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Enhancing well-being of the institutionalized elderly through religious and spiritual practices

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Abstract

Aging has been viewed differently by different people. Whereas to some it means power, authority, wisdom and respect, others consider it as a forced retirement leading to a state of dependency, loss of charm and of physical strength. It appears that the changing family structure has affected the well-being of the elderly by depriving them of the familial support of a traditional joint family set up as well as improving upon them to adjust to the changing values and norms of the younger generation. In the present century, spirituality and religion have become welcome topics for health professionals in general and for mental health professionals in particular. There is a quest to integrate religion and spirituality with human behaviour. For many, spirituality and religion are important sources of strength and coping resources in their lives, and central to their meaning and identity. In this study, the investigator examined the effectiveness of certain religious and spiritual practices such as prayer and meditation in enhancing well-being of the elderly. Three objectives were formulated. One hundred and seven (N=107) institutionalized elderly served as subjects for the present study. The purposive sampling technique was used to draw the sample. Satisfaction with Life Scale (SWLS) developed by Diener, Emmons, Larsen, and Griffin (1985) was administered to measure the well-being of the institutionalized elderly. Religious and Spiritual Practice Inventory (RSPI) developed by the investigator was used to identify the awareness of the respondents for the religious and spiritual practices such as prayer, pilgrimage, fasting and meditation. Three objectives were formulated. Data were analyzed by means of Kolmogorov-Smirnov test and Kruskal-Wallis test. Results of the current study clearly proved the positive effect of religious and spiritual practices on the well-being of the institutionalized elderly.

Keywords: *Well-being, Institutionalized elderly, Religious practices, Spiritual practices, Meditation, Prayer.*

1. Introduction

Aging is the progressive decline in the function and performance, which accompanies advancing years. It is the process of growing old, resulting in part from the failure of body cells to function normally or to produce new body cells to replace those that are dead or malfunctioning. There are bio-medical and philosophical views about aging. Aging has been viewed differently by different people. Whereas to some it means power, authority, wisdom and respect, others consider it as a forced retirement leading to a state of dependency, loss of charm and of physical

strength. To most, aging implies physiological and psychosocial changes that are reflected in their reduced income, lesser activities, and consequential loss of status, both in the family and in the society. The status of the aged person in contemporary times seem to have changed perceptively. Industrialization and urbanization have given rise to migration and emergence of nuclear families with increasing stress on individuality. The phenomenon of large aging population has become one of the most dramatic and influential developments in the 20th century. This situation has profound significance for the society in both the 'developed' and 'developing' nations. As per the Global Population Profile: 2002 by U.S. Census Bureau, the estimated population of the world was 6.2 billion. Of this, about seven percent people could be classified as elderly, that is, those who were 65 year old and above.

Old age has been defined variously in different societies and also cross culturally. It is a relative concept and different meanings have been attributed in different contexts. A still more specific definition of aging was offered by Handler, "Aging is the deterioration of a mature organism resulting from time dependent, essentially irreversible changes intrinsic to all members of a species, such that, with the passage of time, they become increasingly unable to cope with the stresses of the environment, thereby increasing the probability of death" (Handler, 1960, p.200). Aging refers to the regular change that occurs in mature genetically representative organism living under representative environmental conditions as they advance in chronological age. The term 'aged' not only describes individuals but is also used as collective noun, and once individuals are identified as 'old' they are perceived exclusively as such. Hazan (1994, p.16) observes that there are several ways of defining aged, "one way is seemingly unproblematic self-definition: an 'old person' is someone who regards him or herself as such… Another definition of 'aged' is socially constructed, composed of an infinite number of overlapping points of view with regard to a given person. Changing circumstances and the dynamics of social relationships make it difficult

if not impossible to use such a definition vigorously".

