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QUALITY OF LIFE, DEPRESSIVE SYMPTOMS AND RELIGIOSITY IN ELDERLY ADULTS: A CROSS-SECTIONAL STUDY

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ABSTRACT: Quality of life and depression are relevant to the health of the elderly. Studies indicate a positive association between religiosity and health. This study investigated quality of life, depressive symptoms and their relationship with religiosity in the elderly. The study included 287 older people from a unit of the Family Health Strategy. Data were collected by means of the instruments: John Flanagan's Quality of Life Scale, the short Geriatric Depression Scale and the Duke University Religion Index. The elderly showed high levels of religiosity, which, according to Pearson's product-moment correlation coefficient, was positively associated with quality of life ($p<0.004$), but not related to depressive symptoms. Results indicated a high degree of satisfaction among the elderly subjects with their quality of life, whereas 83% showed mild depression. In conclusion, religiosity is related to improvement in quality of life in the elderly.

DESCRIPTORS: Nursing. Aging. Quality of life. Depression. Religion.

QUALIDADE DE VIDA, SINTOMAS DEPRESSIVOS E RELIGIOSIDADE EM IDOSOS: UM ESTUDO TRANSVERSAL

RESUMO: Qualidade de vida e depressão são relevantes na saúde do idoso. Estudos indicam uma associação positiva entre religiosidade e saúde. Este estudo investigou a qualidade de vida, os sintomas depressivos e a relação destes com a religiosidade em idosos. Participaram do estudo 287 idosos de uma unidade da Estratégia Saúde da Família. Na coleta de dados, utilizaram-se os instrumentos: Escala de Qualidade de Vida de Flanagan, Escala de Depressão Geriátrica Abreviada e Escala de Religiosidade de Duke. Os idosos apresentaram elevado índice de religiosidade, o que, de acordo com o Coeficiente de Correlação de Pearson, se associou de forma positiva à qualidade de vida ($p<0,004$), mas não teve relação com os sintomas depressivos. Os resultados indicaram alto grau de satisfação em relação à qualidade de vida, embora 83% dos idosos tenham apresentado depressão leve. Conclui-se que a religiosidade está relacionada a melhores índices de qualidade de vida em idosos.

DESCRITORES: Enfermagem. Idoso. Qualidade de vida. Depressão. Religião.

CALIDAD DE VIDA, SÍNTOMAS DEPRESIVOS Y RELIGIOSIDAD EN LOS ADULTOS MAYORES: UN ESTUDIO TRANSVERSAL

RESUMEN: Este estudio investigó la calidad de vida, síntomas depresivos y su relación con la religiosidad en los ancianos. El estudio incluyó a 287 personas mayores de una unidad de la Estrategia Salud de la Familia. Durante la recolección de datos, se utilizaron los instrumentos: Escala de Calidad de Vida de Flanagan, Escala de depresión Geriátrica y la Escala Abreviada de Religiosidad de Duke. Las personas mayores mostraron altos niveles de religiosidad, que, de acuerdo con el coeficiente de correlación de Pearson, se asoció positivamente con la calidad de vida ($p<0,004$), pero no se relaciona a los síntomas depresivos. Los resultados indican un alto grado de satisfacción con la calidad de vida, mientras que el 83% de las personas mayores han demostrado la depresión leve. Llegamos a la conclusión que la religiosidad se relaciona con mejoras en la calidad de vida en las personas mayores.

DESCRIPTORES: Enfermería. Ancianos. Calidad de vida. Depresión. Religión.

INTRODUCTION

Brazil is experiencing a new social reality, marked by the changing demographic and epidemiological profile of its population. According to the Brazilian Institute of Geography and Statistics, the elderly represent at least 10% of the total Brazilian population, and it is expected that by 2025, Brazil will be the sixth country with the greatest number of people over 60 years.[1] The speed of this process of population aging raises a number of crucial issues, such as the increase in chronic diseases and illnesses typical of advanced age, which significantly influence the quality of life (QOL) of the elderly, and can often lead to the development of depressive symptoms.[2-3]

According to the World Health Organization, QOL is defined as "an individual's perception of their position in life, in the context of the culture and value systems in which they live, and in relation to their goals, expectations, standards and concerns".[4:1405] Depression, on the other hand, is a disorder of the affective domain and mood. This disorder is constantly ignored in the elderly, because health care professionals understand the signs and symptoms of depression to be normal manifestations of aging; however, these symptoms can lead to a loss of autonomy and worsening/exacerbation of existing morbidities.[5] It is important to note that depression has been repeatedly identified as the main determinant of worsening/lowering QOL in the elderly.[6] Thus, it is necessary to seek measures to avoid or reduce the problem of depression among the elderly. In this context, this study emphasizes religiosity as a possible resource.

