Anthropological Review • Vol. 78 (3), 259–268 (2015)

Anthropological Review
Available online at: https://doi.org/10.1515/anre-2015-0021

Religiousness, well-being and ageing – selected explanations of positive relationships

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Abstract: According to research that have been conducted in the field of gerontology, sociology and psychology of ageing, there is a relationship between the level of religious involvement and health status/well-being/quality of life in older age. How does religiousness influence aging process and health status? The aim of the article is to review explanations of a positive relationship between religiousness and health that are discussed in the literature. Those explanations may be grouped in three broad categories reflecting three functions of religion that play a role for well-being in older age. Those functions are: (1) religiousness as a source of coherence and the role of religious coping and provision of meaning in dealing with stressful life events (including ageing losses) (2) religiousness as a source of positive self-perception and a sense of personal control, (3) provision of social resources (i.e. social ties and social support) within religious community and emphasis on interpersonal relations (with special focus on forgiveness as a norm in interpersonal relations). Those functions of religion are discussed in the context of their potential role in successful ageing, as determined by – among others – active engagement in life.

Key words: ageing, successful ageing, health, well-being, religion, coping, coherence, social support

The religious age par excellence would seem the old age.
(W.James, 1985, The varieties of religious experience,
Cambridge: Harvard University Press, p. 19)

Introduction

According to socio-medical research, religious involvement may have a protective effect against a number of diseases, including angina pectoris, coronary heart disease, stroke, hypertension, myocardial infarction, various types of cancer and many other health problems (Levin 2001; Koenig, McCullough and Larson 2012). Religiousness is also a factor moderating risk of mortality (ibid.). Among the populations that are particularly protected are Amish, catholic nuns, orthodox

Review Article Received: May 14, 2015; Accepted for publication: October 22, 2015
DOI: 10.1515/anre-2015-0021

Jews, Mormons, Seventh Day Adventists, protestant clergy, etc. (Levin 2001). Due to the complexity of the research problem (both religiousness and health are multidimensional variables), many of the studies have an interdisciplinary approach, analyzing the issue from various perspectives, including anthropological, sociological, psychological and epidemiological point of view.

Much of the research on religion and health has taken place within the area of gerontology and is focused on people from post-productive age groups (McCullough and Larson 1998). This interest in religion among gerontologists may be explained by a greater religious involvement in older age groups in comparison with the younger (Krause 2008), the benefits that religious involvement is a source of to older persons (Gray and Moberg 1962; Idler 1994; Krause 2008) and other factors related to the specificity of old age, like time budget in retirement allowing for greater devotion in religious rituals (Borowik 2009). Gerontological research indicate that there is a link between the level of religiousness in older age and subjective health status, functional disability, mortality, hypertension, healthy lifestyle, self-esteem, personal control, life satisfaction, depression, anxiety, loneliness and happiness (Levin and Chatters 1998; for Polish research see: Woźniak 2012; Woźniak and Zawisza 2012; Woźniak, Zawisza and Brzyska 2015).

The aim of the article is to review the explanations of a positive relationship between religiousness and health that are discussed in the literature. Those explanations may be grouped in three broad categories reflecting three functions of religion that play a role for well-being in older age. Those functions are: (1) a sense of coherence and religious coping, (2) religiousness as a source of positive self-perception and personal control, (3) provision of a supportive community and emphasis on interpersonal relations.

Religiousness, coherence and coping

"Coherence" is a term introduced by Antonovsky (1979) who defined it as "a global orientation that expresses the extent to which one has a pervasive, enduring though dynamic feeling of confidence that one's internal and external environments are predictable and that there is a high probability that things will work out as well as can reasonably be expected" (p.123). There are two important elements that form the sense of coherence, i.e. predictability and lawfulness and three sources of coherence: psychological, social-structural and cultural-historical. In his salutogenic model of health Antonovsky claimed that the way people view their life has an impact on their well-being (Antonovsky 1979, 1987).

