Association between quality of life and religious coping in older people

Many people draw strength from their spiritual beliefs. In this study in Iran, Jabar Heydari-Fard and colleagues aimed to establish if there were any benefits for those in old age

Abstract

Aim To examine the association between quality of life (QoL) and religious coping in older people living in their own homes.

Method A descriptive analytical study was undertaken in Iran with 200 older people aged over 60 living in their own homes who were selected for inclusion by systematic random sampling. Data were collected by use of the Short Form 36 (SF-36) QoL questionnaire and a religious coping questionnaire developed previously by the authors.

Results There was no significant association between QoL and religious coping. However, mental health \( (r=0.20, P=0.003) \) and social function \( (r=0.20, P=0.004) \) had a significant association with the total score for religious coping. An association between a high level of religious coping and QoL was significant only for the mental health domain of the SF-36 \( (P=0.04) \).

Conclusion In light of these results, it can be suggested that older people's mental health and social function may be improved by strengthening their religious beliefs. Mental health and social function are associated with other QoL domains and so their promotion may also improve overall QoL.

Keywords Ageing, mental health, quality of life, religious coping, social function, spiritual health

POPULATION AGEING is a global phenomenon. Ageing may result in chronic disease, solitude, isolation and lack of social support (Canbaz et al 2003), which can lead to a reduction in quality of life (QoL). Therefore, attention to QoL in the care of older people is important (Donmez et al 2005, Schwarz et al 2007, Williams et al 2009).

People use religion in various ways to cope with stressful situations (Harrison et al 2001). Religious coping can be defined as the use of religious behaviours and practices to adapt to or deal with difficult and stressful situations (Olson et al 2012).

Older people often seek solace in religion and use it as a strategy to cope with the challenges of ageing (Helm et al 2000, Burker et al 2004). Poor religious and spiritual wellbeing are barriers to successful stress management in older people (Traynor 2005). Finding new meaning in life and using coping strategies, such as religion, help older people to accept the changes associated with ageing (Traynor 2005, Bagheri-Nesami et al 2010).

Ageing is associated with increased spirituality, religious beliefs and participation in religious activities (Coleman et al 2004, Koenig 2004, Voas and Crockett 2005, Andersson et al 2008). Evidence from two decades of attitude surveys in Britain shows that religious beliefs, affiliation to particular religions and attendance at religious services have eroded over time; as a consequence, older generations tend to be more religious than younger generations (Coleman et al 2004, Voas and Crockett 2005).

Religion has a significant effect on older people’s health and wellbeing (Shkolnik et al 2001, Schaele et al 2004), therefore attention to their religious needs is important and may improve their QoL.

Literature review

Loeb (2006) reported that reliance on God was an important coping method used by older African
Americans with chronic health conditions. In a qualitative UK study, Clegg (2003) described the views of older, south Asian patients and carers about culturally appropriate care in the NHS as that which respected individuality, created mutual understanding, catered for spiritual needs and maintained dignity.

Another UK study found that most care home managers felt responsible for providing spiritual care for residents, although they expressed concern about the ability of staff to provide it (Orchard and Clark 2001). In a UK study of nurses working in the east Midlands, Narayanasamy et al (2004) found that they responded to the spiritual needs of older patients by, for example, observing religious beliefs and practices and using personal religious beliefs to assist patients.

Some studies have shown that religion and spirituality influence various aspects of physical and mental health and are important sources of strength and support in coping with life’s stressful events (Daaleman et al 2004, Sperry 2006). Keyes and Reitzes (2007) suggested that religious identity can be formed by beliefs and spiritual practice, and may have a direct effect on mental health. Ravanipour et al (2008) stated that spirituality is a powerful factor in adapting to life changes and acts as a support system for older people. Hornig et al (2011) concluded that religious beliefs provide social support and coping strategies, and in this way religion can be beneficial to a person’s health.

However, other researchers have reported conflicting results. Voas and Crockett (2005) found that attendance at religious services was lower than religious belief in all age groups, but that religious affiliation, attendance and belief increased with age. The exception was in very old people, aged 79-86 years, in whom there was a decrease in attendance at religious services, possibly associated with frailty inhibiting attendance; as well as a decrease in affiliation perhaps due to the fall in attendance and belief.

