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Religion and Well-Being

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Abstract

Guests at an Icelandic rehabilitation and health clinic were asked about their religious beliefs, their importance, and their comfort from them. Questionnaires were administered at intake and discharge, 263 people responded, 93 men and 168 women (two did not indicate gender). Age range was 17-80 years, mean age 57.6 years, SD=14.7 years. Older people were more religious than others and women prayed more often than men. Religious people were more optimistic than others and had fewer family problems and alcoholism related problems. They had more mastery, well-being, health control, and optimism, less anxiety and perceived stress, and they smoked less than others. In general, their emotional health seemed much better than that of the non-religious. The results showed that on almost every tested variable, the religious people fared better than the non-religious, whether this was tested by church attendance, reported comfort and strength from religion, or religiosity in general.

Keywords: Faith, religious participation, well-being, health, aging

Introduction

Religious needs seem to be common among the peoples of the world. This study aims to explore the importance of religious beliefs for Icelandic participants, and look at their ways of seeking comfort from those beliefs. Importance of age and gender in this respect will be studied, and importance of religious beliefs as a health related prevention will be looked at as well.

Some studies have been conducted in order to explore the religious beliefs of Icelanders. Religious behaviour, attitudes towards the state church and religion in general was studied in 1986-1987. This study was replicated with slight changes in 2004 (Bjornsson and Petursson, 1990; Petursson, 2005). Hagvangur (1984) conducted the Icelandic part of a European study on values. This study has since been replicated twice in Iceland, in 1990 and 2000, conducted by the Social Science Institute of the University of Iceland (Jonsson and Olafsson, 1991). Summarizing those studies, religious beliefs of Icelanders seem to be more similar to the religious beliefs of North Americans and Catholic European nations than to other nations. More people in Iceland believe in God than in other Nordic countries and more of them state that religious beliefs offer them comfort and strength. Religious beliefs seem to be similar from the first study to the last one. Attending church seems to be similar from the first study in 1984, about 10% of Icelanders attend church once a month or more often (Bjornsson and Petursson, 1990; Gallup, 2004; Jonsson and Olafsson, 1991; Petursson, 2005).

Studies on the relationship between religion and health indicate clearly a positive effect of prayers on well-being and lifestyle, along with decreased depression and help for coping with bereavement and loss in life (Ellison, 1995; Holahan and Moos, 1991; Koenig and Larson, 1998; Levin, 2001). Intercessory prayers are increasingly sought by the public. Such prayers might thus be classified as non-traditional healthcare (Byrd, 1988; Davidsdottir and Gudmundsdottir, 2005; Krucoff et al, 2005; Palmer, Katerndahl and Morgan-Kidd, 2004). Religious beliefs have also been associated with positive effects on lifestyle (Armstrong, van Merwyk and Coates, 1997; Fönnebö, 1988, Levin, 2001), religious attendance provides increased social support (Hummer, Rogers, Nam and Ellison, 1999), and prayer has positive effects on emotions, decreases anger and hostility and thus helps strengthen the immune system (Koenig, McCullough and Larson, 2001; Koenig, Kvale and Ferrel, 1988). Active religious participation seems to offer emotional support, add value to spiritual life, and decrease anxiety, stress and depression, which are risk factors for the immune system (Krause, 2002, 2005). Studies have also shown that religious beliefs can speed recovery from illness, increase life expectancy after surgical operations (Strawbridge, Cohen, Sherma and Kaplan, 1997; Levin, 2001; Koenig, 2001) and decrease frequency of depression based suicides (Koenig, 1994; Larson and Koenig, 2000). Studies have also shown that those who attend church weekly or more often and regard their faith as an important part of their lives have lower blood pressure than others so that their religious activities may indirectly protect them from heart disease (Armstrong et al, 1977; Fönnebö, 1988; House, Robbins and Metzner, 1982). Religious attendance and beliefs thus seem to have some promotional value for well-being and health.

Research questions in this study are based on the above studies:

How important is faith for the participants?

How do participants seek comfort from their faith?

Are age and gender important factors in participants' religious needs?

Does religious participation have preventional value for participants' well-being, and if so, how?

Method

Participants were guests at a rehabilitation and health clinic in Iceland, during the year 2000. Responses at intake were from 263 people, 93 men and 168 women (two did not indicate gender). Age range was 17-80 years, mean age 57.6 years (SD=14.7 years). Questionnaires were administered at intake and discharge. Response rate was 55%. Age range was set rather high and as this is a health clinic, some of the clients were too sick to respond at intake. Bearing this in mind, response rate was expected to be rather low, as it turned out to be.

