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RELIGIOUS FAITH AND HEALTH STATUS SELF ASSESSMENT IN LATE ADULTHOOD

Daniela-Tatiana Şoitu[1*] and Conțiu-Tiberiu Şoitu[2]

[1] *Centre for Ethical Studies and Health Policies, 'Grigore T. Popa' University Iaşi, Buna Vestire Str., 4, 700455, Iaşi, Romania*
[2] *Department of Sociology and Social Work, Alexandru Ioan Cuza University of Iaşi, Carol I, 11, 700506, Iaşi, Romania*

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Abstract

Religious faith is often associated with late adulthood. A poor state of health is, as a rule, associated in the literature with this particular stage of life. We wonder, however, what do people in late adulthood think about religious faith and health status? Do they perceive any connection between these two dimensions? Do their behaviours in the current stage and in previous stage of life reveal such connections? Our paper underlines the main factors perceived by people in late adulthood as being related to their religious faith and self-perceived health status. We interviewed people in the late adulthood stage of life, using qualitative methodology for collecting and interpreting data. The results show that during this life stage, people become really concerned about their health status after their functional autonomy is affected. The revealed personal life experiences show interesting connections between the concerns, attitudes and practices for good health and the religious faith of people. Personal responsibility for health throughout the life stages appears to be linked to a multitude of understandings, beliefs, feelings, practices and experiences.

Keywords: religious faith, concern for health, life stages, personal autonomy, responsibility

1. Introduction

In a postmodern society, knowledge has reserved the role of representing reality, using ideas and words in a language of symbols. Ideas symbolise reality, they are not reality itself. Language reflects various social assumptions, but people often interpret communication in personal ways. Thus, ideas cannot be independent of the character, interests and social position of the individual, who uses them in order to communicate with others and to understand others. Of course, we try to be as accurate as possible in our scientific communication, but

[*] E-mail and additional contact info: danielag_soitu@yahoo.co.uk; phone: (+) 40 722 837241, Department of Sociology and Social Work, Alexandru Ioan Cuza University of Iaşi, Carol I, 11, 700506, Iaşi, Romania

in everyday communication our ideas are invariably affected by these elements, which also influence the others' assumptions.

Postmodern thinking does not accept the reclaim of knowledge, on the contrary, it organises through symbols thee perspectives on social ideas and relations. Understanding is increasingly ambiguous. We can see simultaneously what reality is mentioned, who says it is so, how this individual engages in social relations and how this influences his/her particular manner of interpretation. Through the social relations involved in the creation of this manner of viewing the world, we can begin to acquire alternative points of view. This happens due to the fact that we identify the path taken by an idea or by part of knowledge, in development, through the arguments of others. We never look at just one side of things, thinking this is the only true side, but instead we try to see the complex of arguments or discourses concerning a phenomenon, showing its various facets. This will constitute a more complex, but probably a more representative point of view [1].

Positivist, quantitative research is often accused of ignoring the processuality of the investigated phenomena, the purposes and the motivations behind the actions of the researched groups and individuals, the subjective representations of reality, and the context that gives meaning to the researched variables [2]. However, cognitions, convictions, feelings, attitudes can be understood better in relation to the context they occur in, to the life experiences of the researched individuals, without counting how many individuals had a certain type of experiences, instead underlining personal traits, promoting factors, aspects that underscore a person's autonomy and responsibility.

The life stage we focused on in this article includes both genders, but is formulated according to Daniel Levinson when it refers to the development "seasons of a man's life", using the phrases "late adult transition" – for the 60 to 65 interval –, and "late adulthood" – for the period over the age of 65 [3]. Other authors in the area of age psychology [4] cover the same semantic area using three phrases: 'regression period', 'third age' and 'fourth age' or 'old age' for the stage beginning at the age of 65. Another classification, using the criteria "fundamental type of activity" and "type of relationship" [4, p. 242] identify: the sub-stage of transition to old age (65-75), the sub-stage of middle old age or proper old age (75-85), and the sub-stage of great old age or of longevity (over 85). The authors mention, however, that the seed of the scientific dispute concerning the concept of old age and the stages of involution comes from the lack of homogeneity in the process of aging in different individuals from different climatic areas.

