RESEARCH ARTICLE

Religious Commitment And Its Relationship to Neurotic Depression: A Field Study of eight Clinical Cases

Tekkouk Slimane
University of Oran 2 Mohamed Ben Ahmed
Algeria
Email: slimanetekkouk@gmail.com

Belabed Abdelkader
University of Oran 2 Mohamed Ben Ahmed
Algeria
Email: abdelkaderbelabed.20@gmail.com

Doi Serial https://doi.org/10.56334/sei/8.10.52

Keywords depression; depressed; psychological immunity; religious commitment; religiosity

Abstract

In this study, the researcher attempts to shed light on the relationship between one of the most common psychological illnesses, namely depression, and religious commitment - specifically Islamic religious commitment - considering that Islam is the religion of the Algerian people. This commitment is manifested in a set of devotional behaviors such as prayer, fasting, and others, and everything that is likely - as behavior - to draw closer to God Almighty, where 8 clinical cases were addressed - residing in the state of Oran - suffering from depression (mild or neurotic).

This study aims to attempt to understand the nature of the relationship between religious commitment and neurotic depression, as the researcher seeks to understand the impact of religious commitment on the psychological immunity of the neurotically depressed person, especially since religious commitment as a devotional behavior carries several dimensions: spiritual, psychological, mental and social, carrying meanings that indicate treatment, healing and reassurance. These meanings are rooted - from a psychoanalytic perspective - in what is called the collective unconscious, and this point in particular shows the extent of the importance or influence of Islam as a religion in the life of the Muslim - conscious and unconscious - and its relationship to various areas of his life.

The researcher relied on the clinical interview as a means of investigation and research, in addition to using one of the standardized and previously validated measures of religious commitment, and testing it in the field. We will provide details about this when we discuss the research tools later.

The results of the study confirmed that religious commitment plays a strong and important role in strengthening psychological immunity against neurotic depression in most of the cases studied.

Citation. Slimane T., Belabed A. (2025). Religious Commitment And Its Relationship to Neurotic Depression: A Field Study of eight Clinical Cases. *Science, Education and Innovations in the Context of Modern Problems*, 8(10), 581–595. https://doi.org/10.56352/sei/8.10.52

Issue:https://imcra-az.org/archive/384-science-education-and-innovations-in-the-context-of-modern-problems-issue-10-vol-8-2025.html

Licensed

© 2025 The Author(s). Published by Science, Education and Innovations in the context of modern problems (SEI) by IMCRA - International Meetings and Journals Research Association (Azerbaijan). This is an open access article under the **CC BY** license (http://creativecommons.org/licenses/by/4.0/).

Received: 16.02.2025 | Accepted: 04.07.2025 | Published: 02.08.2025 (available online)

Introduction:

Depression as a mental illness has been at the top of the list of mental disorders and illnesses in recent years, and it still is. This mental illness, which does not differentiate between the segments of society, rich and poor, old and young, educated and illiterate, male and female, occupies the minds of specialists in psychology, sociology, psychiatry, and other social or health sciences, as it still raises several questions and mysteries that still have

unknown answers and solutions, despite the considerable capabilities that the most important scientific bodies and institutions in the world have harnessed to understand and treat depression in its various forms.

In light of what we have mentioned, we cannot exclude our societies, as Arab or Muslim societies, from the danger of this psychological epidemic, regardless of the culture of our societies and their perceptions of psychology and psychological disorders in general, and related to depression in particular. Sadness, unhappiness, and everything in this context, were and still are linked to closeness or distance from God in the perception of the Muslim individual. Misery and wretchedness in life have always been linked to distance from God or weak religious restraint in Muslim societies, not to mention beliefs of a spiritual or metaphysical nature, such as demonic possession, magic, and sorcery, for which the Muslim finds no cure or fight except in what is religious and spiritual, such as Quranic incantations or devotional behaviors such as prayer and fasting.

Muslim societies may be unique from other societies that follow other religions in their awareness and consideration of the Islamic religion. Islam is not a part of life, but rather it is life as a whole. It is an intellectual and psychological belief, and an individual, collective, or social practical behavior, present in all areas of life. There is no field or area in which a Muslim is active without Islamic frameworks that define and direct his outcomes and behavior in it. Therefore, Islam has always carried the meanings of prevention and treatment at the same time, and is the foundation upon which a Muslim builds his perceptions in life and returns to it in cases of joy or sadness, failure or success, health and illness. This is what made us attempt in this study to understand the relationship between depression and religious commitment as one of the Islamic religious manifestations that appear in a set of daily devotional behaviors, which makes them behaviors that can last as long as the Muslim is alive and regardless of his conditions and circumstances. This continuity in practice has a dominant effect, as we mentioned earlier, on the life, feelings, and behavior of the Muslim individual.

1. The problem of the study and its questions:

Therefore, the researcher decided to raise the following problem:

Does religious commitment play a role in enhancing psychological immunity against neurotic depression in the cases studied?

It stems from this problem. Partial questions. **We list them as follows:**

- Does the religiously committed person under study have strong psychological immunity against neurotic depression?

- Does the religiously committed person under study have average psychological immunity against neurotic depression?

-Does the religiously committed person under study have weak psychological immunity against neurotic depression?

-Does the neurotic depressed person under study have a strong religious commitment?

-Does the neurotic depressed person under study have average religious commitment?