Instrument at intake included the following scales:

Mastery (Lachman and Weaver, 1998). The scale consists of seven statements, such as "I have little control over what happens in my life", with responses ranging from 1 (strongly agree) to 4 (strongly disagree). Cronbach alpha reliability of the scale was .64 in this study.

Health control (Wallston, 1992). The scale consists of eight statements, such as "I take good care of my health", responses ranged from 1 (strongly disagree) to 5 (strongly agree). Cronbach alpha reliability was .79.

Affective balance (Bradburn, 1969; Jonsson and Olafsson, 1991). The scale has 10 items, responses yes and no. Examples: "Have you ever during the last weeks felt lonely or isolated from other people?" Scale reliability (Cronbach alpha) was .75.

Self-esteem (Rosenberg, 1965). The scale consists of 10 items, such as "There is not much I can be proud of", responses from 1 (strongly agree) to 4 (strongly disagree). Cronbach alpha reliability was .83.

Anxiety (Spielberger, 1983). This is the part of the scale measuring trait anxiety, 20 items, such as "I feel nervous and restless". Cronbach alpha reliability was .88.

Perceived stress (Cohen and Williamson, 1988). This is a 14 item scale with responses from 0 (never) to 4 (very often). Item example: "How often during the last three weeks have you experienced tension and stress?" Cronbach alpha reliability for this scale was .88.

Optimism/pessimism (Scheier and Carver, 1985). The scale consist of 8 items, such as "Things seldom work for me", with responses from 1 (strongly agree) to 4 (strongly disagree). Cronbach alpha reliability was .70.

Smoking. Participants are asked to respond to statements about smoking best describing them, from: "I have never smoked sigarettes, not even a puff". Reliability could not be calculated, since this was one item only.

Alcoholism (Babor and Grant, 1989). This scale consists of 10 questions, most of them having responses from 0 (never) to 4 (almost daily). Example: "How often do you drink six or more drinks in the same evening?" Cronbach alpha reliability was .77.

Psychosomatic complaints and hostility (Shutty, DeGood and Schwartz, 1986). Ten items measure psychosomatic complaints and eight measure hostility. Questions on psychosomatic complaints (Cronbach alpha reliability of the scale was .84) were such as "How often have headaches bothered you or caused you problems in the past?" and on hostility (Cronbach alpha reliability of the scale .82), such as: "How often has it bothered you in the past to have frequent rows with other people?" Responses were from 0 (not at all) to 4 (very often).

Family situation (Davidsdottir, 1996). Examples of items in this scale were: "I usually like being a member of my family". Responses were from 1 (strongly agree) to 6 (strongly disagree). Cronbach alpha reliability was .87.

At discharge participants responded to questions about religious beliefs from a European study on values from 1990 (Jonsson and Olafsson, 1991). Participants responded to items such as: "Do you believe that faith provides you with comfort and strength or not?"

Results

First, religious practices and beliefs of participants were explored. When they were asked to define their conception of religious beliefs, the great majority of the sample (90%) stated that their religious beliefs included a God or a universal spirit or life force, as is shown in Table 1.

Statements	**%**
There is a God one can seek in prayer	70
There is a universal spirit or life force	20
I honestly don't know what to believe	5
There really is no universal spirit, God is a life force	5

Participants were asked how much difference God made in their lives. Their responses are shown in Table 2. Almost half of the respondents believed that God made a lot of difference for them.

	%
1 Makes no difference	4
2	1
3	2
4	2
5	7
6	8
7	8
8	11
9	7
10 Makes a lot of difference	50

When participants were asked about their religious activities, the great majority of people took time to pray or participate in some religious activities, as shown in Table 3.

	%
Yes	72
No	28

Participants responded to a question on prayer outside of religious services. Half of them stated that they did pray outside of religious services. This is shown in Table 4.

	%
Often	51
Sometimes	29
Almost never	7
Only in grave troubles	7
Never	6

A statistically significant majority of participants in this study agreed to the statement that bereavement and suffering had meaning only if there is a God (32%). Most participants belonged to the state church and the majority had been religiously brought up. A little over 30% of participants had sought intercessory prayer to some extent as a non-traditional healthcare. There was a statistically significant correlation between the frequency of seeking such healthcare and satisfaction with this service (r=.55, p<.001). The more satisfied people were with intercessory prayer, the more frequently they sought it, perhaps not surprisingly.

