

The Relationship between General Health and Religious Coping in Elderly Residing at Homes

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Abstract: Aging is usually defined as gradual and general functional impairment in adaptive responses to reduce stress, coupled with the risk of developing age-related diseases. An elderly clearly needs coping skills to deal with life changes and stress. Since only a few studies have been published in this area, the current study aimed to examine the relationship between general health and religious coping skills of elderly people residing at homes.

A descriptive-analytic study was conducted on 200 elderly residents at home in Sari, northern Iran. A stratified random sampling method was used and eligible elderly were selected from different health centers of the city. Demographic characteristics such as gender, age, educational level and marital status were recorded. GHQ28 questionnaire was used to assess general health and elderly religious coping skills were assessed by religious coping questionnaire. Descriptive and inferential statistics were used to collect the data. For data analysis ANOVA and Pearson correlation coefficient were used in SPSS Version 17. The mean of Religious coping was 102.11 ± 15.74 and the mean of general health was 25.89 ± 10.62 . A significant relationship was found between general health and various aspects of physical symptoms such as anxiety, social dysfunction and depression ($P < 0.0001$). Pearson correlation test revealed no significant relationship between general health and religious coping ($r = -0.12$, $P = 0.08$). There was a negative relationship between religious coping and depression in the dimension of general health ($r = -0.17$, $P = 0.01$). ANOVA test revealed no significant relationship between the aspects of general health and religious coping skills of poor (97 or less), average (107 to 98) and good (108 or more) ($F = 0.44$, $P = 0.64$). The present study found a relationship between general health depression and religious coping skills. Thereby, caregivers should focus more on religion and enhance religious coping skills of elderly people. Further studies should be carried out to investigate the relationship between public health and religious coping skills in different cultures and religions.

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Introduction

One of the major changes in 20th century is aging population which is estimated to rise from 600 million in 2000 to two billion by 2050. This phenomenon is more troublesome in developing countries since such nations cannot easily adapt to the consequences of this phenomenon. Population aging occurs in Iran as well as other countries. It is believed that the mean age of population will increase by 10 years during 2006-2026. Proportion of elderly people in Iran doubled 2.27 times within the last 50 years, which will reach 26 million in 2050 and that is 26% of the total population[1].

Aging is usually defined as gradual and general functional impairment in adaptive response to reduce stress, associated with the risk of developing age-related diseases. Elderly is a period of life that is accompanied with great challenges, acute stress and increased levels

of different physical and psychological requirements[2]. In a study carried out by Traynor, 2005 it was emerged that obstacles such as perception of insufficient income, poor religious believes, poor functional ability to cope with stress and loneliness are the main causes of failure in managing the stress among elderly people. For older adults with physical disabilities who regularly compare themselves with others, finding new meaning in life and applying appropriate coping strategies results in better acceptance of changes[3].

According to psychology, successful aging is attributed with the ability to cope with physical, psychological and social changes in order to achieve happiness, dignity, comfort and satisfaction in life. Since patterns of life are inevitably changing during lifetime, elderly individuals require flexible coping skills to deal with life changes[4]. A meta-analysis study revealed that proper

coping strategies in elderly influence their health status[5]. Stowell *et al.* 2001 indicated an effect of coping strategies on immune response and increased level of leukocytes among elderly people[6]. It was also found that efficient coping skills improved the health status of older adults compared to that of the younger individuals[7]. Coping skills help reducing the vulnerability associated with health problems in elderly. Due to many reasons old age people are more vulnerable than young people; therefore, the need for coping skills is greater among this age group. By increase in the number of old people the rate of chronic illnesses will rise. Optimal aging also concerns chronic health issues. Attempts to understand the cognitive-behavioral efforts is called coping, which will lead to better management in this situation. Another reason could be higher vulnerability of elderly people compared to young individuals exposed to stress that is associated with impairment of various organs of the body, including hypothalamus - pituitary - adrenal, which could result in chronic diseases. Furthermore, elderly people experience difficult times due to experiencing decease of others, which could expose them to psycho- social stress[8]. Some studies showed that older populations are able to continue a normal life if they achieve a correct perception of aging and also benefiting from the belief that healthy aging is a period of well adapting to new situation[4, 9, 10]. According to these, researchers consider one of necessary condition of aging phenomenon as a successful coping[8, 11-14]. On of the coping strategies include attention to religious and spiritual, which are the products of coping skills in a way that makes personal adjustment in old age[4]. Other scholars believe that more attention on religious coping could act as a support system and power for the elder[15]. Similarly, results of a qualitative study found relying on God as the coping style among American Indian older population[16]. Religion makes life more meaningful and is essential for physical and mental health, life satisfaction and successful aging[17]. Considering spiritual and religious issues helps elderly to satisfy a happy life and support[14]. A study has also shown that attention to religion in elderly makes acceptance of death easier and reduces the fear of death and the future [2, 14]. Some studies found a relationship between religious attendance and health; however, their data did not indicate that the effect of religious attendance on religious coping is associated with health or social participation and presence in groups[18].