-Does the neurotic depressed person under study have weak religious commitment?

2. Study hypotheses:

To answer the general problem of the research, the researcher poses the general hypothesis. As follows:

Religious commitment plays a role in strengthening psychological immunity against neurotic depression in the studied cases, or vice versa.

The student can infer from the general hypothesis the partial hypotheses. Next:

The religiously committed person under study has strong psychological immunity against neurotic depression or vice versa.

The religiously committed person in the study has average psychological immunity against neurotic depression or vice versa.

The religiously committed person under study has weak psychological immunity against neurotic depression or vice versa.

The neurotic depressed person under study has a strong religious commitment or vice versa.

The neurotic depressed person under study has average religious commitment or vice versa.

The neurotic depressed person under study has weak religious commitment or vice versa.

3. Study objectives:

Based on the general problem and the general hypothesis of the research, the researcher put forward the following general objective:

An attempt to understand the relationship between depression and religious commitment, and the mechanisms that control it.

The researcher also deduced from the partial problems and partial hypotheses. **The following sub-goals::**

Trying to understand the nature of the impact of religious commitment on the individual's psychological immunity against...

An attempt to understand the influence of religiosity in shaping perceptions of depression.

An attempt to understand the role of religiosity or religious commitment as a therapeutic mechanism for depression.

4. Importance of the study:

The importance of this study lies in shedding light on the factor of religion, or Islam specifically, as a pivotal reference in the life of the Algerian individual as a Muslim. We cannot deny that Muslims visit exorcists, imams, and other practitioners and specialists in faith and Sharia, for the purpose of issuing fatwas or even what is called spiritual treatment. Many Muslims attribute depressive symptoms such as sadness, distress, or loss of desire to spiritual or supernatural matters, such as the evil eye, possession, and magic. They do not see any preventative or therapeutic means other than exorcism, reciting the Qur'an, fasting, prayer, and other manifestations of religious commitment. This, if anything, indicates a mental perception of the Muslim individual that there is a close connection between the spiritual and doctrinal aspects of faith and religious commitment, and everything that could upset the psychological balance of the Muslim individual, causing him to become depressed or suffer from other psychological illnesses and disorders. This suggests the possibility that religious commitment has a role or influence on what is called the psychological immunity of the Muslim individual, not only against depression, but against illness or psychological disorder as a whole.

Therefore, the researcher believes that the importance of the study lies not only in shedding light on the relationship between depression and religious commitment, but also in its findings that may open the way for a

better understanding and exploration of the mechanisms and perceptions related to mental health and mental illness for the Muslim individual.

5. The theoretical framework of the study:

Definition of depression:

Language: Depression is derived from the word "melancholy," which means extreme sadness.

As for the termFDepression is defined in psychology as: "A nearly constant medical condition, characterized primarily by sadness, a decrease in vitality and energy, and anxiety. The depressed person is unable to face the simplest problem and is unable to take any initiative. He also suffers from impotence and a decline in his mental abilities, especially those related to attention and memory."

Religious commitment:

Definition of commitment in language From necessity, meaning stability and permanence, as we say: something became obligatory for him, meaning it became a fixed obligation upon him.

As for the term commitment, there are two definitions: one of them has a general meaning, and the other has a specific meaning. The general meaning is that a person obligates himself to do something that he does willingly, such as buying, selling, or other transactions. So the commitment here has the character of the field or area in which it is in the context, such as a professional or family commitment. If it is compelled by Sharia and religion, such as prayer or other obligatory acts of worship, then it is a religious commitment.

Psychological immunity:

It is defined by "Sely" (1976) as an expression of resistance and psychological resilience that an individual shows in the face of daily pressures. It is also defined by (Albert. (2012) as a set of personal traits that contribute to the individual's ability to endure exhaustion and pressure and to integrate the acquired experience with that in a pattern that does not affect the effective functions of the individual. It also produces a psychological immunity that protects the individual from negative environmental influences.

6. Operational definitions:

Depression: is a psychological condition that the patient in question suffers from, and whose symptoms are characterized by a deep sense of sadness and grief, low self-esteem or severe self-criticism, disturbance of instincts (eating, sleeping, sex), loss of desire and interest in life, and the prevalence of pessimistic, catastrophic, or even suicidal thoughts in some cases.

Religious commitment: It is all the behavioral manifestations of Islamic religiousness (prayer, fasting, reading the Qur'an, etc.) that the studied cases are obligated to adhere to (as they are Muslim by religion). The studied cases may be actually committed to performing them, or they may be negligent or interrupted in performing these devotional behaviors (all or some of them).

7. Study methodology:

Due to the nature of the study topic, the researcher adopted the clinical approach.Considering that he is studying a clinical case (eight clinical cases exactly), Leitnerwitzmer defined the clinical method as the method that uses the results obtained through examining a case (patient) or several cases and studying them successively and separately (separately), in order to extract general laws that indicate the efficiency or deficiency of these studied cases. In order for the researcher to be able to reach this, he uses the case study that allows him to deeply understand the studied cases by shedding light on their details across time, place, and psychological, physiological, familial, and social life.