The authors concluded that it is difficult to determine whether religious belief makes a difference to the lives of the very old (Voas and Crockett 2005). In a UK study, religious activities were not found to be helpful in dealing with depression in various religious groups (Loewenthal et al 2001). Religious activity was seen as less helpful by people who had experienced depression than those who had not, and was also viewed as less helpful by women than by men.

Iranian culture respects and values older age and nursing home care for older people is not seen as desirable. Instead most older people in Iran live in their own homes or with their families, even those who may have complex needs. The majority of the population in Iran is Muslim and religious leaders state that Muslims should regard older people as valuable members of the community. Older Iranians may undertake religious activities such as prayer at home and in mosques (Darvishpoor et al 2010, Amini et al 2013).

Nurses have a role to play in encouraging and supporting those older people who are unable to perform religious activities or find it difficult to perform them as a result of ill health. Nurses have not received specialist training in care of older people in Iran. However, as in many developing countries, the numbers of older people in the country are rising rapidly (Amini et al 2013). Therefore, the need for specialist care for this group is being recognised and addressed in nursing education (Rejeh et al 2011, Erichsen and Büssing 2013, Lopez et al 2014).

Aim
The aim of this study was to examine the association between QoL and religious coping in older people living in their own homes.

Method
This descriptive analytical study was part of an approved project by Mazandaran University of Medical Sciences. It was undertaken with 200 Muslim older people living in their own homes in Sari, a city in northern Iran, from October to December 2011. Systematic random sampling was used to select eligible participants from 20 health centres.

The medical history of each participant was reviewed and his or her family questioned. People who were recorded as having chronic disease at the time of the study were included, but those with cognitive impairment, acute and end-stage disease were excluded.

Religious coping was assessed by a questionnaire developed by the authors for another study in Iran (Azimi and Zarghami 2002). The questionnaire is available from the corresponding author. It consisted of 31 questions about participants’ religious beliefs, religious activities and religious coping strategies and their views about the effect of religion on dealing with their problems. A five-point Likert scale was used for scoring. Religious coping was divided into three levels - low (<97), moderate (97-113) and high (>113) - according to the total score. Reliability of the questionnaire was determined by test-retest in 30 students in Azimi and Zarghami’s (2002) study (r=0.88), then by split half test (0.88), obtaining a Cronbach’s α coefficient equal to 0.90. Validity of the questionnaire to assess religious coping in various
The Short Form 36 (SF-36) questionnaire was used to measure QoL. The SF-36 consists of 36 questions in eight domains: physical function, physical role limitation, vitality, emotional role limitation, mental health, social function, physical pain and general health. Responses were measured on a Likert scale (very high, high, moderate, relatively low, not at all), with a minimum score of zero and a maximum score of 100. QoL questionnaires, such as the SF-36, are standard tools and are suitable for use with older people in the community (Haywood et al 2005).

Descriptive statistics, such as frequency, mean and standard deviation, and analytic statistics, such as ANOVA, Pearson correlation coefficient and Chi-square tests, were used.

**Ethical considerations** The study was approved by the ethics committee of Mazandaran University of Medical Sciences. All participants received an information form about the study aim, the type of questions they would be asked, how the questionnaires would be anonymised and the security of the data they provided. If they agreed to participate, they were given a consent form to sign.

### Results

Two hundred older people (122 women and 78 men) aged over 60 participated in the study. Table 1 shows their demographic characteristics and association with religious coping.

The mean score for religious coping in all 200 participants was 102.11 ± 15.74. Level of religious coping was low (81.25 ± 14.37) in 28%, moderate (107.22 ± 4.85) in 51%, and high (116.45 ± 2.10) in 22% of participants.

The age group with the highest level of religious coping was 65-69. Participants cited the following beliefs: religion gives my life meaning (78%); I rely on God to feel safe (82%); religious practice (74%) and religious services (70%) are effective in creating mental peace. Fifty per cent of participants stated that belief in God was sufficient in itself and meant, for example, that they did not have to pray; 26% said they performed religious practices out of habit but did not feel any positive effect; and 43% felt the need to strengthen their religious behaviour. The Chi-square test showed no significant association between religious coping and gender, age, marital status, education or chronic disease (Table 1).