Few researches have been conducted on the probable relationship between religious coping skills and general health of the elderly. Religious coping strategy and its role in promoting mental, physical, and social health made the authors to answer the following question: Is

there any relationship between public health and religious coping skills?

Materials and Methods

A descriptive – analytic study was performed on 200 elderly residents at home in Sari, Iran. A stratified random sampling method was used and eligible subjects were selected from different health centers. First the ethics committee of Mazandaran University of Medical sciences approval was obtained. Then, the researchers completed the study questionnaires by referring to homes of the elderly after obtaining written consent from the participants. Those who were unwilling to participate in the study were excluded and the nearest household's number was selected to complete the questionnaires. The obtained data included demographic characteristics, gender, age, educational level and marital status. General Health Questionnaire (GHQ28) was also used to assess the general health. This international standard questionnaire contains four subscales including somatic symptoms (7 questions), anxiety (7 questions), depression (7 questions), and social functioning (7 questions). If the total score is higher than 23 it indicates a problem in public health. In addition, if the score achieved for each dimension is more than 14 it shows general health impairments[19]. Noorbala *et al* explained the validity and reliability of the questionnaire of all sub-components of two-scale questionnaire between GHQ28 and Scl-90 showed a significant correlation ($P > 0.001$). Test-retest reliability of the questionnaire was $r = 0.85$ [20]. Religious coping skills were measured by religious coping questionnaire designed by Azimi *et al* that investigates the virtual aspects which helps people in understanding different situations, receiving supports and problem solving in everyday life. Reliability of the questionnaire was determined by test-retest ($r = 0.88$), then by split half test (0.88) and Cronbach's alpha (90%). This scale has 31 questions, each with five options which are scored according to Likert method of scoring (0-4). The mean and standard deviations of scores are ranked on three levels of low (97 or less), moderate (107 to 98) and high (108 or more)[21]. The data was analyzed using SPSS, ANOVA and Pearson correlation coefficient.

Results

The study was done by recruiting 200 elderly aged from 61 to 85 years old. The participants included 61% females of whom 66% were married, 1% single, 1.5% divorced and 31.5% widowed. The respondents included retired (57.5%), workers (8.5%), business man (4.5%), unemployed (12%) and self-employed (17.5%). Levels of education in 36.6% of participants was illiterate, 15% were able to read and write, 22.5% had primary education, 8.5% of the interviewees educated until junior high school, 12% had diploma and 5.5% had

university degrees. Chronic physical illnesses were seen among 68% of the elderly. The mean of religious coping skills and general Health was $1.2.11 \pm 15.74$ and 25.89 ± 10.62 , respectively. The mean and the standard deviation of general health are shown in Table 1. As it can be seen, all aspects of general health scores were lower than 14. In the dimension of general health social functioning had the highest average, while depression had the lowest average. Higher score in general health indicates lower general health. Pearson correlation test showed no significant relationship between general health and religious coping ($r = -0.12$, $P = 0.08$). In contrast a significant relationship was found between religious coping and depression in the domain of general health ($r = -0.17$, $P = 0.01$). There is also a significant relationship between general health and its various aspect (somatic symptoms, anxiety, social dysfunction and depression) ($P < 0.0001$). The data are summarized in Table 2. In present study the highest average of general health (26.74 ± 10.77) belonged to the low religious skill's group and the lowest mean general health was related to high religious skill's group

(24.72 ± 11.05). Since higher rating of general health is presence of health disorders, thus, in this study, promoting the religious coping, the general health was being increased (Table 3). However, the lowest mean was related to depression of the general health and strong religious skill's group. The ANOVA showed no significant relationship between the four dimensions of general health and three dimensions of religious including: poor coping skills (97 or less), moderate (107 to 98) and high (108 or more) ($F = 0.44$, $P = 0.64$) (diagram 1).