8. Study tools:

The researcher used the following tools in his study:

Clinical interview (Half-directed) **:**It is one of the most important investigative methods that clinical psychologists rely on. The American Psychological Association defines the interview - in general, not the semi-structured interview specifically - as a type of goal-oriented interview. It was used with children, but is now applied to several contexts, including research on human factors, psychological assessment, and planning treatment for patients by a specialized psychologist.[1]

It can also be defined as the process of evaluating a client to uncover valuable information regarding his psychological state. This method is primarily used in psychiatry, and also in medical fields to uncover the individual's strengths and weaknesses in his current and past life.[2]

As for the semi-structured clinical interview, it is an interview in which the specialist targets specific points, a topic, or a specific area of the client or case. This may be done by preparing specific questions before starting it, or by simply limiting the clinical interview to this topic or area as a general framework for it. However, this framework, framing, or control over the content of the interview is partial and not complete, as the specialist leaves space or room for the client or case to express its needs or ideas, even if they are outside the framework of the objectives previously set by the specialist, provided that this space granted to the case does not negatively affect the course of the interview, the collection of information, or the desired objectives.

The therapist tries to help the client feel comfortable revealing frank information relevant to the condition he is suffering from. The initial interview also focuses on gathering general information and the problem of the case in order to ask the most appropriate questions for the case and develop an appropriate treatment plan.[3]

The researcher indicates that he scheduled 5 clinical interviews with each of the eight cases studied, as he targeted a specific topic in each interview through some questions directed to the case - considering that the interviews were semi-directed - as the researcher presents the content of each interview in succession:

First interview: The interview was an introduction between the clinical psychologist (the student) and the case, as the student introduced himself professionally, and explained the nature of the profession or the tasks assigned to the clinical psychologist and the limits of his therapeutic and psychological care interventions. After that, he explained to the studied cases that he was preparing a graduation thesis to obtain a doctorate in clinical psychology. Then he addressed the subject of the study and explained in a simplified manner to the cases the research variables and the relationship between them and the aim of the study. He explained to the studied cases their role and what is required of them as they represent a variable of the study variables. He also emphasized the necessity of the desire to participate in the research, and that the case is not forced to participate.

After the cases agreed to participate in the researcher's study, the researcher focused on collecting as much data as possible related to the primary data (age, educational level, civil status, etc.). After that, he addressed details related to depression, which are related in general to the following:

- History of depression diagnosis (since when?)

- Follow-up with a psychiatrist (since when?), and taking medication (if any: since when? And if the patient stopped taking the medication: since when and why?)

[1]Clinical interview «american psychology association», retrieved 01/31/2022.edited
[2](Khaty reynolds (03/03/2019), « what is clinical interviewing ? bizfluent, retrieved 01/31/2022. edited.
[3](Clinical interview, psychology, retrieved. 01/31/2022. edited.

- Previously consulting a clinical psychologist (if any: when? And in case of abandoning psychological follow-up: why?).

At the end of the interview, the cases were prepared for the next (second) interview, which was related to answering the content of the religious commitment scale.

Second interview: In this interview, the researcher ensured the case's psychological and mental readiness, and emphasized to the case that if she was suffering from exhaustion or had not slept well the previous night, then we could postpone the application of the scale to a later date, after ensuring the case's readiness.[4]Everything related to the scale, how to answer its content, the importance of being honest and frank in answering, and the impact of this on the credibility of the research and results were explained in great detail.

The researcher then provided each case with a copy of the scale and a pen, and left the interview room, giving the case a period not exceeding 30 minutes. If the case completed answering all the questions before the end of the period, she could inform the researcher of this and hand him a copy of the scale.

After the case submitted a copy of the Religious Commitment Scale to the researcher, the latter thanked the case for her efforts and cooperation in contributing to the research, and asked the case if she encountered any ambiguity, confusion, or difficulty in answering some of the questions, in order to address the issue if necessary.

At the end of the second interview, the cases were prepared for the objective or theme outlined in the subsequent clinical interview.

The third interview: In this interview, everything related to religiosity and the Islamic religion was addressed, from perceptions, representations, and behavioral and devotional commitment, by posing some questions prepared in advance by the researcher. The aim of this interview was not only to monitor the status or position of behaviors such as prayer, fasting, and others, but also to monitor the imprint of religiosity, religious deterrence, or religious convictions in general in the life of the case, and her reliance on that as a reference in life or her dealings, or as a defense mechanism that relieves her tension, pressure, or anxiety regarding the difficulties she faces.

The above was verified by first addressing the family and social environment in which the case was raised, and the extent of the presence of religiosity as a vital axis in her life. The influence of active educational individuals, such as educators and teachers, was also addressed, and whether they had a role in strengthening or encouraging religiosity and religious commitment in the case. The researcher tried, as much as possible, from what was mentioned above, to monitor the type and position of educational discourse of a religious nature in the case's life since her childhood, with the aim of understanding its impact on the case's perception of life, her thoughts, emotions, and behavior.

At the end of the interview, the cases were prepared for the objective or theme outlined in the subsequent clinical interview.

The fourth interview: In this interview, the researcher identified the topic of doubts and suspicions. The aim of this interview was to determine whether the case had gone through periods of doubt about the validity of Islam as a religion, or the actual and real existence of the Islamic faith, such as believing with certainty in the existence of God Almighty, belief in Heaven and Hell, the prophetic mission, the existence of angels and jinn, and other sacred things in Islam. The case also had the desire to convert to another religion or to atheism.

At the end of the interview, the cases were prepared for the objective or theme outlined in the subsequent clinical interview.