The mean total score for QoL was 53.52 ± 19.38. Figure 1 shows overall mean scores in the eight QoL domains of the SF-36. Social function had the...
highest score (66.75 ± 23.25) and emotional role limitation the lowest (47.27 ± 14.99). The Pearson correlation coefficient showed no significant association between religious coping score and total QoL score (r=0.04, P=0.56). Only mental health (r=0.20, P=0.003) and social function (r=0.20, P=0.004) had a significant association with the total score for religious coping.

Table 2 shows QoL scores in the eight domains of the SF-36 based on levels of religious coping. The QoL scores increased with higher levels of religious coping in all domains except general health and physical function. However, this increase was statistically significant only for the mental health domain (P=0.04).

Discussion
An association between some aspects of QoL and religious coping in older people was observed in this study. However, the age at which people began to undertake religious activity and its effect on physical and mental health, the difference between older people living in nursing homes and their own homes, and degree of religiousness, for example, frequency of prayer and attendance at religious services, were not assessed.

Participants’ mean QoL score was nearly half of the mean total score (53.52 ± 19.38), which supports the results of previous studies (Orfila et al 2006, Heydari et al 2012). This score is to be expected because older people experience various physiological and psychological problems (Donmez et al 2005, Schwarz et al 2007, Williams et al 2009). In this study, the score for general health was low. Chronic and debilitating diseases and various stressors that are common in older people, such as disability and solitude, can affect general health. The highest QoL score was seen in social function, which may be due to cultural factors. Most Iranians are interested in social activities and relationships because these are seen as valuable in Iranian culture. This belief is especially strong in Iranians living in the north of the country, where the study was undertaken. The Islamic religion also favours social communication. Thus it is to be expected that social function would be stronger in this study population.

<table>
<thead>
<tr>
<th>Quality of life domains</th>
<th>Level of religious coping (mean ± standard deviation)</th>
<th>P value</th>
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<tbody>
<tr>
<td></td>
<td>Low (&lt;97)</td>
<td>Moderate (97-113)</td>
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<tr>
<td>Physical function</td>
<td>54.54 ± 29.55</td>
<td>50.14 ± 31.42</td>
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<tr>
<td>Physical role limitation</td>
<td>47.72 ± 41.74</td>
<td>48.01 ± 41.03</td>
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<tr>
<td>Vitality</td>
<td>55.81 ± 44.40</td>
<td>58.11 ± 44.09</td>
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<tr>
<td>Emotional role limitation</td>
<td>45.45 ± 13.65</td>
<td>46.58 ± 14.88</td>
</tr>
<tr>
<td>Mental health</td>
<td>49.89 ± 14.52</td>
<td>51.36 ± 14.89</td>
</tr>
<tr>
<td>Social function</td>
<td>62.04 ± 22.68</td>
<td>67.20 ± 22.97</td>
</tr>
<tr>
<td>Physical pain</td>
<td>57.04 ± 25.00</td>
<td>53.41 ± 28.29</td>
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<tr>
<td>General health</td>
<td>50.09 ± 17.67</td>
<td>46.13 ± 17.56</td>
</tr>
<tr>
<td>Total score</td>
<td>52.82 ± 18.25</td>
<td>52.62 ± 19.87</td>
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</table>
The mean score for religious coping in all 200 participants was moderate (102.11 ± 15.74). Among all aspects of QoL, higher scores in the domains of mental health and social function were significantly associated with higher levels of religious coping.

Other studies have shown that participation in social activities and religious communities promotes social relationships and leads to improved general health (Lawler-Row and Elliott 2009, Horning et al 2011). In addition, previous studies have shown that religiosity is associated with mental wellbeing and a reduction in depressive symptoms (Shkolnik et al 2001, Parker et al 2003, Koenig 2004, Black et al 2007, Keyes and Reitzes 2007).