Table 1: Mean and standard deviation of various aspects of general health and total scores of GHQ28

variable	Mean	Std. Deviation
Somatic symptom	7.48	3.80
anxiety	7.48	3.88
Social function	7.96	2.65
depression	2.96	3.61
total score of GHQ28	25.89	10.62

Table 2: The relationship between different aspects of general health and religious coping

Religious coping	GHQ domains	Somatic symptom	anxiety	Social function	depression
r		-.11	-.07	-.03	-.12
P-Value, Sig. (2-tailed)		.11	.30	.62	.04

Table 3: Mean and standard deviation of various aspects of general health in terms of poor, medium and strong religious coping

Religious coping	N	Mean of GHQ	Std. Deviation
(≥ 97)	55	26.74	10.07
(98-107)	101	25.93	10.77
(≤ 108)	44	24.72	11.05

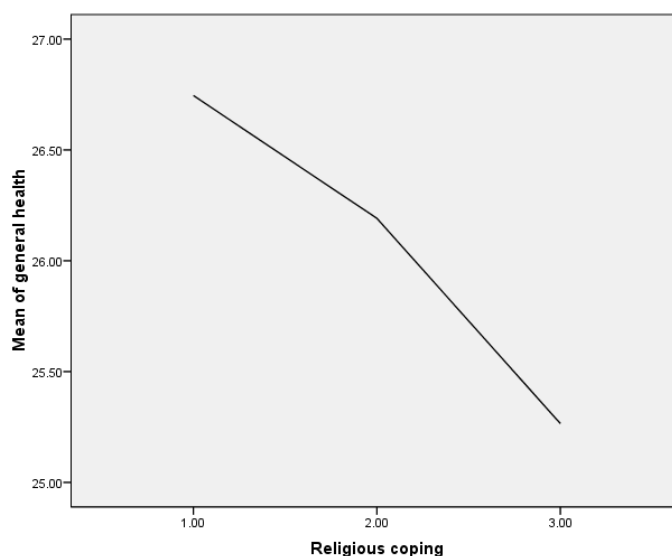


Diagram 1: The relationship between different aspects of general health based on poor, medium and strong religious coping

Discussion

Based on the results of present study, the average of general health among elderly was 25.89 ± 10.62 . Since the studied elderly were rated higher than 23 scores, thus, they are suspected to disorders in general health. The elderly scores of general health in all dimensions were below 14. It means that the elderly had no problems in dimensions of general health and their scores were the normal range. The highest average related to depression. Since low score of GHQ instrument is along with better general health, so this study elderly in depression dimension had better condition.

In accordance with the results of other studies of elderly, spouse decease and loneliness[22-25], Social Isolation[22, 26, 27], menopause [22, 28], failure to perform the activities and several diseases [22, 27, 29-31] experienced depression and depressive symptoms such as sadness and suffering are seen as a part of their life[26]. However, it must be said, depression is an illness that affects one-in-four to one-in-five elderly people in the community and will lead to reduced quality of life, physical deterioration, functional dependence, and a lot of medical expenses[27]. Most elderly lose their spouses or close friends, and they are subject to experience bereavement, grief and sorrow[22]. Fortunately, in present study, this domain of the general health is considered normal. It seems lower rates of depression in Iranian elderly is to be due to social and cultural context. The results of other studies also show that there are many psychosocial problems associated with depression symptoms. The symptoms associated with neglect, grief, economic pressures, concerns, home, life and the pressures of social separation[26]. Results of the

study indicated a strong association between depression and social, interpersonal, socio - economic, familial, and environmental co- incidence[27]. It can be said that depression is one of the several factors that affect general health and aging process and aging changes are not the causes; however, it is created in the context of physical, psychological, social, economic, cultural and spiritual life of each person. In addition, there was significant correlation between the four main general health aspects of somatic symptoms, anxiety, depression, and social functioning in the present study. The religious coping could be one of the factors that affect the mental health and consequently on other aspects of health[32].