Problems of the elderly

Aging is a social problem and is often studied from the point of view of one or more of the basic perspectives. From the functionalist perspective, aging is a problem because institutions of modern societies are not working well enough to serve the needs of the dependent aged. The extended families which once allowed elderly people to live out their lives among kin has been weakened by greater sociomobility and a shift to the nuclear family as the basic kinship unit. As grand parents, for example, once played an important role in socializing the young, teaching them the skills, values, and ways of life of their people. Now these functions are performed by schools and colleges, for it is assumed that the elderly cannot understand or master the skills required in today's fast changing world. Instead, they most often are cared for either at home or institution such as old age homes, which free the productive member of society to perform other functions.

Bhattacharyya (1995) outline several problems of the aged such as finance, physical security, loneliness, isolation etc. Moreover, loss of status, prevalence of corruption and indiscipline in various spheres of life create frustration and mental tension in them. The old age diseases like falling eyesight and hearing capacity, slow and faultering steps, declining energy, forgetfulness etc. make their life all the more miserable. Falling health and sickness, nutritional deficiencies and poor housing facilities affect their physiological and economic condition. The physio-social and environmental problems create feeling of neglect, loss of importance in the family, feeling of unwantedness and inadequacy etc. Elderly become intolerant, short tempered, sentimental, rigid and suspicious when they loose friends, spouse, power, influence, income and health. Thus their psychological make up makes their living and adjustment in society more problematic. Poor health, economic dependence and non-working status tend to create among them a feeling of dependency and powerlessness. The elderly in rural areas are worse off than those

in urban areas. The gradual breakdown of the joint family system and consequent separation and migration of earning members to distant urban areas are other important aspects of the problem. As such, there is a total lack of security, affection and mental satisfaction and they are left alone to face the problems of the advancing age.

Bhattacharyya (1995) classified old people into two categories: (1) Those who have retired from an active service and are in receipt of pensions and other benefits. They do not generally suffer from financial constrains. They are in need of social support. (2) The other category is those who are poor. These people continue to work as long as they are physically capable and retire when the advancing age has full grip on them. They are often deprived of family support and left to themselves. A sense of insecurity and helplessness persist throughout the remaining days of their lives. Economic and social security are necessary for this category of people.

Institutional care

Just few decades back, in majority of cases, the institution of family was enough to take care of their aged. Urbanization, industrialization and modernization have, however, brought about exogenous as well as endogenous changes in the family system. Because of the ever growing economic difficulties, the newer concepts of small sized nuclear families have emerged and the idea of 'joint families' living under one roof is breaking down. The tendencies amongst the younger lot are growing wherein it is argued that the care of older member of the 'family' is not their responsibility. The values of life are increasingly becoming individualistic wherein the conjugal type of family, that is, the married couples and their unmarried children, offer limited care for older people (Amesur, 1959).

In recent past, family was looked upon as the only institution to take care of the elderly and provide both emotional and financial support to them. But changes in the living arrangements and family structure, migration of children for jobs outside, and more prominently, radical changes in the nature of people from accommodative to an

independent, self-centered, and individualistic outlook with callous concern for even very near relations, have compelled many old people to live alone.

Institutional services for older persons are not new. In the second half of the nineteenth century, charity experts began categorizing the poor and moving people into specialized institutions. Those judged to be lunatics were confined to asylums for the insane. Destitute children were placed in orphanages. Homes for the deaf and blind were established (Rosenberg, 1987). As other categories of paupers were moved into specialized institutions, the almshouses increasingly became de facto old age homes for the impoverished elderly. By the end of the nineteenth century, one third of almshouse residents were aged; by 1923, 67 percent were (Haber & Gratton, 1994).