The concept of religiosity refers to how much an individual believes, follows and practices a particular religion.[7] Among the elderly, studies indicate that religious beliefs contribute to the pursuit of personal balance, in addition to providing better conditions for individuals to cope with their dependency and tendency towards isolation.[8]

The importance of this study is based on the need to increase knowledge and discussion on possible ways to improve QOL among the elderly, in order to prevent and reduce depressive symptoms in this population. Furthermore, it is expected that the study will contribute to the discussion among nurses and other healthcare professionals on how religiosity can be used to promote the health of elderly patients. After all, religiosity plays a significant role in coping with everyday challenges that cause stress, thereby providing greater conditions for elderly individuals to deal with problems typical of this age group.[8] The aim of this study was to investigate QOL and the presence of depressive symptoms in the elderly, and to identify the relationship of these variables with religiosity.

METHODOLOGY

This was a cross-sectional study approved by the Research Ethics Committee of the Federal University of Alfenas under protocol n. 030/2011. The study population consisted of 497 elderly patients enrolled in a unit of the Family Health Strategy (FHS) in the city of Alfenas, in the Brazilian state of Minas Gerais, in 2011. The sample was sized by simple random sampling, with a maximum error of 3.8% and 95% confidence, totaling 287 seniors who met the established inclusion criteria: aged 60 years or more, of both sexes; oriented in time, space and person; and able to verbally express themselves. After invitation and agreement to participate in the study, all subjects signed a free and informed consent form.

The following instruments were used for data collection: Flanagan's Quality of Life Scale (QOLS); the short Geriatric Depression Scale (GDS-15); the Duke University Religion Index (DUREL); and a form containing demographic information for sample characterization.

The QOLS was created in the United States,[9] and translated into Portuguese by a group of researchers.[10] This scale evaluates QOL according to the satisfaction of the individual in relation to various aspects of life, which are covered by the five dimensions of the instrument: physical and material well-being; relationships with others; social, community and civic activities; personal development and fulfillment; and recreation. These dimensions are measured by means of fifteen items, and responses are given on a Likert scale of seven points (1-very dissatisfied to 7-very satisfied). The maximum score is 105 points whereas the minimum score is 15 points, so that the higher the value, the greater the satisfaction of the individual.

The GDS-15 was authored by Sheikh and Yesavage,[11] and the Brazilian version of the short-

ened instrument was proposed in 1999 by Almeida and Almeida.[12] This scale is used to investigate the presence of depressive symptoms in elderly subjects and has 15 questions with objective answers (yes or no) as to how the individual has been feeling during the past week. One point is added for each affirmative answer. A score between 0 and 5 is considered normal, 6-10 indicates mild depression, and 11-15 indicates severe depression. According to the Ministry of Health's book on primary care on aging and health of the elderly, the Geriatric Depression Scale is not a substitute for a diagnostic interview conducted by mental health care professionals, though it is a useful rapid assessment tool for easy identification of depression in elderly patients.[13]

The DUREL[14] was originally developed in the United States, and validated in Brazil by Lucchetti et al.[15] in 2012. The scale has five items that capture three dimensions of religiosity that most relate to health outcomes: organizational religious activity (OR - attendance at religious meetings such as mass and church services); non-organizational religious activity (NOR - attendance at private religious activities such as prayers); and intrinsic religiosity (IR - search for internalization and full experience of religion as the main goal of the individual). In analysis of results from the DUREL, scores on all three dimensions (OR, NOR and IR) should be analyzed separately, and their scores should not be summed for a total score.

The form for characterization of the subjects was based on the Ministry of Health's book on primary care on aging and health of the elderly,[13] and subjected to a process of evaluation of appearance and content, performed by three judges that study the research issues. All suggestions related to the format of the form, and were incorporated. A pre-test with the instruments mentioned above was carried out with 29 seniors who were not part of the study sample, in order to ascertain their understanding of the instrument items, and no comprehension problem was detected.

Data were collected by means of interviews during home visits, when the aim of the study was explained, and participation of the subjects was requested. The interview was chosen in order to facilitate participation of the subjects, since most had some visual impairment that would hinder their reading and writing of responses. It is important to mention that there was no interpretation of the questions by the interviewer.