[4]In this regard, all cases confirmed their readiness, and the scale was applied in the second interview for each case without any obstacles. The application of the scale was smooth and positive in terms of its progress and the cases' interaction with it.

The fifth interview: In this last clinical interview, the patient's attitudes towards spiritual treatments such as ruqyah were discussed, as well as her opinion regarding metaphysical causes of psychological or organic illness, such as magic, sorcery, the evil eye, and demonic possession, and whether the patient had previously experienced such experiences.

Considering that this was the last clinical interview, the researcher would like to thank all cases for their cooperation and contribution to the study.

This was the content of the clinical interviews in order, as 05 interviews were conducted with all eight clinical cases, in the same systematic order mentioned above, and the researcher indicates that he did not encounter any kind of difficulties or obstacles regarding the progress of the clinical interviews, and that all cases responded smoothly and spontaneously and adhered to the instructions starting from respecting the interview times and answering the content of the religious commitment scale and the questions and inquiries directed to them by the researcher with complete transparency while avoiding as much as possible ambiguity and vagueness.

Clinical observation: It is one of the tools included in the clinical interview, and indeed one of the pillars of the latter, as it can be defined as the actual activity of sensory perceptions in intentional and unintentional observation with the aim of understanding what the client reveals and what he does not reveal.[5]

Form: The researcher applied a questionnaire as a measure of religious commitment, as this measure was previously prepared and approved by Dr. Bakhita Muhammad Zain Ali Muhammad.[6]The researcher did not see any need to reformulate or standardize the scale questions, due to the similarity between the original social environment in which the scale was previously applied - Sudanese society - and the Algerian environment, as both peoples profess Islam and are affiliated with Arabism.

This form consisted of 32 questions to which the studied cases answered with "yes" or "no" (one point for the answer "yes" and 00 points for the answer "no"), where the final score or total score indicates the percentage or estimate of religious commitment among the studied cases (see Appendix No. 01).

The researcher classified the level of the degree obtained in the religious commitment scale into 3 levels:

- From 00 to 11 points. It is considered a weak religious commitment.

- From 12 to 22 points. It is considered a moderate religious commitment.

- From 23 to 32 points. It is considered a strong religious commitment.

9.Results and discussion:

1.9. Results of the religious commitment scale for the eight clinical cases studied:

strong religious commitment (From 23-32)	Moderate religious commitment (From 12-22)	weak religious commitment (From 00-11)	Full mark	Cases
	X		21	Status 01

[5] Jalal Abdel Khaleq, Working with Individual Cases, Alexandria, Modern University Book, 2001, p. 247
[6]Associate Professor at Sudan University of Science and Technology, Department of Psychology, Faculty of Education, 1444 AH / 2022 AD

X			26	Status 02
X			26	Status 03
X			23	Status 04
	X		15	Status 05
	X		16	Status 06
	X		22	Status 07
	X		12	Status 08
/	/	/	20.12	General average For points
03 cases	05 cases	00 cases	the total	/

2.9. General summary of the results of clinical interviews conducted with the eight clinical cases studied:

In general, it can be said that despite the individual differences between the eight cases, the researcher expressed his satisfaction with the cases' response during the interviews and their cooperation in achieving the study's objectives. He did not find any material or moral obstacles that negatively affected the course of the interviews with the clinical cases.

The researcher states that three out of the eight cases studied expressed their desire to begin a process of psychological care and treatment with the researcher after the end of the study - that is, after the end of the five scheduled interviews - in his capacity as a clinical psychologist. This indicates - albeit relatively - the positive regard given to the clinical psychologist in these depressed clinical cases.

As for the content of the clinical interviews, the researcher noticed through collecting data related to the subject of each interview that, despite the difference in religious commitment between the cases, religion or Islam has a sacred place in the lives of all the cases. The latter generally agreed on the necessity of religiosity and religious commitment, even if some of them showed negligence in performing acts of obedience and worship and everything related to behavior and religious commitment.

The researcher believes that the most important factors that shaped the perceptions and responses of the cases towards religion, religiosity or religious commitment are the environment, social and family upbringing, and the educational patterns or models that the cases were subjected to, and through which they affected each case's perception of its relationship with God Almighty, and the position of religious behavior or commitment in its life. However, the researcher's attention was drawn to a very important matter, which is that most of the cases were subjected to a practical separation between what is moral and what is religious commitment. In other words, the upbringing was more moral and social than religious or religious. In this regard, the researcher cites the fact that all the studied cases did not receive reprimand, accountability or strictness during their social upbringing regarding the performance of acts of obedience and worship, such as prayer, fasting, or wearing the hijab for females or others, while most of them were subjected to educational strictness in most of what is moral or social, such as respecting the prevailing social culture, for example, for females not exceeding a specific time to enter the house or modesty in dress without the necessity of wearing the hijab, for example. This is what led the researcher to consider that the cases studied were generally subjected in their upbringing to what is cultural and social, more

than what is religious and Islamic, and if we hypothetically accept this fact, then we can conclude that religiosity or religious commitment - in the clinical cases studied - was merely an automatic performance of inherited behaviors without any practical or applied benefit in daily life, so most of the cases were not inclined towards religious treatments represented by legal ruqyah to treat their depression, despite their statement that such treatments might be effective with other cases.