In the current study, religious coping skills of older people in the study averaged 102.11, which means moderate and there was no significant correlation between total score of general health and religious coping. However, there was an inversely significant correlation between religious coping and depression domain of general health. As a response to increasing skills, depression declined. Study results also suggest a similar relationship between religious coping and depression domain of general health[33]. In one study, the data analysis regressions showed that prayer help spiritual health and predicted mental health, subjective well-being, physical symptoms and depression[34]. Similarly, in a qualitative study of the lived experiences of 20 elderly depressed women, using ethnography interviews, the results showed that according to elderly religious beliefs prevent the onset of depression. One elderly expressed depression due to illness, loneliness and bad memories, which he believed that a talented person can overcome it. Elderly believes that depression is

associated with pain and sadness that usually occurs after a life of poverty. They prayed for help for these problems. According to their religious beliefs, their way of relieving depression and negative situations improved and made them strong to endure problems[26]. Other studies have also expressed a relationship between depression and religious coping skills[32, 33]. The use of coping strategies has variety of outcomes in different people[8]. Among the coping strategies used in elderly, only functional coping strategies has a positive impact on human health[13, 35, 36]. Religion and spirituality are the common effective strategies that are especially used by the elderly and help them to improve their psychological well-being. In an elderly study, researchers identified components of successful aging. One of the variables which were examined in this study was seniors' religiosity and their role in successful aging. In this study, successful aging was identified using two measures of life satisfaction and general health questionnaire and religious orientation test was used to identify the role of religiosity. Statistically significant results indicated that successful elderly tend to have more religious trust[37].

As previously mentioned, old age is associated with many common stressors in elderly life that may be normal variation of aging such as impaired physical function, impaired activity, appearance and disability caused by chronic diseases[27, 35, 38-40], psycho-social lacks, loss of earnings, loss of ability to play the role and the previous activities[35, 39, 41-43] and the death of loved ones[24, 44-46]. Moreover, the researchers found that as elders spend the aging process, they experience loss of confidence, feelings of isolation, alienation and worthlessness and move towards the problems of physical, mental, emotional - social and spiritual experience[12]. Although in this study there was an inverse significant relationship only between religious coping skills and depression in general health, many expressed the mental – emotional, socio- cultural and economic deprivations which are results of different ways of lifestyle may occur under conditions of confounding variables, and they are as well considered the factors influencing physical dysfunction. Therefore, there is a constantly vicious cycle of deprivations between physical dysfunction - psychological, emotional, social - cultural and economic deprivations[4, 22, 35, 38, 47, 48]. It can be said that health is considered a two-way interaction; on one hand it is a product of selection and use of effective and appropriate coping with change and stress, and on the other hand it is pavement to a healthy psychological environment, which makes diagnosis of a coping strategy possible, in the light of true knowledge and assessment of stressful situations[49]. It seems referring to spirituality and religion is one of the most important strategies for coping with aging events.

With regard to the results of the current study and other studies, it can be concluded that religious coping skills can

influence general health of elderly. However, more studies in different cultures and religions are recommended.