Data analysis was preceded by the development of a database in a spreadsheet for coding variables and validation by double entry. The software Statistical Package for the Social Sciences version 17.0 was used for statistical analysis. Descriptive statistics summarizes the data obtained, characterizing the study population. The Kolmogorov-Smirnov test was used to verify the presupposition of data normality, and Bartlett's test for homoscedasticity. The existence of a statistical association between the variables quality of life, presence of depressive symptoms, religiosity and sociodemographic variables was assessed using the Pearson product-moment correlation coefficient, Spearman's rank correlation coefficient and the Kruskal-Wallis one-way analysis of variance, followed by the Dunn and Mann-Whitney U tests. The significance level established was 5%.

RESULTS

Sociodemographic characteristics

The study included 287 subjects with a mean age of 72 years (SD=8 years). Women totaled 60% of the participants; 24% never studied whereas 76% had complete elementary school at the most; 56% were married and 33% widowed; 7% were single and 4% divorced. As for monthly income, 52% received only one minimum wage and 42%, two to three wages (minimum wage in the period of data collection: R$545.00 per month, or about US$ 250.00). A total of 89% of the subjects lived with family members, 83% did not perform any kind of paid or unpaid professional activity, and only 8% depended on a caregiver.

Quality of life

With regard to the results obtained on the QOLS, from a possible score of 15 to 105, in which the higher the value, the greater the satisfaction of the individual, response values between 63 and 105 were obtained, with a mean of 86.4 (SD=7.3). The values (mean) obtained on the QOLS, according to the dimensions of the scale, were: 5.8 (SD=1.4) for physical and material well-being; 6.0 (SD=1.2) for relationships with others; 5.2 (SD=1.2) for social, community

and civic activities; 5.7 (SD=1.1) for personal development and fulfillment; and 5.8 (SD=1.2) for recreation. The mean of all 15 items was 5.8 (SD=0.56). Both the results, total sum of the items on the scale and the mean of the items reflect a high degree of satisfaction with the aspects covered by the instrument, so all of the participants were between satisfied and very satisfied with the quality of their lives.

The items listed as sources of greatest satisfaction among participants and their respective means were: material comfort (6.2; SD=1.1) and building a family: having and raising children (6.2; SD=1.1); close friends: sharing interests, activities and opinions (6.2; SD=0.7); and socialization: "making friends" (6.3; SD=0.7). The sources of least satisfaction included: participation in associations and activities of public interest (4.6; SD=1.0); learning: attending other courses for general knowledge (4.9; SD=1.2); and participation in recreational activities (5.0; SD=1.2). The value obtained for Cronbach's alpha was 0.72, which confirms the reliability of the scale for the sample studied.

According to the correlation coefficient, QOL is inversely related to age (r=-0.195; p=0.001), and directly related to level of education (r=0.143; p=0.016). When related to marital status, QOL was higher among married seniors; however, in relation to dependency on a caregiver, QOL was different between subjects dependent on a professional caregiver and those who were not dependent, with elderly subjects who depend on professional caregivers having lower QOL, according to the Kruskal-Wallis test, followed by the Dunn test (Table 1).

Table 1 - Mean and median rank according to the Kruskal-Wallis test for the values from Flanagan's Quality of Life Scale, as related to marital status and dependence on caregivers. Minas Gerais, 2012

Variables		Mean rank*	Median	p
Marital status	Single	99.89[b]	83	<0.001
	Divorced	100.65[b]	84	
	Widowed	122.83[b]	84	
	Married	165.06[a]	89	
QOLS †				0.007
Dependence on a caregiver	Professional caregiver	49.83[b]	65	
	Relative	91.56[ab]	81	
	Paid relative	97.75[ab]	83	
	No caregiver	148.8	86	

*[a,b] Means followed by the same letter do not differ from each other (p>0.05) by the Kruskal-Wallis test and Dunn's multiple comparisons; †Flanagan's Quality of Life Scale.

Depression

Depressive symptoms investigated by the EDG-15 were observed in 88% of participants (83% had mild depression, whereas 5% had severe depression). The elderly subjects with scores less than five were considered as showing no depressive symptoms, comprising 12% of participants. A total of 92% of respondents stated that they feel satisfied with life; 91% feel good about life most of the time, and 97% think it is wonderful to be alive. The negative item "fear that something bad will happen to you" was reported by 91% of the subjects.

Religiosity

In regards to variables related to religiosity, 78% profess to be Catholic; 15% Protestant, 4% Spiritist and 3% consider themselves to be non-religious but spiritual. Among study participants, 97% consider religion to be important or very important in their lives. The results of the evaluation of religiosity by the DUREL are presented in table 2.