The researcher does not deny the possibility that depression and its symptoms at the present time – that is, the stage in which the researcher conducted his study of the cases – may have affected perceptions and representations related to religion and religiosity, and even the motivation, desire, and ability to adhere to religion and perform acts of obedience and worship, and all that is devotional behavior. We know that depression affects the individual's activity and his performance at all levels, but this does not deny that the cases acknowledged the necessity of religious commitment, but justified their failure to do so due to the influence of depression and its symptoms. Some of the cases acknowledged that they intended to strive for religious commitment when they recovered from depression first, and this also indicates that these cases do not believe in the religious approach as a solution or treatment for their condition, as we mentioned previously.

10. Presentation and discussion of hypotheses:

1.10. Presentation and discussion of the first partial hypothesis.

Text of the first partial hypothesis: The religiously committed person under study has strong psychological immunity against neurotic depression or vice versa.

The results reached by the researcher through field procedures for studying the cases showed that the religious commitment of the cases - based on the results of the religious commitment scale - was mostly of average religious commitment.**(05 cases) and 03 cases with strong religious commitment** These results indicate that the religious commitment of the studied cases is generally average, and this level of religious commitment is estimated by the researcher as a significant level or as having a relative presence in the psychological and social life of the studied cases. Evidence of this is that the researcher did not record a single result from among the results of the religious commitment scale applied to the cases, indicating a weak level of religious commitment.

Dr. Abbas bin Mohammed Bawazir's study showed that[7]Critical analysis entitled. **Depression among commentators and psychologists in light of the Holy Quran'**[8]It is possible for a believer to suffer from depression, and it is not limited to non-Muslims only. This is because the believer is characterized by sadness, which is the basis of depression in the Holy Qur'an.

Dr. Gamal Farweez, a consultant psychiatrist at the Military Medical Academy in Cairo, Egypt, adds:Mental illness in general, and not just depression in particular, is organic in the brain and its symptoms appear psychologically. It has a genetic nature, which makes it vary among individuals, as some people are affected, but not all of them. Therefore, religiosity or religious behavior has no relation to whether or not one is affected by mental illness.

This is what the study conducted by Professor Michael King's research team adds.[9]At University College London, titled "Spiritual and Religious Beliefs as Predisposing Factors for Depression," this study followed more than 8,000 people with depression. Cambridge University published the results of this study, which demonstrated that religiously committed people (regardless of their religion or belief) are more vulnerable to depression. The results of the study also showed no evidence of a protective or defensive role of religiosity against depression or its symptoms.

[7]Assistant Professor, Department of Interpretation and Qur'anic Sciences, College of the Holy Qur'an and Islamic Studies, Islamic University, Saudi Arabia
[8]Journal of the Islamic University for Sharia Sciences, a refereed periodical scientific journal - Issue 198 - 09/2021.
[9]Head of the Department of Psychiatry at University College London.

Based on the results of the researcher's study mentioned above, and based on the field studies we mentioned, the first hypothesis does not hold true, meaning that the religiously committed person in the study does not have strong psychological immunity against neurotic depression.

2.10. Presentation and discussion of the second hypothesis.

Text of the second partial hypothesis: The religiously committed person under study has a moderate psychological immunity against neurotic depression or vice versa.

Considering that the results reached by the researcher through field procedures for studying the cases showed that the religious commitment of the studied cases was generally average, the researcher adds to what was revealed by the same critical analytical study previously mentioned in the discussion of the first partial hypothesis of Dr. Abbas bin Muhammad Bawazir. What the researcher adds, in addition to what he mentioned in this regard, is that the believer who suffers from depression is more able to live with his depression compared to the depressed non-believer, and Dr. Abbas bin Muhammad Bawazir provides evidence.The low suicide rate of depressed people in Muslim countries compared to other countries is evidence of this.

The researcher here points out an important detail, which is that psychological immunity does not necessarily mean complete absence of mental illness, but it is also useful and plays a role in bearing the losses and psychological suffering that the depressed person is exposed to as a result of his depression. If psychological immunity is strong, this reduces the possibility of the individual being afflicted with depression and does not negate his complete immunity to the latter. However, if it is average, this increases the possibility of the individual being afflicted with depression. If the individual is afflicted with depression, his average psychological immunity allows him to bear the symptoms of depression and coexist with it in a way that relatively limits the losses of depression on all levels and levels, psychologically, socially and organically.

Not to mention that the studied cases were proven to be suffering from depression, and despite their psychological suffering and symptoms that prevented them from adapting positively and properly to the requirements of daily life, they were not completely withdrawn from the arenas of life, as they were performing their social, familial and professional roles, as required by their psychological state and what resulted from their drug and psychological treatment, even if there was negligence in terms of their performance, the researcher did not record a complete withdrawal and negligence in terms of life responsibilities.

As proven by a study led by psychologist Lisa Miller,[10]A study of 103 people with depression showed that religiousness or spirituality has positive effects in combating the symptoms of depression, without completely eliminating the depression. This indicates that religious commitment, while not treating depression or preventing its occurrence, reduces its consequences and symptoms..

Based on the results of the researcher's study mentioned above, and based on the field studies we mentioned, the second partial hypothesis was actually achieved, meaning that the religiously committed person in the study has a moderate psychological immunity against neurotic depression.

3.10. Presentation and discussion of the third partial hypothesis.

Text of the third partial hypothesis: The religiously committed person under study has weak psychological immunity against neurotic depression or vice versa.

