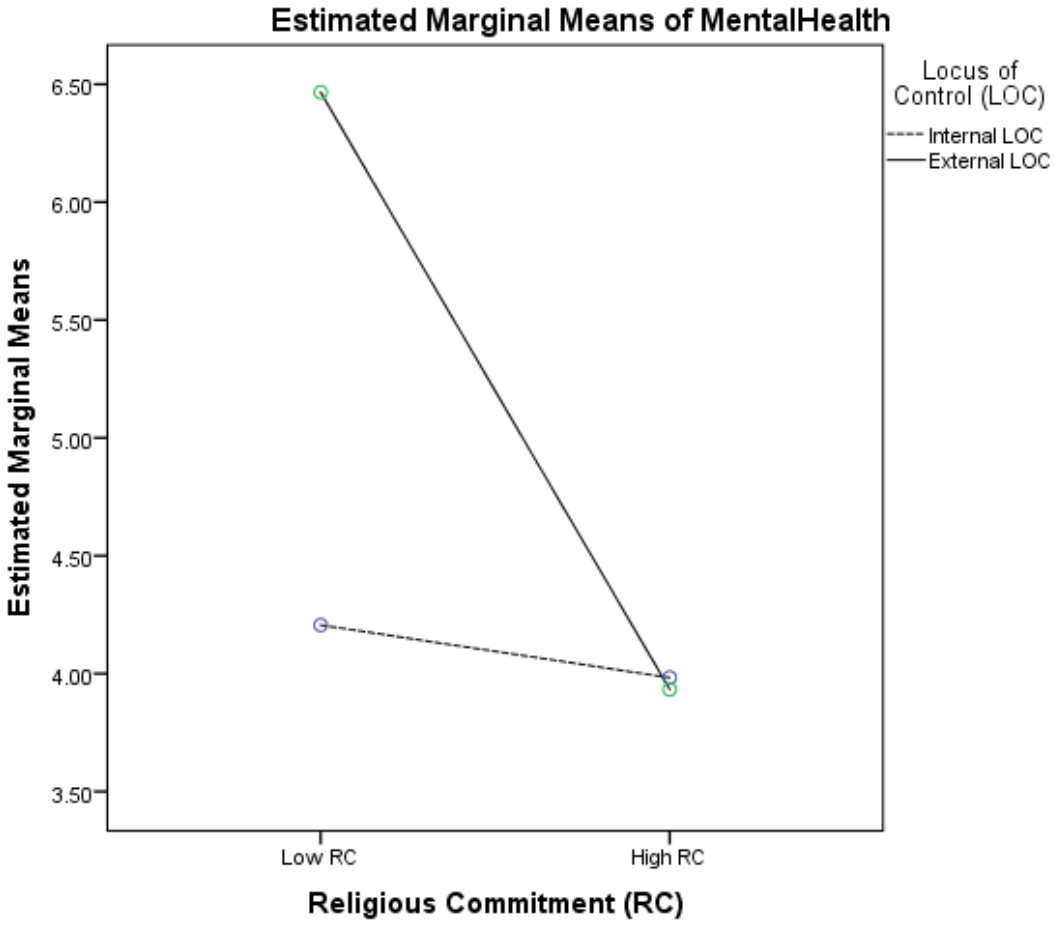

Figure 1**:** Slope of the three-way interaction effect of religious commitment and locus of control on mental health.

The findings imply that religious commitment and locus of control produced a significant combined influence on mental health among parishioners of the Church of the Assumption, Asokoro, Abuja. Therefore, the third hypothesis of this study was confirmed.