Difference in religious activities by age groups was explored. Means for each age group were used. Results are shown in Table 5.

	17-49 years	**50-66 years**	**67-80 years**	
	Mean	**Mean**	**Mean**	**F**
Attending church	5.78	5.57	4.97	1.51 *n.s.*
Religiosity	1.18	1.22	1.19	.07 *n.s.*
Importance of God	7.30	7.79	8.00	.76 *n.s.*
How often prayed	2.00	1.83	1.87	.23 *n.s.*
Life has a meaning if there is a God	2.23	1.90	1.53	11.16***
Death has a meaning if there is a God	2.50	2.17	1.57	18.32***
Bereavement and suffering has a meaning if ...	2.59	2.28	1.78	12.63***

Tukey tests of significance showed that the difference was between the age groups 67-80 on the one hand and the younger groups on the other hand, in the direction of the older group agreeing more to the statements that life, death, bereavement and suffering had meaning if there is a God.

Differences in religious activities by gender were explored as well. No differences were found there, except for women praying more often than men (t=2.20, p<.05).

Connection between religiosity and health was explored next. Religiosity was categorized into three groups: religious, not religious, and convinced atheist. This variable was set up as an independent variable and the scales in the study were set up as dependent variables. Calculations are shown in Table 6.

Scales	**Religious**	**Not religious**	**Atheist**	**Df**	**F**
Mastery	2.76	2.70	2.36	2,146	2.32 *n.s.*
Well-being	1.72	1.63	1.55	2,132	2.41 *n.s.*
Psychosomatic complaints	2.07	1.77	2.50	2,117	2.58 *n.s.*
Hostility	1.42	1.22	1.75	2,143	1.99 *n.s.*
Anxiety	2.22	2.20	2.59	2,119	1.23 *n.s.*
Health control	3.17	3.21	3.02	2,152	.23 *n.s.*
Self-esteem	3.26	3.29	3.11	2,147	.25 *n.s.*
Perceived stress	2.60	2.42	3.19	2,138	2.68 *n.s*
Optimism	3.42	3.17	2.92	2,132	3.12*
Family situation/stress	2.19	.20	3.44	2,71	6.25**
Alcholism related problems	2.97	3.47	7.50	2,11	3.33*
Smoking cigarettes	3.03	2.81	4.00	2,149	.87 *n.s.*

Tukey test revealed that optimism was significantly higher among religious people than non-religious, but stress in family situations and alcoholism related problems were more common among convinced atheists than among the other groups.

Differences in health and well being between the groups that attended church once a year or more often and those who attended church never or less than once a year are shown in Table 7. Those who attended church with some regularity fared better on all measured variables. They reported more well-being, self-esteem, optimism and health control, and less psychosomatic complaints, hostility, anxiety, perceived stress and family stress than others.

	Once a year or more		**Less than once a year or never**		
Scales	**Number**	**M (SD)**	**Number**	**M (SD)**	**t-test**
Mastery	75	2.81 (0.39)	45	2.68 (0.54)	1.43 *n.s.*
Well-being	68	1.74 (0.21)	39	1.60 (0.29)	2.65*
Psychosomatic complaints	64	1.90(0.64)	35	2.31 (0.80)	- 2.80*
Hostility	77	1.33 (0.36)	42	1.61 (0.79)	-2.36*
Anxiety	66	2.18 (0.46)	32	2.43 (0.62)	-2.01*
Health control	79	3.23 (0.53)	43	2.96 (0.64)	2.54*
Self-esteem	75	3.34 (0.46)	43	3.10 (0.71)	2.01*
Perceived stress	72	2.48 (0.67)	40	2.99 (0.75)	-3.72***
Optimism	65	3.50 (0.52)	41	3.10 (0.70)	3.12**
Family situation/stress	40	2.16 (0.58)	21	2.54 (0.74)	-2.19*
Alcholism related problems	61	3.11 (3.45)	34	4.15 (3.54)	-1.39 *n.s.*

Smoking cigarettes	75	2.99 (1.77)	48	3.69 (2.20)	-1.85 *n.s.*

Differences between health and well-being among those who said that they found comfort and strength in their religion (91%) and those who said that they did not find such comfort and strength in religion (9%) was explored next, as shown in Table 8.