Table 2 - Responses of the subjects interviewed, according to the Duke University Religion Index. Minas Gerais, 2012

Organized religion	%
A) How often do you attend a church, temple or other religious meeting?	
More than once per week	25
Once per week	31
Two or three times per month	16
A couple of times per year	15
Once per year or less	7
Never	6
Non-organized religion	
B) How often do you dedicate your time to individual religious activities such as prayer, meditation, reading the Bible or other religious texts?	
More than once per day	46
Daily	51
Two or more times per week	2
Once per week	-
A few times per month	-
Rarely or never	1
Intrinsic religion	
C) I feel the presence of God (or of the Holy Spirit) in my life	
Completely true	96
Mostly true	3
I am not sure	1
Mostly not true	-
Not true	-
D) My religious beliefs are the foundation of my way of living	
Completely true	68
Mostly true	20
I am not sure	4
Mostly not true	0
Not true	8
E) I struggle a lot to put my religion into practice in all aspects of my life	
Completely true	69
Mostly true	19
I am not sure	2
Mostly not true	1
Not true	9

Pearson's correlation coefficient (Table 3) reveals that religiosity (OR, NOR and IR) is directly and positively associated with QOL. Furthermore, OR was directly associated with age; the importance that the subjects gave religion in their lives was directly linked to QOL. Religion had no association with depressive symptoms.

Table 3 - Pearson's correlation coefficients for religion, quality of life, depression and age. Minas Gerais, 2012

Variables	Correlation coefficient	p
DUREL* (OR†) x QOLS‡	0.274	<0.001
DUREL* (NOR§) x QOLS‡	0.171	0.004
DUREL* (IR||) x QOLS‡	0.252	<0.001
DUREL* (OR†) x EDG-15¶	-0.5	0.395
DUREL* (NOR§) x EDG-15¶	0.1	0.871
DUREL* x EDG-15¶	0.38	0.522
DUREL* (OR†) x Age	-0.195	0.001
IRE ** x QOLS ‡	0.177	0.003

* Duke University Religion Index; †Organizational Religiosity; ‡Flanagan's Quality of Life Scale; §Non-Organizational Religiosity; ||Intrinsic Religiosity; ¶shortened Scale of Geriatric Depression; **Importance that individuals gave to religiosity in their lives.

According to the Kruskal-Wallis test (Table 4), subjects who were divorced and depended on a caregiver showed higher levels of religiosity.

Table 4 - Mean and median rank according to the Kruskal-Wallis test for the values of the Duke University Religion Index, as related to marital status and dependence on caregivers. Minas Gerais, 2012

Variables			Mean rank*	Median	p
DUREL† (RI‡)	Marital status	Married	137.72[b]	3	0.008
		Widowed	143.38[b]	3	
		Single	154.74[ab]	4	
		Divorced	210.58[a]	7	
DUREL† (RO§)	Dependent on a caregiver	Not dependent	138.80[b]	2	0.001
		Relative	190.88[a]	4	
		Professional	247.67[a]	6	
		Paid relative	279.00[a]	6	

[a,b] Means followed by the same letter do not differ from each other (p>0.05) by the Kruskal-Wallis test and Dunn's multiple comparisons. †Duke University Religion Index; ‡Intrinsic religiosity; §Organizational religiosity.

The Mann-Whitney test, followed by Dunn's test (Table 5) demonstrated that religiosity was associated with sex, with men being more religious than women.

Table 5 - Mean and median rank according to the Mann-Whitney test for the values of the Duke University Religion Index, as related to the variable sex. Minas Gerais, 2012

Variable	Sex	Mean Rank*	p
DUREL† (OR‡)	Female	135.30[b]	0.026
	Male	157.01[a]	
DUREL† (NOR§)	Female	131.66[b]	<0.001
	Male	162.45[a]	
DUREL† (IR‡)	Female	136.33[b]	0.033
	Male	155.47[a]	

[a,b] Means followed by the same letter do not differ from each other (p>0.05) by the Kuskal-Wallis test and multiple Dunn comparisons; †Duke University Religion Index; ‡Organized Religion; §Non-Organized Religion; ||Intrinsic Religion.