The option of interviewing individuals at this stage of life about their concern for health during previous life stages as well as in the current one in relation to the experience of faith is also supported by a study on seniors from 11 countries in Europe and North and South America [5]. Focusing on the quality of life, this study concludes by grouping people over 60 in three categories: a) *active individuals* who enjoy good health and significant resources, consumers of cruises, cars and spas – mainly in the 60 - 70 age group; b) *fragile individuals*,

a group including the majority of those over 65, but generally located in the 70-85 age group; these individuals remain autonomous, but require medical support and intervention; c) *dependent individuals*, who use the progresses of medicine in order to survive; the latter are defined as a slow population, whose living standards depend closely on their physical status.

There are other perspectives, aside from those based on age, that start from an individual's ability to perform everyday activities, from the assessment of their functional ability or inability. The degree of functional autonomy will determine the definition of their role and social status. By operationalising daily activities (for instance 'feeds herself'), Lalive d'Épinay defined three functional categories, corresponding to the stages in the classification: the independents – those who manage to carry out daily activities without difficulty; the fragiles, who have difficulty in performing one or more activities; the handicapped/ dependents – those who are unable to carry out on their own more then one activity. This classification shows the predictability of the greater influence of the functional status on various aspects of health status (mental health, physical health, sensory capacity, self-assessment of health etc.) than of the chronological age [6].

The division according to functional status differs from the division by age group. Thus, the 'handicapped' category may include a large part of those over 80, but also a subgroup from the 60–79 categories. Also, people over 80 are viewed by some as independent, and by others as fragile or handicapped. These elements prove the difficulty of defining the third and fourth age base solely on chronological criteria. At the same time, such a classification is harmful, because it tends to assimilate – falsely – most of the people who are over a certain age to the 'dependent' category [7].

Bearing in mind that the literature and previous studies underline the potential for fragility and dependence in adulthood and in the late adulthood life stage, we asked ourselves whether the individuals reaching or living this stage are aware of these aspects and whether they have any concerns in this matter.

The principle that dominates life after the age of 60 is that of opposition between freedom and past history, including contrasts in variables such as work, time, relationships, employment, environment, family [8]. Physiological changes have a strong impact on mental status and health. On the one hand, biological fragilisation brings with it the feeling of powerlessness, causing major changes in the self-image of the elderly; on the other hand, the aging of the neuro-hormonal system causes changes in the relationship with the family and the social environment.

Meanwhile, in agreement with Erikson, this is a time of assessing personal development, of weighing the successes and failures had in life, an assessment that may bring contentment or, on the contrary, frustration [9]. The willingness to remember personal events and experiences are a facilitating factor in the interview.

2. Methodology

The aim of the research was to identify the concerns of individuals in late adulthood regarding their own health in relation to the experience of religious faith. We were wondering whether there were such concerns, what they consisted in, how were they manifested, what they consisted of, what influenced them and under what form.

The research was exploratory. We placed ourselves in a postmodern and post-structuralist paradigm, the data collection methodology focussing on the interviewees' assumptions regarding knowledge, society and the understanding of reality [10]. The postmodern theory firmly rejects Hegel's theory of absolute and atemporal knowledge (uninfluenced by history). The study starts from fundamental ideas of postmodernism and post-structuralism, such as: 'reality is multiple, oftentimes conflicting', 'there are no absolute truths', 'our knowledge depends on the historic, social and cultural context', the empirical validation of knowledge is not always necessary', 'the descriptions and explanations of phenomena are not and cannot be neutral'.