	Yes, comfort and strength		**No comfort or strength**		
Scales	**Number**	**M (SD)**	**Number**	**M (SD)**	**t-test**
Mastery	127	2.77 (0.44)	15	2.48 (0.46)	2.40*
Well-being	116	1.72 (0.24)	13	1.55 (0.22)	2.51*
Psychosomatic complaints	104	2.04 (0.74)	14	2.21 (0.61)	- .85 *n.s.*
Hostility	127	1.43 (0.63)	14	1.49 (0.46)	-.40 *n .s.*
Anxiety	108	2.19 (0.52)	12	2.53 (0.60)	-2.14*
Health control	134	3.18 (0.61)	14	2.80 (0.50)	2.30*
Self-esteem	120	3.27 (0.53)	14	3.01 (0.74)	1.31 *n.s.*
Perceived stress	122	2.58 (0.72)	14	3.02 (0.70)	-2.15 *
Optimism	120	3.43 (0.57)	13	2.78 (0.59)	3.92**

Family situation/stress	62	2.17 (0.57)	9	2.91 (0.77)	-3.46**
Alcholism related problems	98	3.06 (4.75)	12	3.46 (3.84)	-1.58 *n.s.*
Smoking cigarettes	132	2.93 (1.93)	13	4.39 (2.26)	-2.55*

t-tests between the groups showed that statistically significant differences on all tested variables was in the direction of people finding comfort and strength in their religion faring better than others, and they reported less smoking.

Finally, differences in health and well-being of participants were explored by their responces to statements about life, death, bereavement and suffering. Those who agreed to the statement "Life has meaning only if there is a God", were happier and less stressed than others, whereas mastery was higher in the group that disagreed to this statement. Other differences were not statistically significant. Those who agreed to the statement "Death has meaning only if there is a God" were less anxious and stressed than others and had less alcoholism related problems. On the other hand, mastery was higher in the group that disagreed, as for the first question. For the statement "Bereavement and suffering have meaning only if there is a God", the only differences found were for mastery as higher among those who disagreed, and they also smoked more than those who agreed.

Discussion

To summarize descriptive analysis of responses, it seems that this sample can be considered quite religious, and that religion is an important factor in the lives of participants. Perhaps this is related to the fact that the survey was administered to guests at a health and rehabilitation clinic, and mean age of the sample was rather high, meaning that this sample is aging and ailing. This supports the claim that religious needs increase with increased age and with chronic, serious illness (Koenig, 2001, 2003). The majority of the participants reported taking time for prayer and meditation. Church attendance seems to be a protective factor in itself here, which is in accordance with other studies (Strawbridge, Cohen, Shema and Kaplan, 1997; Levin, 2001; Koenig, 2001; Koenig, 1994; Larson and Koenig, 2000). Those who reported attending church with some regularity had higher scores than others on well-being, health control, self-esteem and optimism, and lower scores on psychosomatic complaints, hostility, anxiety, perceived stress and family stress.

Older people were more religious than other age groups and women seemed to be somewhat more religiously active than men. This is in concert with other studies as well (Bjornsson and Petursson, 1990; Jonsson and Olafsson, 1991; Koenig, 2001, 2003; Petursson and Bjornsson, 1986). Older people also seemed more inclined to ponder existential questions about God, agreeing more than others that life has a meaning if God exists, and that death, bereavement and suffering have a meaning if one believes in God.

Interestingly, where there was a difference in health and well-being between groups, it was almost everywhere in the direction of religious people faring better than others. Thus, people in the group that reported finding comfort and strength from religion rated themselves higher than others on mastery, well-being, health control, and optimism, and lower on anxiety, perceived stress, family stress, and smoking. In addition, alcoholism was much

higher in the atheist group than among the religious. These findings rhyme with other studies on the same issues (Koenig 2001, 2003; Krause, 2002, 2005). The only finding in the opposite direction was for those who disagreed with the statement that death, bereavement and suffering only had a meaning if there was a God, also stating that they had more mastery in their lives than others. This can possibly be explained by more wondering about existential questions by those who already have lost some control over their lives, relying more on devine provision at that phase in their lives than before.

Looking at these results, one can hardly overlook the question whether religious needs of aging clients are sufficiently met in our healthcare systems. If a drug had the effects described above, it would probably be welcomed and used in most healthcare settings. However, since it is religion we are talking about here, the reception may not be as enthusiastic. Levin (2001) asserts that in spite of overwhelming numbers of indicators from epidemiologic studies on the positive effects of religion on health, it is still met with reluctance by researchers and clinicians, simply because it is religion and not a new drug. In an era of dwindling resources for healthcare and rising costs of same, perhaps this position could be rethought. If prayer and meditation have positive effects on client well-being, how can we justify not using it?

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