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References

- .1 Teymoori, F., A. Dadkhah, and M. Shirazikhah, *Social Welfare and Health (Mental, Social, Physical) Status of Aged People in Iran*. Middle East Journal of Age and Ageing, 2006. **3**(1): p. 39-45.
- .2 Caldas, C.P. and C.M. Bertero, *Living as an oldest old in Rio de Janeiro: the lived experience told*. Nursing science quarterly, 2007. **20**(4): p. 376-382.
- .3 Traynor, V., *Understanding the lives of older women*. Nursing standard, 2005. **19**(44): p. 41-48.
- .4 Bagheri-Nesami, M., F. Rafii, and S.F.H. Oskouie, *Coping strategies of Iranian elderly women: A qualitative study*. Educational Gerontology, 2010. **36**(7): p. 573-591.
- .5 Penley, J.A., et al., *The association of coping to physical and psychological health outcomes: a meta-analytic review*. Journal of behavioral medicine 2002. **25**: p. 551-603.
- .6 Stowell, J.R., J.K. Kiecolt-Glaser, and R. Glaser, *Perceived stress and cellular immunity: when coping counts*. Journal of behavioral medicine 2001. **24**(4): p. 323-39.
- .7 Thomsen, D.K., et al., *Negative thoughts and health: associations among rumination, immunity, and health care utilization in a young and elderly sample*. Psychosom Med, 2004. **66**(3): p. 363-371.
- .8 Yancura, L.A. and C.M. Aldwin, *Coping and health in older adults*. Current psychiatry reports, 2008. **10**(1): p. 10-15.
- .9 Carlsson, M., S. Berg, and C.G. Wenestam, *The oldest old: patterns of adjustment and life experiences*. Scandinavian journal of caring sciences, 1991. **5**(4): p. 203-210.
- .10 Hansen-Kyle, L., *A concept analysis of healthy aging*. Nurs Forum, 2005. **40**(2): p. 45-57.
- .11 Chang, S.O., et al., *[The concept analysis of ego-integrity in the elderly]*. Taehan Kanho Hakhoe chi, 2004. **34**(7): p. 1172-83.
- .12 Chung, Y.G., et al., *Korean older adults' perceptions of the aging process*. Journal of gerontological nursing. 2008 , **5**(5): p. 36-44.
- .13 Dune'r, A. and M. Nordstro'm, *Intentions and strategies among elderly people: Coping in everyday life*. Journal of aging studies, 2005. **19**: p. 437-451.
- .14 McCann Mortimer, P., L. Ward, and H. Winefield, *Successful ageing by whose definition? Views of older, spiritually affiliated women*. Australasian journal on ageing, 2008. **27**(4): p. 200-204.
- .15 Ravanipour, M., et al., *Sense of Power Among Older People in Iran*. Educ Gerontol, 2008. **34**(10): p. 923-938.
- .16 Loeb, S.J., *African American older adults coping with chronic health conditions*. Journal of transcultural nursing 2006. **17**(2): p. 139.
- .17 Nagalingam, J., *Understanding successful aging: a study of older Indian adults in Singapore*. Care management journals 2007. **8**(1): p. 1825.-