In Lawrence et al’s (2007) study, 92% of old age psychiatrists in the UK stated the importance of spiritual care for older people with mental health problems. However, respondents were less clear on how spiritual and pastoral care services could be integrated into multidisciplinary teams in the NHS (Lawrence et al 2007). Loewenthal et al (2001) compared beliefs of different religious groups including Christians, Hindus, Jews and Muslims in the UK, and reported that religious activity was not helpful in dealing with depression compared with other coping mechanisms. Faith and prayer were seen as the most helpful religious activities (Loewenthal et al 2001). Muslims believed more strongly than other religious groups in the efficacy of religious coping for depression; they were more likely to use religious coping behaviour and least likely to seek social support or professional help in dealing with depression (Loewenthal et al 2001).

Religion, by way of social interaction and support, has a positive effect on stress and promotes physical and mental health (Hughes et al 2004, Dulin 2005, Krause 2006, Keyes and Reitzes 2007). Gabriel and Bowling (2004) reported that good social relationships, having help and support, maintaining social activities and retaining a role in society were some of the main QoL themes that emerged in a national survey of 999 people aged 65 and over living in private households in the UK. However, Lawler-Row and Elliott (2009) found that a religious community had a greater effect on wellbeing than frequency of attendance, which suggests that the sense of belonging to a group is more important than the group’s activity.

Religious behaviours have beneficial effects on wellbeing and mental health by creating a sense of meaning, worth, effectiveness and credibility that are associated with life satisfaction, self-esteem and optimism (Krause 2003, Keyes and Reitzes 2007, Lawler-Row and Elliott 2009). Most participants (78%) in our study stated that religion gave their life meaning. Horning et al (2011) found no significant difference between religious people and non-religious people in terms of wellbeing or satisfaction with social support. However, highly religious people reported greater satisfaction with life and had greater social support compared with those who were non-religious. Religious individuals tended to use religious coping strategies, whereas non-religious people preferred to use other coping strategies, such as humour (Horning et al 2011).

Prayer can provide peace of mind and help people to face or escape the vicissitudes of life. Religion and religious activities, such as praying, promote a sense of control and wellbeing, coping, and physical and mental health (Fiori et al 2006, Nagalingam 2007, Lawler-Row and Elliott 2009). Helm et al (2000) found that private religious practices, for example, prayer, if initiated before loss of functional skills, reduced morbidity and mortality. In our study, 82% of participants relied on God to feel safe.

A meta-analysis by Chida et al (2009) showed that spirituality reduced mortality in healthy populations but not in diseased populations. Organised religious activity, such as attending church, was also associated with increased survival in healthy populations (Chida et al 2009). However, in our study, we found no association between religious coping and general health. Fifty per cent of participants in our study believed that faith in God meant there was no need to pray and practise religious activities. The lack of association between religious coping and some QoL domains, such as general health, can be explained by:

- Older people did not believe that religion could help them control events.
- Late onset of religious practice, for example, in response to a life event such as disability or bereavement.
- The need to increase older people’s religious behaviour and beliefs.
- Older people do not use religion actively for coping with the challenges of ageing, as indicated by a mean moderate coping score in this study.
- Low membership of religious communities.
- Effect of religious coping on physical and mental health, depending on the expectations of the individual (Horning et al 2011).

Conclusion

According to our results, religious coping promotes mental health and social function in older people, but it does not promote any other areas of QoL. Higher levels of meaning in life, social support and a sense of control are mechanisms that can improve religious coping skills. Therefore, increasing
religious beliefs and activities is recommended for improving mental health in older people.

These results may provide a basis for developing appropriate care strategies. Policymakers, community health services, nurses and other healthcare providers can use these results for developmental, educational and preventive purposes. If older people are willing, healthcare professionals may encourage them to attend religious activities, especially in social settings; educate them and their families about the importance of strengthening their religious identity and using religious coping strategies to address the challenges of ageing; and provide opportunities for older people to participate in religious activities.

Implications for practice

- Nurses caring for older people must take into account their religious needs.
- Mental health in older people may be improved by attention to their religious beliefs and practices.
- Older people may be helped to cope with the adverse effects of ageing by attention to their religious beliefs and practices.
- If they wish to, older people should be encouraged and enabled to participate in private and social religious activities.

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Clinical Nursing in a community hospital setting.

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Coping, psychological distress and disability.

Coping strategies of Iranian elderly women: a qualitative study.