Psychological well-being

The roots of well-being can be traced from the beginning of human civilization. Since times immemorial men have prayed, " sarve sukhino bhavantu " (let all enjoy well-being). For centuries the emphasize have been on the negative aspect of well-being, emancipation from suffering – suffering from the consequences of events of actions, or suffering from the tensions of desire. Indeed any objective state of things to constitute a state of one's well-being must be experienced by one self as satisfying. Rogers (1959) has emphasized man's reality is what he experiences and perceives with a certain degree of dependable predictability, and one's satisfaction consists in the satisfaction of one's need as experienced in the field as perceived. Well-being, however, is not merely as self based experience. It is primarily affective and is largely of the nature of a feeling and essentially a positive or pleasant feeling, a state of happiness or satisfaction. Well-being may also be induced by qualities of one's own or other's behavior. The sources of well-being are different in childhood, adolescence, youth, adult and old age. Well-being is also associated with the historical period in which one lives, the part of the world to which one belongs, one's nation, country, religion, occupational group, organization and family as well as one's own

personality. People also draw a lot of well-being from those with whom they come in contact physically, socially, intellectually or otherwise.

General well-being refers to the subjective feelings of contentment, happiness, satisfaction with life, experience of one's role in the world of work, sense of achievement, utility, belongingness with no distress, dissatisfaction and worry, etc." (Verma & Verma, 1989). In other words, general well-being implies hope, optimism, happiness and faith in the normal absolutes of truth, beauty and goodness, a proper perception of the means and ends related to the purpose of life and more than all a realization of the value of life. General well-being is a part of the broad concept of positive mental health which is not a mere absence of disease or infirmity (Verma, 1988). Verma (1988) opines that the absence of psychological ill-being / ill-health does not necessarily mean presence of psychological well-being. Most studies in the past defined "wellness" as not being sick, as an absence of anxiety, depression, or other forms of mental problems. The new conception emphasizes positive characteristics of growth and development. There are six distinct components of psychological well-being. These are:

(a) having a positive attitude towards oneself and one's past life(self-acceptance)
(b) having goals and objectives that give life meaning (purpose in life)
I being able to manage complex demands of daily life (environmental mastery)
(d) having a sense of continued development and self-realization (personal growth)
I possessing caring and trusting ties with others (positive relations with others), and
(f) being able to follow one's own convictions (autonomy).

Religious practices

Practices based upon religious beliefs typically include:
Prayer
Worship
Regular assembly with other believers

A priesthood or clergy or some other religious functionary to lead and/or help the adherents of the religion Ceremonies and/or traditions unique to the set of beliefs

A means of preserving adherence to the canonical beliefs and practice of that religion

Codes for behavior is other aspects of life to ensure consistency with the set of beliefs, i.e., a moral code, like the ten yamas (restraints) of Hinduism or the Ten Commandments of the Old Testament, flowing from the beliefs rather than being defined by the beliefs, with the moral code often being elevated to the status of a legal code that is enforced by followers of that religion

Maintenance and study of scripture, or texts they hold as sacred uniquely different from other writings, and which records or is the basis of the fundamental beliefs of that religion

Adherents of a particular religion typically gather together to celebrate holy days, to recite or chant scripture, to pray, to worship, and provide spiritual assistance to each other. However, solitary practice of prayer and meditation is often seen to be just as important, as is living out religious convictions in secular activities when in the company of people who are not necessarily adherents to that religion. This is often a function of the religion in question.

Spiritual practices

The term spirituality is coined from the Latin word spiritus, meaning "breath of life". The definition of spirituality provided by the tenth edition of Oxford English Dictionary is as follows: "the quality or condition of being spiritual, attachment to or regard for the thing of the spirit as opposed to material or worldly interest".

Spirituality has been variously defined by social scientists in terms of relationships, "the presence of a relationship with a higher power that affects the way in which one operates in the world" (Amstrong, 1995, p.3); the inner motivation, "our response to a deep and mysterious human

yearning for self-transcendence and surrender, a yearning to find our place" (Benner, 1989, p.20); the existential quest, "the search for existential meaning" (Doyle, 1992, p.302); the prescriptions, the systematic practice of and reflection on a prayful, devout, and disciplined Christian life" (O'Collins & Farrugia, 1991, p.228).

Significance of the study

The proposed study will be helpful to understand how institutionalized elderly can move forward towards enhancing their psychological well-being through observing religious and spiritual practices. Furthermore, religious and spiritual practices such as prayer, fasting, pilgrimage, meditation, etc; might be beneficial for institutionalized elderly as the potential way into their spiritual and psycho-social functioning, and for cognitive behavioural changes. Religious and spiritual practices can be a resource for helping institutionalized elderly people in respect of enhancing their well-being.