Considering that the results reached by the researcher through field procedures for studying the cases showed that the studied cases generally have an average religious commitment, the researcher adds that the content of the clinical interviews with the studied cases confirmed that the cases are not only in a state of resistance to the symptoms of depression, but are in a state of diligence and perseverance to improve their social performance, meaning that the cases are not completely withdrawn from life and its aspects, and the researcher did not record or notice any complete surrender to the symptoms of depression, and this indicates a desire and secrets to

[10] Director of the Mind-Body Spirituality Institute at Columbia University.

recover, so that some cases expressed that their current preoccupation is getting rid of depression, and the researcher did not record - during the clinical interviews conducted with the studied cases - any suicidal tendencies in the current stage that the cases are going through, and this indicates that the psychological immunity of the cases cannot be described as weak because it is an immunity that still plays its role in tolerating and coping with the symptoms of depression.

This is also supported by the aforementioned study by Lisa Miller, which shows that religious commitment, even if it does not eliminate depression and its symptoms, limits or reduces its symptoms. This does not indicate a complete surrender to depression.

Based on the above-mentioned results of the researcher's study, and based on the field studies we mentioned, the third partial hypothesis was not achieved, meaning that the religiously committed person in the study has no weak psychological immunity against neurotic depression.

4.10. Presentation and discussion of the fourth partial hypothesis:

Text of the fourth partial hypothesis: The neurotic depressed person under study has a strong religious commitment or vice versa.

The results reached by the researcher through field procedures for studying the cases showed that the religious commitment of the cases - based on the results of the religious commitment scale - was mostly of medium religious commitment (05 cases) and 03 cases of strong religious commitment. These results indicate that the religious commitment of the studied cases in general was of medium and not strong.

Based on the results of the researcher's study mentioned above, and based on the field studies we mentioned, the fourth partial hypothesis was not achieved, meaning that the neurotic depressed person in question does not have a strong religious commitment.

The researcher explains the failure of this hypothesis to be achieved by the type of social upbringing that the studied cases received, as this upbringing did not support religious commitment with a correct cognitive basis that gives it a preventive or therapeutic role, but rather made it merely an inherited ritual practiced as a behavioral tradition only without the presence of a desire to achieve the goal of religious behavior or worship and obedience, and this is what made most of the studied cases (5 cases out of 8 cases) not give priority to religious commitment in their lives, and the researcher supports his interpretation by the absence of a feeling of remorse regarding negligence in the obligatory or voluntary worship and obedience during the clinical interviews conducted, despite the recognition of the reality of this negligence.

The researcher also supports his study's denial of this hypothesis, with what the National Health Service (NHS) stated: In Britain, based on research from the University of Leeds, there are individual indications of the impact of the Islamic religion in treating psychological and mental disorders. This indicates the effective role of religious commitment and religious behavior in combating these disorders.

The researcher also adds in this regard to a study conducted by Lisa Miller in 2012, the results of which were published in the American Journal of Psychiatry, which showed a 90 percent decrease in depression symptoms in a sample of depressed adults who practiced religious or spiritual rituals.

5.10. Presentation and discussion of the fifth partial hypothesis.

Text of the fifth partial hypothesis: The neurotic depressed person in question has average religious commitment or vice versa.

The results reached by the researcher through field procedures for studying the cases showed that the religious commitment of the cases - based on the results of the religious commitment scale - was mostly of medium religious commitment (05 cases) and 03 cases of strong religious commitment. These results indicate that the religious commitment of the studied cases is generally average.

Based on the results of the researcher's study mentioned above, and based on the field studies we mentioned, the fifth partial hypothesis was actually achieved, meaning that the neurotic depressed person in the study has an average religious commitment.

The researcher attributes the realization of this hypothesis, i.e. the average level of religious commitment of the studied cases, to the same thing he mentioned in his discussion of the fourth partial hypothesis. However, in the same context, the researcher points out an important detail, which is that some cases admitted that they were diligent in their religious commitment related to obligatory or voluntary acts of worship and obedience (and not related to social dealings or religious convictions and ideas), but depression hindered this diligence and caused a decrease in its outcome. In other words, the average level of religious commitment may be a result of depression and its symptoms.

In the theoretical part of the study, and in his chapter devoted to depression and religious commitment, the researcher pointed out that depression negatively affects many psychological, cognitive and physical faculties and abilities. If we take into consideration that acts of worship and obedience require cognitive and physical effort, then reciting, memorizing or listening to the Qur'an requires the use of concentration, attention and memory, and prayer and fasting require physical and motor performance that the depressed person may not have, especially if we take into consideration the effect of some drugs and pharmaceutical treatments on the body and its physiological activity, all of this is likely to disrupt or negatively affect the depressed person's performance and religious commitment.

6.10. Presentation and discussion of the sixth partial hypothesis.

Text of the sixth partial hypothesis: The neurotic depressed person under study has weak religious commitment or vice versa.

The results reached by the researcher through field procedures for studying the cases showed that the religious commitment of the cases - based on the results of the religious commitment scale - was mostly of medium religious commitment (05 cases) and 03 cases of strong religious commitment. These results indicate that the religious commitment of the studied cases in general is of medium and not weak.

Based on the results of the researcher's study mentioned above, and based on the field studies we mentioned, the sixth partial hypothesis was not achieved, meaning that the neurotic depressed person in question has a weak religious commitment.