People consciously try to give meaning and significance to life-challenges they encounter. According to Idler, "attributing meaning to a situation is the activity of defining the subject in terms of and organizing it according to a scheme of values, beliefs and symbols that contains the potential for generating causal and moral judgments, with the effect that the individual sees his experience as shared and relativizes his experience by de-individualizing it" (1994: 24). Religion is one of the most powerful sources of meaning, legitimate social order and serves as a template for interpretation of human life events (Ellison 1994; Berger 1967). In order to reduce uncertainty

people constantly cultivate "just-word theory" – it is a general belief that one receives what s/he deserves to (Idler 1994; Ellison 1994). Just-world orientation that religious beliefs are source of (God rewards/will reward good and punishes evil) is reversely correlated with the level of depression (Ellison 1994). Coherent view of the world may be threatened by death, severe illness or trauma. Under such circumstances coherence turns into chaos calling questions about the meaning of life (Sorajjakool and Seyle 2004).

According to a popular saying, "there are no atheists in foxholes". A lot of studies confirm its accuracy showing that religious involvement increases during times of serious crises and health problems (Koenig, McCullough and Larson 2012) and that people being in very difficult position often seek help from God, even if they are atheists (Sasser 2008). Religious coping is used not only by people experiencing extreme stressors ("foxhole religion") but is also widely used in dealing with minor stressors and daily hassles (Koenig, McCullough and Larson 2012). In Pargamnt's definition, „coping is a search for significance in times of stress" (1997: 90). When facing crises, people bring to the process of coping their own "orienting system of resources", that consists of habits, values, relations, beliefs and personality. Among the resources that are used in coping there are material, psychological and socio-cultural (e.g. religious) resources (Pargamnet 1997). The critical events are constructed with significance and people cope in ways that maximize the sense of meaning. The impact that negative life event has on individual's life depends of significance. In the coping process religion may be used as a source of meaning, as a defensive strategy, a way of avoiding stress or as a mean of secondary control (Pargament, Van Haitsma and Ensing 1995).

The role of religious coping is especially important in existentially critical, boundary situations, when the most important values, like life, health or safety are threatened. Death of a loved one, fatal disease, disability are like "foxholes" that open up under one's feet and recalling about the impermanence of life (Idler 1994). Coping responses employed in such situations include active (problem-focused) or palliative (emotion-focused) coping. Active coping is aimed at problem-solving through changing external conditions, whereas palliative coping is focused on threat appraisal and emotional management (Levin and Chatters 1998; Folkman and Lazarus 1988). The latter way of coping is especially useful when an individual has a limited possibility to change the difficult situation due to a lack of resources, dependence, etc. – it is why emotion-focused coping is seen as a typical way of dealing with life challenges in older age. The most popular way of palliative coping is prayer, whereas mobilization of social resources (including church-based social support) is usually related to active, problem-solving coping (ibid.).

Religion provides personal as well as social resources which enhance coping with age-related losses (Levin and Chatters 1998). Prayer is a mean of coping and a defensive response buffering the adverse consequences of stress for individual's well-being (Levin 2004). Religious meanings serve as a framework for interpretation of negative life events, including challenges in old age (ageing losses) (Idler 2004). Religion is a source of "existential certainty" that everything that happens in life (including stress

and trauma) is meaningful and can be explained in terms (e.g. of religious interpretations). In objective conditions of illness and disability, higher level of religious involvement is associated with lower subjective perception of suffering (Idler 1994).

Promise of life after death (and a just reward in heaven), provision of paradigm for suffering as well as role-models for suffering (e.g. Hiob, Jesus, Isaiah) (Koenig 1994) are among the most important advantages that one can have form religion, especially in later life, when multiple losses occur and question on ultimate meaning of life cannot be ignored. "Every person who faces death desires that his or her life had purpose and meaning" (Sorajjakool and Seyle 2004: 85) and religion is like a "cognitive map" guiding through uncertainty of human existence (Bowkler 1973; Idler 1994). Theodicy, i.e. religious doctrine that justifies the existence of injustice, evil, undeserved suffering and finally death, is an essence of religion (Berger 1967). That is why religion is prevalent among "negatively privileged" groups: uneducated, of lower socio-economic status, women, older people, ethnic minorities, etc. Religion not only helps them to cope with their unprivileged life situation but also offers promise of ready accessibility, because religion is available for everyone, regardless of age, social class or any other element of social characteristic (Koenig 1994).

Religiousness, positive self-perception and personal control

Feeling of personal control is an important correlate of psychological well-being, and – according to some researchers working in the field of gerontology – a crucial determinant of successful ageing (Rowe and Kahn 1997; Worthington, Berry and Parrott 2001). Those people who have low personal control are more likely to see own life as shaped by external forces without any possibility to change/modify them. Such fatalism is related to meaninglessness (Idler 1994), whereas coherence and meaning – as discussed in the paragraphs above – are important elements of psychological well-being.