Objectives of the study

(1) To examine difference between the mean scores of institutionalized elderly males and institutionalized elderly females on well-being after one month of religious and spiritual practices.
(2) To examine difference between the mean scores of institutionalized young old and institutionalized old on well-being after one month of religious and spiritual practices.
(3) To examine difference among the mean scores of institutionalized elderly Hindus, institutionalized elderly Muslims and institutionalized elderly Christians on well-being after one month of religious and spiritual practices.

2. Methodology

The purpose of the study was to enhance well-being of the institutionalized elderly through religious and spiritual practices.

Subjects:

One hundred and seven (N=107) institutionalized elderly served as subjects for the present study.

The purposive sampling technique was used to draw the sample. Subjects were selected from eight institutionalized homes of the elderly (both private and government) situated in Kerala State, India. Subjects belonged to Hindu, Muslim, and Christian religion. Both male and female subjects were included in the sample. The sample was also split on the basis of age i.e., young old (60-70 yrs) and old (71-84 yrs). The mean age male, female, young old, old, Hindu, Muslim and Christian subjects was 70.34, 0.01, 64.96, 77.06, 70.09, 70.6 and 70.27 respectively.

Tools:

Satisfaction With Life Scale (SWLS) Subjective well-being was measured by using the 5-item Satisfaction With Life Scale (SWLS). The SWLS was developed by Diener, Emmons, Larsen, and Griffin (1985). Individuals responded to items using a 7-point Likert scale ranging from 1 = strongly disagree to 7 = strongly agree. Internal consistency (.87), test-retest reliability (.82, eight weeks), and validity of the SWLS are good (Diener et al., 1985). The total SWLS score ranges from 5 to 35. Internal consistencies of .85 and test-retest coefficients of .84 were reported.

Religious and Spiritual Practice Inventory (RSPI) was developed by the investigator. It consisted of seven items. It was designed to identify the awareness of the respondents for the religious and spiritual practices such as prayer, pilgrimage, fasting and meditation. For this purpose, the investigator prepared certain items and gave to the judges for selection of items. Judges were asked to select only those items that relates well with the religious and spiritual practices. Fortunately, judges considered all the items relevant for the purpose of assessment of religious and spiritual practices. In this way the content validity of the inventory was established.

Meditation Technique was used by the investigator. Following are the steps of this technique.

(1) Choose a quiet spot where you will not be disturbed by other people.
(2) Sit quietly in a comfortable position.

(3) Eliminate distractions and interruptions during the period you will be meditating.

(4) Commit yourself to a specific length of time and try to stick to it.

(5) Pick a focus word or short phrase that's firmly rooted in your personal belief system. A non-religious person might choose a neutral word like one, peace, or love.

(6) Close your eyes. This makes it easy to concentrate.

(7) Relax your muscles sequentially from head to feet. This helps to break the connection between stressful thoughts and a tense body. Starting with your forehead, become aware of tension as you breathe in. Let go of any obvious tension as you breathe out. Go through the rest of your body in this way, proceeding down through your eyes, jaws, neck, shoulders, arms, hands, chest, upper back, middle back and midriff, lower back, belly, pelvis, buttocks, thighs, calves, and feet.

(8) Breathe slowly and naturally, repeating your focus word or phrase silently as you exhale.

(9) Assume a passive attitude. Don't worry about how well you're doing. When other thoughts come to mind, simply say, "Oh, well," and gently return to the repetition.

(10) Continue for 10 to 20 minutes. You may open your eyes to check the time, but do not use an alarm. After you finish: Sit quietly for a minute or so, at first with your eyes closed and later with your eyes open. Do not stand for one or two minutes.

Personal Data Sheet includes information pertaining to name, age, sex, religion and the name of home.