DISCUSSION OF FINDINGS

The present study investigated the influence of religious commitment and locus of control on mental health among parishioners of the Church of the Assumption, Asokoro, Abuja, Nigeria. Three hypotheses were tested. The first hypothesis stated that there would be a significant positive association between religious commitment and mental health among Parishioners of the

Church of the Assumption, Asokoro, Abuja. The result of the findings revealed that religious commitment was negatively associated with locus of control (*r* = -.13, *p.05*) and mental health status measured by symptoms of mental disorders (*r* = -.29, *p.001).* In other words, being more committed to religion was associated with fewer symptoms of mental illness, which, according to the categorical perspective of mental health (Scheid and Brown, 2010), implies good mental health. To further explain this, a regression model was used, which showed that religious commitment was a negatively significant predictor of mental health *(*= -.29, *t*(270) = -4.93, *p.001).* The Unstandardised regression coefficient (*B*) showed that for every one unit rise in religious commitment, mental illness symptoms decrease by -.16 units. The contribution of religious commitment to explaining the variance in mental health was 8% (R^2 =.08), and the overall model was significant (*F*(1, 268) = 24.27).

Based on the first hypothesis, the present findings are consistent with previous studies. For example, when Eke (2021) investigated the association of social support, hardiness, and religious commitment on the psychological well-being of psychiatric patients' carers in eastern Nigeria, multiple regression results showed that social support and religious commitment positively predicted psychological well-being. Similarly, a longitudinal study examining the effect of religious commitment activities on mental health reported a significant positive effect of religiosity or spirituality on mental health (Garssen et al., 2021). Similar findings have been reported by some other previous studies (e.g., McCullough and Larson, 2001; Lawrence et al., 2006; Hodapp and Zwingmann, 2019; Weinberger-Litman et al., 2020).

The second hypothesis stated that there would be a significant positive association between Locus of Control and mental health among parishioners of the Church of the Assumption, Asokoro, Abuja. The findings of this study showed that Locus of control was positively associated with mental health (*r* =.18, *p.01).* Thus, those with an external locus of control reported more symptoms of mental illness. Furthermore, the study revealed that indeed, locus of control was a positively significant predictor of mental health *(*=.15, *t* (270) = 2.52, *p.05.* The Unstandardised regression coefficient (*B*) showed that for every one unit rise in locus of control scores (indicating external locus of control), mental illness symptoms decrease by 23 units. The contribution of the locus of control to explaining the variance in mental health was 2% (R^2 change =.02), and the overall model was significant (*F* change (1, 267) = 6.35). The hypothesis, therefore, is confirmed by the findings.

The finding above is consistent with a previous study carried out by Kurtovi et al. (2018) to determine the effect of locus of control on university students' mental health and the possible mediation of self-esteem and coping. Based on a sample of 418 university students, Kurtovi and colleagues found the external locus of control to be an important predictor of symptoms of depression, anxiety, and stress. It was further suggested that beliefs about control affect beliefs about one's self-worth and coping strategies, which in turn can affect one's mental health (Kurtovi et al., 2018). In another study, Enwere and Mbakwe (2021) found a significant positive relationship between locus of control and psychological well-being. There is substantial evidence suggesting similar findings in the literature (Shojae and French, 2014; Sidola et al., 2020).

Finally, the third hypothesis stated that religious commitment and locus of control will have a significant independent and joint effect on mental health among Parishioners of the Church of the Assumption, Asokoro, Abuja. The finding showed a significant main effect of religious commitment on mental health, *F* (1, 266) = 5.87, *p. 001.* Participants with higher religious commitment had

lower symptoms of mental illness (*M* = 3.95, *SD* = 3.47) than those with low religious commitment (*M* = 5.74, *SD* = 5.42). Also, there was a significant main effect of locus of control on mental health, *F* (1, 266) = 3.77, *p.05.* Participants with an external locus of control (high scores on the locus of control) had higher symptoms of mental illness (*M* = 4.98, *SD* = 4.80) than those who had low locus of control scores (internal locus of control) (*M* = 4.06, *SD* = 3.54).