Feeling of personal control could be divided into primary control, that is focused on changing the external circumstances, and secondary control, aimed at modification of the way that the problem is perceived by individual (Krause 2008). The role of religion in shaping personal control is ambiguous. Some researchers argue that religions promote external locus of control (Benson and Spilka 1973), whereas others emphasize that faith empowers (Koenig, McCullough and Larson 2012). Through its specific functions religiousness could enhance indirect control over life and as such should be seen as a promoter of internal locus of control (ibid.).

According to Krause (2008) social and religious factors could play an important role in maintaining the sense of secondary control. Secondary control could be manifested as a proxy control (i.e. a sense of confidence that the challenges are turning out in a desired way because others, e.g. co-religionists, are working to ensure this outcome, providing instrumental, emotional or spiritual support). Another form of secondary control is vicarious control (Koenig 1994), usually taking form of so-called God-mediated control (Krause 2008). God-mediated control means "collaboration with God" in order to change the

difficult situation/solve the problem. Alternatively, an individual can transfer the whole responsibility for controlling the situation to God. Similar concept is present in early Pargament's works, where he distinguished deferential (ceding control over problems to God), collaborative (partnership with God in problem-solving) and self-directed (resolving problems without any help from God) style of coping (Pargament et al. 1988).

In ageing process people relinquish primary control in some domains of life in order to concentrate resources in other, more important spheres. Old age, characterized by multimorbidity and dependency, when people have limited ability to control external circumstances, secondary control becomes very important and people willingly pass control to divine/supernatural others (i.e. God, saints or angels; Woźniak 2012). Older people who have strong sense of God-mediated control are more satisfied with life, have higher self-esteem, are more optimistic and are characterized by lower fear of death. Church-based support not only helps people in dealing with stress but also allows them to maintain self-worth, personal control and meaning in life that otherwise could be threaten by negative life circumstances and age-related losses (Krause 2007, 2008).

Self-esteem may be defined as "the sum of evaluations across salient attributes of one's self or personality. It is the overall affective evaluation of one's own worth, value and importance" (Levin 2001: 117). Self-worth tends to decline across the life-course (Robins et al. 2001). Moreover the relationship between stress and depression is moderated by self-esteem as well as personal control (Ellison 1994). According to research, religious involvement is a predictor of greater self-esteem (Krause 2008). Religious belonging increases a sense of intrinsic moral self-worth and influences self-image through establishing contact with the "divine other". Through such a relationship, religious follower gains strength, a sense of being unconditionally loved, and a sense that it is to turn to in the times of crises (Ellison and Levin 1998).

Provision of a supportive community and forgiveness

Any discussion on the relationship between religiousness and health can overlook the powerful role that social support can play in this context (Gray and Moberg 1962; Idler 1994; Krause 2008; Woźniak 2015). In their classic study, Berkman and Syme (1979) proved that people having strong social ties, including people actively participating in community aspects of their religion, had lower mortality rates in comparison with people without such bonds. Social network worked as a factor decreasing the risk of death even when variables, such as smoking, alcohol drinking, being overweight or lack of physical activity, were controlled so longevity-increasing influence of network persists regardless of the harmful effects of unhealthy behavior.

Religiousness generate social resources, particularly social support (Ellison 1994). Cobb defined social support as "information leading the subject to believe that he is cared for and loved, esteemed, and a member of a network of mutual obligations" (Cobb 1976; in: Levin 2001: 60). Regular religious fellowship benefits health by providing support that buffers the effects of stress and isolation so it is particularly important in

older age. People having social support cope better with adverse life events and adapt more effectively to changes. They are also less vulnerable to negative consequences of stress (Levin 2001).

Apart from obvious health benefits coming from social network and support, church belonging is a source of additional specific advantages for individuals. First of all, anticipated support (awareness that others are willing to help in case of need) is greater in religious that in secular settings because supporting others is an important religious norm. Also providing support is beneficial for health of the support-provider because it enhances the sense of control over life and positively influences self-esteem (Krause 2008). Church-based social support encourages the adoption of positive health behavior and creates opportunity to self-disclosure, that may have a psychotherapeutic value. Religions discourage excessive self-preoccupation (i.e. self-absorption) which may be important for well-being in later life (Krause 2008). Opportunity for pastoral counseling and spiritual support (i.e. efforts by members of the religious community to deepen/maintain one's faith and commitment) are another potential benefits from church belonging (ibid.).