Procedure:

The data were collected individually from the subjects through face-to-face interview method. Each subject was contacted in the homes of the elderly. Prior to interviewing the subjects, the investigator introduced himself and explained the purpose of investigation. Each subject was interviewed and assured that his/her responses would be kept strictly confidential and would be used for research purpose only. The data were collected in two phases. In the first phase the investigator identified the awareness of the

respondents for the religious and spiritual practices such as prayer, pilgrimage, fasting and meditation with the help of Religious and Spiritual Practice Inventory (RSPI).

In the second phase, assessed psychological wellbeing of all subjects before imparting training in religious and spiritual practices. After that subjects were asked to practice either meditation or prayer as religious and spiritual practice. Investigator allowed each subject to pray on the basis of their own religious belief system. For the purpose of imparting training in meditation, the investigator gave a demonstration in small groups comprising of five subjects. This meditation technique was simple and suitable for elderly and considered their psycho-physical condition. Subjects performed meditation two times in a day. The duration of each session was 15 minutes. Careful monitoring was done with respect to attending and meditating by the institutionalized elderly. This instruction was given in a language familiar to the elderly people. After the lapse of one month, investigator assessed the effect of religious and spiritual practices on well-being of each subject.

Data analysis:

Data were analyzed by means of Kruskal-Wallis test (H-test), and Kolmogorov-Smirnov test (D-test). Kruskal-Wallis test was used to determine the significance of difference between the mean scores of Hindu, Muslim and Christian institutionalized elderly. Kolmogorov-Smirnov test was used to determine the significance of difference between the mean scores of (a) male and female institutionalized elderly (b) young old and old institutionalized elderly. Chi-squire was used to analyze the data obtained on the items of religious and spiritual practice inventory.

Results and Discussion

These abbreviations are used in the following tables.

Institutionalized Elderly Male = IEM
Institutionalized Elderly Female = IEF
Institutionalized Young Old = IYO

Institutionalized Old = IO
Institutionalized Elderly Christian = IEC
Institutionalized Elderly Hindu = IEH
Institutionalized Elderly Muslim = IEMM

The following tables show difference between the mean scores of institutionalized elderly subjects on the basis of sex, age, and religion. Tables include assessment of well-being after one month

Data analyzed by means of Kolmogorov-Smirnov test and Kruskal-Wallis test are presented in the following tables:

Table 1: Indicating difference between the mean scores of institutionalized elderly male and nstitutionalized elderly female on well-being before imparting religious and spiritual practices.

Subjects	N	D	P
IEM	m = 50		
IEF	n = 57	0.1589	P>0.05

Significant difference was not found to exist between the mean scores of male and female subjects (D = 0.1589, p>0.05) on well-being before imparting religious and spiritual practices.

Table 2: Indicating difference between the mean scores of institutionalized elderly male and institutionalized elderly female on well-being after one month of religious and spiritual practices.

Subjects	N	D	P
IEM	m = 50		
IEF	n = 57	0.0712	P>0.05

The mean scores of male and female subjects (D = 0.0712, p>0.05) did not differ significantly after after one month of religious and spiritual practices.

Table 3: Indicating difference between the mean scores of institutionalized young old and institutionalized old on well-being before imparting religious and spiritual practices.

Subjects	N	D	P
IYO	m = 61		
IO	n = 46	0.1226	P>0.05

Significant difference was not found to exist between the mean scores of young old and old subjects (D = 0.1226, p>0.05) on well-being before imparting religious and spiritual practices.

Table 4: Indicating difference between the mean scores of institutionalized young old and institutionalized old on well-being after one month.

Subjects	N	D	P
IYO	m = 61		
IO	n = 46	0.1155	P>0.05

The mean scores of young old and old subjects (D = 0.1155, p>0.05) did not differ significantly after one month of religious and spiritual practices.

Table 5: Indicating difference among the mean scores of institutionalized elderly Hindus, institutionalized elderly Muslims and institutionalized elderly Christians on well-being before imparting religious and spiritual practices.