The researcher explains the failure of this hypothesis to be achieved by the fact that the religious commitment of the cases is present, albeit relatively, in relational and transactional aspects of daily and social life, or in relation to ideas and beliefs regarding religious sanctities and axioms. This covered the cases' shortcomings in obligatory or voluntary acts of worship, such as prayer, fasting, or reciting the Qur'an, etc. The researcher attributes this to the fact that despite the cases studied being subject to a social upbringing that did not highlight the preventive or therapeutic role of religious commitment represented in acts of worship and obedience, it focused on the importance and sanctity of performing religious rituals as a behavior or commitment for which God punishes negligence. This is what made the cases maintain some acts of obedience and worship as one of the behavioral aspects present in their lives, at the very least, and compensate for this shortcoming with regard to obligatory or voluntary acts of worship with what is socially relational in life.

There is a positive correlation between religiosity and social adjustment, and religiosity and self-esteem, as also shown by the results of Dr. Ayman Awad Gharib's study. Dr. Ali Abdullah Allan: "The impact of religious behavior on psychological and social adaptation among deaf people in the Hashemite Kingdom of Jordan."[11],The result s of the study showed a fundamental and positive impact of religious behavior on the research sample with regard to psychological and social adaptation.

[11]Dr. Ayman Awad Gharib, and Dr. Ali Abdullah Allan, "The Impact of Religious Behavior on Psychological and Social Adaptation among Deaf People in the Hashemite Kingdom of Jordan." Al-Balqa Applied University, Amman College of Financial and Administrative Sciences.

Without forgetting the researcher to refer to many of the noble Qur'anic verses, or even the noble prophetic hadiths that link between psychological reassurance and religious commitment, such as the Almighty's saying: "Those who have believed and whose hearts are assured by the remembrance of Allah. Unquestionably, by the remembrance of Allah hearts are assured." (28/Al-Ra'd)

The researcher adds that, apart from what is Islamic religious, many Western studies that have attempted to reveal the relationship between religion in general and mental illness have proven the importance of religiosity as a preventative or therapeutic mechanism against mental illness in general and depression in particular. Perhaps the best evidence for this is the studies and research of one of the pillars of psychoanalysis. **Carl Jung** Which confirms the connection between religion and mental health, and even attributes mental illnesses to the loss of religious tendencies among the mentally disturbed.

7.10. Discussing the hypothesis General:

The general hypothesis of the research was formulated as follows:

Religious commitment plays a role in strengthening psychological immunity against neurotic depression in the cases studied, or vice versa.

Through the results of the study, the content of the clinical interviews, and the results of the religious commitment scale, and considering that the latter's results indicated an average religious commitment in general - or at least - in the studied cases (5 cases out of the eight studied cases), noting that the religious commitment of the remaining three cases according to the results of the scale was strong, these results indicate a significant presence of religious commitment in the lives of the studied cases, and religious commitment in the studied cases cannot be considered marginal or weak in any way. Based on all of this, the researcher adds the data obtained during the clinical interviews regarding the study of the cases through the content of the five clinical interviews conducted with each case, which demonstrated resistance to depression and its symptoms, and the lack of total withdrawal from life aspects or final surrender to the influence of the pathological symptoms. The researcher concluded that religious commitment has a role in strengthening psychological immunity against neurotic depression in the studied cases.

The researcher supports the achievement of the general hypothesis of his study with many field studies that demonstrated the importance of the role played by religiosity in general (as behavioral commitment or psychological convictions). The researcher mentions among them the study of Asmaa Bin Aoud And Hanan Talbo titled **Religiosity and its relationship to some psychosocial variables (social adjustment, self-esteem) in a sample of university students[12].** The results of this study proved a positive correlation between religiosity and social adjustment, religiosity and self-esteem. The results of Dr. Ayman Awad Gharib's study also showed that Dr. Ali Abdullah Allan: "The impact of religious behavior on psychological and social adaptation among deaf people in the Hashemite Kingdom of Jordan."[13]The results of the study showed a fundamental and positive impact of religious behavior on the research sample with regard to psychological and social adaptation.

Not to mention what a new American study published in the January 2021 issue of the American journal "Religion and Health" has proven about the religious individual's use of some tools that psychologists have deemed effective in increasing well-being and protecting against distress, anxiety, and depression. The researchers conducting the study at the University of Illinois College of Medicine in the United States explained that the religious individual succeeds in finding positive ways when thinking about difficulties. This is what psychologists call "cognitive reappraisal," which results in effectiveness in dealing with difficulties. The researchers have named this trait "coping self-efficacy." Dr. Florine Illinois Champagne stated:[14]"Research conducted in this regard has

[12]Dr. Asmaa Bououd, Dr. Hanan Taleb, "Religiosity and its Relationship to Some Psychosocial Variables (Social Adjustment, Self-Esteem) in a Sample of University Students," Journal of Social Sciences, Issue 27, November 2016

[13]Dr. Ayman Awad Gharib, and Dr. Ali Abdullah Allan, "The Impact of Religious Behavior on Psychological and Social Adaptation among Deaf People in the Hashemite Kingdom of Jordan." Al-Balqa Applied University, Amman College of Financial and Administrative Sciences.

[14] Professor of Psychology at the University of Illinois and supervisor of the study

proven the importance of having faith and self-confidence to reduce the negative side effects of exposure to anxiety and depression."