Religious belonging may have not only direct, but also indirect impact on individual's social network. Religions emphasize importance of interpersonal relations – like in Christianity, where „love your neighbor as yourself" is emphasized as a norm, with prescript to forgive others as its implication. Forgiveness analyzed in the context of health is a neglect source of research ideas (Kaplan, Munroe-Blum and Blazer 1994). Forgiveness is "a willingness to abandon one's right to resentment, negative judgement, and indifferent behavior toward one who unjustly injured us, while fostering the undeserved qualities of compassion, generosity and even love towards him or her" (Enright, Freeman and Rique 1998: 46-47). Analyzed in the context of health forgiveness may be seen as a healing power that helps to overcome negative emotions related to unforgiveness and restoring moral order that resentment can be a barrier to (Kaplan, Munroe-Blum and Blazer 1994).

Unforgiveness is a combination of negative emotions, like resentment, hostility, anger and fear. When a person is unable to forgive, then ruminations (i.e. repetitive cognitive activity surrounding the event) and escalation of negative emotions occur resulting in a desire of revenge (Worthington 2004). Such negative emotions may have physiological consequences (e.g. hostility and chronic anger are predictors of problems with immune and circulatory system and premature death; Bono and McCullough 2004). Two types of forgiveness are distinguished in the literature: emotional forgiveness, i.e. emotional juxtaposition of positive other-oriented feelings against the negative emotion of unforgiveness, and motivational-decisional forgiveness, i.e. intentional decision of not seeking revenge (Worthington 2004). Due to reduction of negative emotions, each of these two types of forgiveness is beneficial for health.

Forgiveness in older age could be seen as a tool in realizing integrity over despair (referring to Erikson's concept of life-stages; Erikson 1998) and as an element of successful life-review process (Bono and McCullough 2004). In older age sources of meaning become more interpersonal and, when the relationship is threatened by disintegration, motiva-

tion to repair it is strong (Worthington 2004). Forgiveness could also be seen as an emotion-focused coping strategy that helps to deal with interpersonal problems (ibid.).

Conclusions

In their model of successful aging, Rowe and Kahn (1997) distinguished its three components: low probability of disease and disability, high functional and cognitive capacity and active engagement in life. The last element seems to be the crucial part of successful aging and may be realized in various ways, among others by interpersonal relations and productive activity. The former involve social contacts, ties and emotional support exchanged with others, and the latter – each activity that creates societal value, like caring for family members or working as a volunteer in the church (Rowe and Kahn 1997).

Erikson in his classical book entitled "The life-cycle completed" (1998) emphasizes that successful functioning in later life includes the ability to maintain a vital involvement in life despite suffering the losses associated with the ageing process as well as ability to reintegrate identity in order to confront the inevitability of death. Engagement in purposeful and enriching activities is an element of vital involvement. Erikson emphasized the role of activities undertaken for the benefit of others. There may be a link between religiousness and vital involvement, especially in traditional style of religious involvement, promoting social committment and community engagement. When it comes to social capital, the modern forms of individualized and privatized religiousness are less likely to be beneficial (Putnam 2000; Dillon and Wink 2003), but older people's religiousness is still traditional and with great importance attached to collective aspects of devotion (CBOS 2013).

According to Wink and Dillon (2001), there are two strategies of adaptation to old age. The first one is an inner-focused process of self-exploration, personal growth and reintegration of identity. The other is outer-directed and focused on maintaining harmonious relation with others (Wink and Dillon 2001). In both strategies, religious involvement may serve as a powerful tool for adaptation. Achieving the successful ageing is more difficult for people having limited economic or social resources – religion may be a source of the latter, readily accessible for everyone, regardless of the socio-economic status or other factors (Koenig 1994).

Limitations

Presented paper is focused on selected explanations of the observed positive relationships between religiousness and well-being in older age. This selection reflects subjective opinion of the author on the relevance of presented mechanisms. The author deliberately focuses on the positive relationship between religiosity and well-being but is also aware of possible negative interactions between analyzed variables.

Acknowledgements

Presented article is a part of the author's research conducted for the purpose of PhD thesis. The author was financially supported by the Ministry of Science and Higher Education in Poland (grant no N N116 445737).

Conflict of interest

The author declares that there is no conflict of interest regarding publication of this paper.

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