DISCUSSION

In the elderly population, religiosity may have a direct relationship with QOL.[8] This relationship may be due to the fact that higher levels of involvement with religion are positively associated with indicators of psychological well-being such as satisfaction with life, happiness, positive affect, and higher morale.[16] Moreover, as shown in the results of this study, the elderly subjects acknowledge the role of religiosity in their lives. Therefore, religiosity is one aspect that should be taken into account in the planning of healthcare for the elderly population, with the goal of improving QOL in this age group, and as a form of respect for what is important to them.

In this study, divorced individuals showed greater religiosity, which is supported by the idea that positive religious coping methods, such as the practice of prayer and spiritual rituals, are important for individuals who experience divorce, since religiosity helps to transcend feelings of anger, hurt and fear.[17] Furthermore, religiosity may attenuate the deleterious effects of divorce[18] by being a means of seeking forgiveness, reducing feelings of guilt, restoring a sense of wholeness, and increasing a sense of connection with transcendental forces, all of which are important to reduce feelings of isolation.[17]

In relation to sex, studies indicate that women are more religious than men;[19] however, in this study, men showed greater religiosity than women. Historically, women show more religious involvement than men, which may be explained by the social roles assigned to women. From childhood, women are educated to be more passive, which facilitates their acceptance of religious beliefs and involvement;[20] however, this does not mean that men do not seek religion at some point in life. Men in situations of chronic disease report that religiosity, among other factors, is part of their support networks to cope with the disease.[21]

According to this study, as age advances, the organizational aspect of religion decreases; however, having a caregiver can mitigate this situation. It can be inferred that seniors who have

someone to support their coping with functional disabilities have greater ability to perform activities outside the home, such as participating in religious community activities. Still, results from the evaluation of QOL show that social activities are critical for the elderly subjects, since this was the lowest score dimension, which corroborates the fact that elderly people associate a good QOL with opportunities for social interaction.[8] It is noteworthy that attending religious activities can promote social interaction of elderly individuals, as participation in such activities promotes meetings with friends and involvement in community activities.[22]

Due to the conditions of physical frailty imposed by senescence, many seniors cease to participate in groups, which is detrimental to their mental health. Social engagement, through feelings of usefulness, identification with the aspirations and values of the group, and inclusion and personal fulfillment, encourages the experience of a state of wholeness and well-being that enables elderly individuals to strengthen their existential state.[22] Furthermore, active participation in the community and the formation of social support networks are factors that can significantly influence the QOL of elderly persons.[23]

Age was also an important aspect observed in assessing the QOL of the elderly respondents. Certainly, the increased number of morbidities as a consequence of their advanced age will influence the different areas of their QOL, due to the change in functional capacity.[3] In contrast, studies show that younger seniors between 60-70 years may also have their QOL compromised for still not having realized the meaning of their existence.[2]

In relation to schooling, this study found that the higher the level of education, the higher the QOL, which can be attributed to the fact that elderly people with higher levels of education have better access to medical care, activities that stimulate their cognitive and mental functions and higher levels of social participation, thus leading to higher QOL.[22]

Marital status also influenced the QOL of the elderly subjects. Married life may indicate companionship and a more regular and satisfying sex life.[22] Similarly, dependence on a caregiver was also an influential factor on QOL, as dependence on another person to perform daily living activities generates a feeling of disappointment.[24]

With regard to the investigation of depressive symptoms, an important aspect in the health care of elderly patients, it was observed that despite feeling satisfied and good about life most of the time, and thinking it is wonderful to be alive, the survey participants had symptoms indicating mild depression. The fear that something bad will happen to them demonstrates the subjects' concern for the future. Issues such as health, finances and fear of abandonment can generate anxiety and worry in elderly persons,[25] and therefore worsen their depressive symptoms.

CONCLUSION

The seniors who participated in this study showed high levels of religiosity, which was positively associated with quality of life, but showed no relationship with depressive symptoms. Particularly with regard to quality of life, the results reflected a high degree of satisfaction with the dimensions addressed in the study, although most of the elderly respondents showed symptoms that indicate mild depression.

Religiosity is an important tool that can contribute to addressing issues related to health and aging, as it has a positive relationship with the quality of life of the elderly respondents, and can undeniably contribute to promote their health. Therefore, when an elderly individual has religious beliefs that directly influence their life, these can be identified by nursing professionals as a possible resource to be used for improving their quality of life. Thus, it is important that healthcare professionals recognize religiosity as a resource that can be included in the healthcare of elderly patients.

This was a cross-sectional study, which precludes the establishment of causal relationships. Therefore, further research to investigate the existence of causal relationships between the variables studied is recommended, as well as more studies that seek to investigate the influence of religiosity on various aspects of human health.

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