Subjects	N	Mean rank	H	P
IEH	44	49.7		
IEMM	15	43.73	5.0977	
IEC	48	61.14		P>0.05

Significant difference was not found to exist among the mean scores of Hindu, Muslim and Christian subjects (H = 5.0977, p>0.05) on well-being before imparting religious and spiritual practices.

Table 6: Indicating difference among the mean scores of institutionalized elderly Hindus, institutionalized elderly Muslims and institutionalized elderly Christians on well-being after one month.

Subjects	N	Mean rank	H	P
IEH	44	48.6		
IEMM	15	43.5	6.8349	P<0.05
IEC	48	62.22		

Significant difference existed among the mean scores of Hindu, Muslim and Christian subjects (H = 6.8349, p<0.05) on well-being after one month of religious and spiritual practices. Results show that Christian subjects perceived higher level of well-being than Muslim and Hindu subjects. Muslim subjects perceived low level of well-being after one month of religious and spiritual practices.

These results show that demographic factors are weakly correlated with well-being. For example, Campbell and others (1976) found that all demographic factors together accounted for less than 20 percent of the variance in subjective well-being (SWB). The influence of demographic factors on SWB did not appear because most of the individuals in the sample are concerned with improving rather maintaining their satisfaction or happiness level by offering religious and spiritual practices.

Mean scores of subjects on well-being after one month of religious and spiritual practices

Phases	Male	Female	Young old	Old	Hindu	Muslim	Christian
Before imparting religious and spiritual practices	19.8	20.2	20.2	19.9	19.6	19.1	20.8
After one month of religious and spiritual practices	21.5	21.5	21.5	21.6	21	20.4	22.4

On the basis of the description of psychometric properties of the Satisfaction with Life Scale given by Pavot and Diener (1993), investigator divided all subjects into various categories i.e. extremely dissatisfied, dissatisfied, slightly dissatisfied, neutral, slightly satisfied, satisfied and extremely satisfied.

Percentages of all subjects in each category before religious and spiritual practices and after

Category	Before imparting religious and spiritual practices (%)	After one month of religious and spiritual practices (%)
Extremely dissatisfied	.93	0
Dissatisfied	2.8	1.8
Slightly dissatisfied	30.84	17.7
Neutral	17.7	10.2
Slightly satisfied	43.9	65.4
Satisfied	3.7	4.6
Extremely satisfied	0	0

The most challenging aspect of research is interpretation and discussion of the results obtained. Not only does each individual statistic obtained have to be given meaning but also the composite and integrated picture of the phenomena must be evolved. Until the past decade, however, the impact of religious and spiritual practices on well-being was an unexplored area of psychological research. Many elders are living in various institutions with psychophysical ailments like depression, loneliness, alienation, and various psychomotor problems. Perhaps, one source of discomfort is that religious involvement and spiritual practices are underrepresented among old age homes for the well-being of the institutionalized elderly. Sensitivity and responsiveness to spiritual practices do not require that one has be a believer, any one may adopt it for his emotional, social, physical, mental and spiritual well-being.

In the present study investigator categorized all subjects into various groups based on sex, age and religion i.e., male and female, young old and old and Hindu, Muslim and Christian. Main aim of this categorization was to examine the significant difference between these groups on well-being scores and the frequency of Religious and Spiritual Practices.

4. Conclusion

Most of the time, a doctor's advice for successful aging is to follow the right path for the health maintenance, i.e., quit smoking, exercise regularly, and eat five times but in little quantity, consume fruits and vegetables everyday. In recent years the focus has been shifted from medicine to spiritual practice i.e., attending of worship places for prayer and performing meditation. Recent researches are integrating spirituality in treatment of illness and consequently to maintain health. Numerous studies have shown that faith and participation in religious services offer benefits for healthy aging. Strawbridge, Cohen, Shema, and Kaplan (1997) reported that people with a strong personal faith who regularly attend religious services generally have lower blood pressure; are less likely to suffer from depression; have a greater sense of well-being; have stronger immune systems; and live longer-23% longer.

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