Similarly, the two-way interaction effect of religious commitment and locus of control on mental health was found to be significant, *F* (1, 266) = 4.13, *p.05.* The graphical representation in Figure 1 showing the slope of the interaction indicated that those with low religious commitment who had an internal locus of control reported low symptoms of mental illness (*M* = 4.21, *SD* = 3.76) compared to those who had an external locus of control (*M* = 6.47, *SD* = 5.92). Similarly, those with high religious commitment who had an internal locus of control reported fewer symptoms of mental illness (*M* = 3.93, *SD* = 3.50) compared to those who had an external locus of control (*M* = 3.98, *SD* = 3.44). This is also a confirmation of the third hypothesis.

This finding is also consistent with the findings of previous similar studies. For instance, Park et al. (2012) examined, using Multiple regression analyses, the extent to which religious coping and religious resources, the health locus of control (HLOC) regarding their congenital health failure (CHF), and their interactions related to subsequent depressive affect Neither religious coping efforts nor religious resources were related to depression. However, when examined in conjunction with internal HLOC, active coping and organised religious commitment were related to less depression for those higher in internal HLOC, while daily spiritual experience was related to less depression for those lower in HLOC. One study investigated associative relationships and pathways of mediation between religious functioning, locus of control (LOC), and health using 122 Christians (79 women, 43 men) who were predominately Catholic, ranging in age from 18 to 80 (*M* = 45.47, SD = 15.0) in the western suburbs of Melbourne, Australia, and found that awareness of God and internal LOC were associated with better health, whereas external LOC and instability were associated with poorer health (Ryan and Francis, 2012). Abadi et al. (2020) found a significant relationship between religious orientation (r = -0.328, p 0.04) and locus of control (r = -0.365, p 0.01) in addicts with a tendency towards substance abuse.

Conclusion

Based on the findings of this research, the following conclusions can be deduced:

First, the study found that participants who were highly committed to the tenets of their religion fared better in mental health as they showed lower symptoms of mental illness (*M* = 3.95, *SD* = 3.47) than those who had low religious commitment (*M* = 5.74, *SD* = 5.42). In a nutshell, this implies that religious commitment can influence improved mental health, which addresses the first question raised in this research.

Secondly, the study revealed that locus of control had a significant influence on mental health: *F* (1, 266) = 3.77, *p.05.* Participants with an external locus of control (i.e., high scores on the locus of control) had higher symptoms of mental illness (*M* = 4.98, *SD* = 4.80) than those who had low locus of control scores (internal locus of control) (*M* = 4.06, *SD* = 3.54), which answers the second research question.

Thirdly, religious commitment and locus of control produced significant independent and combined influences on mental health among Parishioners of the Church of the Assumption, Asokoro, Abuja, thus answering the third research question.

Recommendations

The following recommendations are made based on the outcome of the research:

1. Mental health professionals, particularly in Nigeria, should pay attention to elements of religious faith in clinical practise, as sound religious faith could lead to improved mental health. Consequently, it would be desirable for clinicians to conduct comprehensive assessments of clients, including their religious background histories.
2. Clinicians should take cognizance of the critical role of religiosity and theism in the mental health and wellbeing of individuals and embed elements of religiosity and spirituality in interventions.
3. Mental health professionals should endeavour to create an appropriate therapeutic environment that allows the involvement of religious experts or the clergy in the care of clients with strong religious inclinations. Additionally, religious experts or the clergy should be encouraged to refer individuals who demonstrate the need for psychosocial care and clinical attention to qualified mental health professionals rather than giving religious or spiritual interpretation to clearly psychological problems.
4. Motivational enhancement Therapy should focus on strengthening the locus of control of individuals and enhancing psychological coping and resilience to traumatic stress.
5. Mental awareness seminars should be constantly organised in religious institutions. This is because some participants in this study privately indicated the necessity of such seminars. This will also enable mental health experts to work collaboratively with religious experts for the betterment of the mental health of religious adherents. More specifically, religious institutions should engage the services of mental health professionals where necessary during counselling, as there are always mental health issues that require professional handling. More research can be carried out specifically on the necessity of collaborative relationships between mental health experts and religious experts.

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