- .18 Yeager, D., et al., *Religious involvement and health outcomes among older persons in Taiwan*. Social Science & Medicine, 2006. **63**(8): p. 2228-2241.
- .19 Dadkhah, B., M. Mohammadi, and N. Mozafari, *Mental health status of the students in Ardabil University of medical sciences*, 2004. Journal of Ardabil University of Medical Sciences, 2006. **6**(1(19)): p. 31-36.
- .20 Noorbala, A. and K. Mohammad, *The validation of General Health Questionnaire-28 as a psychiatric screening tool*. Hakim Research Journal, 20 : (4)11 .09p. 47-53.
- .21 Azimi, H. and M. Zarghami, *Religious coping and anxiety in students of Mazandaran University of Medical Sciences 1999-2000*. Journal of Mazandaran University of Medical Sciences, 2002. **12**(34): p. 37-46.
- .22 Bagheri-Nesami, M., *Exploration of elderly women lived experiences about psychological-emotional changes: a qualitative study*. Journal of Mazandaran University of Medical Sciences, 2012. **21**(1): p. 204-215.
- .23 Chi, I., et al., *Prevalence of depression and its correlates in Hong Kong's Chinese older adults*. The American journal of geriatric psychiatry 2005. **13**(5): p. 409-416.
- .24 Day, R., *Local environments and older people's health: dimensions from a comparative qualitative study in Scotland*. Health Place, 2008. **14**(2): p. 299-312.
- .25 Strydom, H., *Perceptions and attitudes towards aging in two culturally diverse groups of aged males: a South African experience*. Aging Male, 2005. **8**(2): p. 81-89.
- .26 Black, H.K., T. White, and S.M. Hannum, *The lived experience of depression in elderly African American women*. The Journals of Gerontology, 2007. **62**(6): p. S392-398.
- .27 Proctor, E.K., et al., *Perceptions about competing psychosocial problems and treatment priorities among older adults with depression*. Psychiatric services 2008. **59**(6) : (p. 670-5.
- .28 Guillemin, M.N., *Managing menopause: a critical feminist engagement*. Scand J Public Health, 1999. **27**: p. 273-278.
- .29 Cyr, N.R., *Depression and older adults*. Association of periOperative Registered Nurses Journal, 2007. **85**(2): p. 397-401.
- .30 Easley, C. and J. Schaller, *The experience of being old-old: life after 85*. Geriatric nursing 2003. **24**(5): p. 273-277.
- .31 Kempen, G.I., et al., *Performance-based and self-reported physical functioning in low-functioning older persons: congruence of change and the impact of depressive symptoms*. J Gerontol B Psychol Sci Soc Sci, 1999. **54**(6): p. 380-386.
- .32 Olson, M.M., et al., *Religious Coping and Mental Health Outcomes: An Exploratory Study of Socioeconomically Disadvantaged Patients*. Explore: The Journal of Science and Healing, 2012. **8**(3): p. 172-176.
- .33 Bahrami, F., A. R Farani, and J. Younesi, *Role of internal and external religious beliefs in Mental Health and rate of depression in elderly people*. Iranian Rehabilitation Journal, 2007. **5**(5): p.29.-24 .
- .34 Lawler-Row, K.A. and J. Elliott, *The role of religious activity and spirituality in the health and well-being of older adults*. Journal of Health Psychology, 2009. **14**(1): p. 43-52.
- .35 Fiksenbaum, L.M., E.R. Greenglass, and J. Eaton, *Perceived social support, hassles, and coping among the elderly*. Journal of applied gerontology, 2006. **25**(1): p. 17-30.
- .36 Folkman, S. and J.T. Moskowitz, *Coping: pitfalls and promise*. Annual review of psychology, 2004. **55**: p. 745-774.
- .37 Motamedi, A., *The role of life events on successful aging*. Journal of Social Sciences and Humanities of Shiraz University, 2005. **22**((4 (45)): p. 189-203.
- .38 Chen, Y.M., *The Meaning of Health and Health Promotion Practices of Taiwanese Elders with Chronic Illness*. Care management journals 2003. **15**(6): p. 505-510.
- .39 Oh, B.H., *Psychosocial Aspects of Normal Ageing*. Journal of Korean American Medical Association, 2004. **47**(4): p. 351-360.
- .40 Wadensten, B. and M. Carlsson, *Nursing theory views on how to support the process of ageing*. Journal of advanced nursing 2003. **42**(2): p. 118-124.
- .41 Andersson, M., I.R. Hallberg, and A.K. Edberg, *Old people receiving municipal care, their experiences of what constitutes a good life in the last phase of life: a qualitative study*. International journal of nursing studies, 2008. **45**(6): p. 818-828.
- .42 Nomura, C., *Worth Living of Elderly: A Concept Analysis*. Journal of Japan Academy of Nursing Science, 2005. **25**(3): p. 61-66.
- .43 Ouwehand, C., D.T.D. de Ridder, and J.M. Bensing, *A review of successful aging models: Proposing proactive coping as an important additional strategy*. Clinical psychology review, 2007. **27**(8): p. 873-884.
- .44 Alagiakrishnan, K., P. McCracken, and H. Feldman, *Treating vascular risk factors and maintaining vascular health : is this the way towards successful cognitive ageing and preventing cognitive decline?* Postgraduate medical journal 2006. **82**(964): p. 101-5.
- .45 Perrig-Chiello, P., et al., *Impact of physical and psychological resources on functional autonomy in old age*. Psychology, health & medicine, 2006. **11**(4): p. 470-482.
- .46 Pierce, L.L., L.K. Wilkinson, and J. Anderson, *Analysis of the concept of aloneness. As applied to older women being treated for depression*. Journal of gerontological nursing, 2003. **29**(7): p. 20-25.
- .47 Felten, B.S. and J.M. Hall, *Conceptualizing resilience in women older than 85: overcoming adversity from illness or loss*. Journal of gerontological nursing, 2001. **27**(11): p. 46-53.
- .48 Torres, S. and G. Hammarstrm, *Speaking of 'limitations' while trying to disregard them: A qualitative study of how diminished everyday competence and aging can be regarded*. Journal of aging studies, 2006. **20**(4): p. 291-302.
- .49 Ghazanfari, F. and P.E.A. Ghadam, *The relationship between mental health and coping strategies in citizenship of Khoramabad city*. The Quarterly Journal of Fundamentals of Mental Health, 2008. **10**(37): p. 47-54.