The researcher should not neglect to point out many of the noble Qur'anic verses, or even the noble prophetic hadiths that link between psychological reassurance and religious commitment, such as the Almighty's saying: "Those who have believed and whose hearts are assured by the remembrance of Allah. Unquestionably, by the remembrance of Allah hearts are assured." (28/Al-Ra'd)

The researcher adds that, apart from what is Islamic religious, many Western studies that have attempted to reveal the relationship between religion in general and mental illness have proven the importance of religiosity as a preventative or therapeutic mechanism against mental illness in general and depression in particular. Perhaps the best evidence for this is the studies and research of one of the pillars of psychoanalysis. **Carl Jung** Which confirms the connection between religion and mental health, and even attributes mental illnesses to the loss of religious tendencies among the mentally disturbed.

11. Conclusion:

The researcher started from several questions, which mainly revolved around the effect of religious commitment on the immunity of the neurotically depressed individual, as he conducted his study in one of the cities of northwestern Algeria, the city of Oran, in the psychological clinic A.A., on a sample of Algerian society, represented by eight clinical cases, to crown his study in the end with results indicating the existence of an influential relationship between religious commitment and the immunity of the individual suffering from depression.

In order for the researcher to be objective, he points out that the results of the study may be more objective and reliable if it is completed by descriptive statistical studies on significant statistical samples and across the country's states, in order to achieve more comprehensive results that can be generalized to the Algerian social fabric for a clearer and more general understanding of the role of religion and religiosity and how to invest in it positively in future generations, and benefit from it educationally and socially.

Given the importance of religion in general in the lives of societies, and the Islamic religion in particular in Arab societies and our Algerian society, the researcher points to a set of recommendations that this study may open up areas towards other research problems, as he deduced through the data and study of clinical cases presented in this study, especially with regard to the social and educational upbringing of generations that influence or refine perceptions related to religion and religiosity or religious commitment and religious rituals or rites, through specific educational models, as the researcher noticed in most cases the absence of a connection or applied relationship between religious commitment and its role in life as one of the mechanisms of positive adaptation or prevention and treatment, which made religious commitment only formal or a traditional behavioral inheritance in the life of the individual in general, whether for the psychologically disturbed or the normal, which forces us to reconsider the educational philosophy, social or parental in particular, and to find field and applied mechanisms that have a practical and field impact on the cognitive and behavioral structure of the emerging generations with regard to religious commitment and how to employ it and benefit from it practically to overcome Life's obstacles and difficulties.

Statement of conflict

Authors declare that there is no any conflict in article.

References

1. Saleh, F. M. (2007). Religious commitment and its relationship to mental health among students of the College of Islamic Sciences. Journal of Education and Science, 14(4).
2. Asalia, M. I., & Hamduna, O. S. (2015). Religious commitment and its relationship to death anxiety and the experience of hope. Humanities and Social Sciences Studies, 42(3).

3. Bououd, A., & Taleb, H. (2016). Religiosity and its relationship to some psychosocial variables (social adjustment, self-esteem) in a sample of university students. Journal of Humanities and Social Sciences, (27).
4. Fromm, E. (2003). Religion and psychoanalysis (F. Kamel, Trans.). Al-Gharib Library.
5. Dovis, D. G. A., & Dobson, K. S. (2015). Prevention of anxiety and depression (A. A. Askar, Trans.; 1st ed.). National Center for Translation.
6. McKenzie, K. (2013). Depression (Z. Munim, Trans.; 1st ed.). Dar Al-Mu'taf.
7. Al-Sharbiny, L. (2001). Depression: Disease and treatment. Knowledge Establishment.
8. Dawood, H. A. H., & Brillant, S. (2008). The concept, status, and impact of the deterrent on achieving the influence of Sharia. Journal of Sharia and Law Studies, 35(2).
9. Al Khater, A. (n.d.). Sadness and depression in the light of the Qur'an and Sunnah. Islamic Forum.
10. Bououd, A. (2014, November 19). Psychological treatment for psychological disorders from an Islamic perspective: Depression as a model. Journal of Social Sciences, (209).
11. Al-Mahdi, M. A. F. (2002). Psychology of religion and religiosity (1st ed.). Al-Bitash Center for Publishing and Distribution.
12. Al-Marshadi, I. H., & Al-Sagri, R. K. (2015). Islamic psychology (1st ed.). Al-Manhajiyya Publishing and Distribution House.
13. Al-Aissawi, A. R. M. (2011). Psychological immunity. Dar Taiba for Publishing, Distribution and Scientific Equipment.
14. Al-Shaarawy, M. M. (2005). Faith immunity. Modern Library for Printing and Publishing.
15. Malouhi, N. M. E. (2019). The psychological immune system: Power and creativity. Dar Al-Ghashq Publishing House.
16. Mangiavillano, J. (2020). La dépression. Edition999.
17. Madhouj, O. (2015). The place of spirituality in the burden of mental maladies and addictions (Doctoral dissertation, University of Paris VI).
18. Perrin, L. (2003, October 1). Le psychisme, le stress et l'immunité. In La santé est en nous. Odile Jacob.
19. Mel. (2023). Islam and depression.
20. Huguelet, P. (2021, January 25). Santé mentale et religion. Séminaire.
21. Massin, C. (2024). Save your immune system. Odile Jacob.