The interviews – of 'life story' type – were held with people of both genders, both from the rural and the urban environment, with ages between 60 and 84. Fourteen were women and five were men. The selection criteria were age (over 60) and the willingness to take part in the research. The interviewed individuals were asked for permission to be recorded on tape. Seventeen agreed, while two asked not to be recorded on tape, but only in writing (notes). The 19 people taking part in individual interviews were informed beforehand about the research topic. The research took place in the interval October 2011- January 2012, using as interview operators second-year students from the Social Work Department of the Roman-Catholic Theology Faculty ('Al. I. Cuza' University, Iaşi). The option concerning the topic, its clarification, the decision on the methodology of data collection and interpretation, has been decided by the authors.

For data analysis and interpretation we used a phenomenological approach, aiming to capture the relationship between the respondents and the real world, the way they perceive it, experience it, what is and remains important for them out of the experiences had in relation with their faith and their health status. Cognitions, beliefs, feelings, attitudes are sought in connection with the aspects approached in the research rather than in relation to pre-existing discourses. Similarly, through the phenomenological analysis we did not aim to see the frequency of certain words or quantifications, focusing instead on the interpretation of the respondents' life experiences [11]. The themes and the analysis codes were identified gradually, while the data collected was browsed.

Thus, we chose to focus in our analysis and interpretation on the behavioural-attitudinal indicators of the concern regarding health, looking for practices, axiological hierarchies, cognitions, beliefs and feelings concerning the relationship between the experience of faith and the health status throughout life.

The interpretation made is not limitative and opens the way for in-depth, contextualised analyses of the concerns regarding health within the Romanian adult population. There is a limit, identified by Silverman, concerning the loss of uncategorised activities [12], but this was the way we could give unity to the presentation. We took the analysis to a level of clarity of meaning, using shared meaningful themes and concepts, picked up and underlined along the way.

3. Results and discussions

The individual concern for health throughout the lives of the respondents takes religious, medical and paramedical forms.

One result of our study highlights the coping strategies [13] of the individuals who have reached late adulthood in their relationship with health status. Throughout their evolution, when facing situations that affected their heath, most have used and still use at first strategies focused on the problem, in the shape of actions inherited from generation to generation: rubbing with various substances, herbal teas, cupping, hot and cold poultices, baths using various medicinal plants or infusions of such plants.

"*I couldn't walk. My mother used to carry me to church in her arms and carry me back. There were no doctors in the village and at some point a midwife who was not from the village [a nurse from the city] came to our door and she told my mother: 'Mrs. X, I know you have a sick child. Get her to treatment, otherwise she'll die and you'll get locked up!' This was around 1950-1951-1952. And they gave me a bath, I don't know what was in it. They put me in a tub with hot water and a lot of herbs. Either the water was too hot, or the herbs too strong, and I fainted.*" (female, 66, rural environment, talking about the time when she was 6-8 years old)

Emotion-centred coping strategies can be found in distinct stages of life. In their proactive form they are used by people in late adulthood, after periods in which they have faced negative emotions, expressing the positive ones and seeking social support [14, 15].

Emotion-centred coping strategies are also used in their passive form, through avoidance, denial, repression of emotions, and in the end through accepting the situation for what it is: "*I cannot say I was ill when I was young. I didn't know what illness was at the time, maybe just colds. How do you expect young people to go to the doctor? It wasn't like it is today, to start using medicine straight away. It's only when you get old and see you lose your power that you start thinking about doctors. That's what I think. I don't know. I look at my daughters: they go to the doctor, but it's the same thing, they only go when they can't stand it anymore and everything hurts.*" (female, 68, rural environment)

The same person brought up several times 'treating illnesses with indifference', and thus they go away. The effects of previous neglect in health resurface now, when "*you try to lift something and realise you can no longer do it. While I could do it, it was no problem. But now it's hard. There's a lot of work*

to be done, and you suffocate with frustration at not being able to do it. But in the countryside, where we live, we adapt to the money we have."

Faith in God remains an important resource in ensuring the connection between the forms of adaptive defence mechanisms and of coping strategies.

Similar to the findings of Vaillant's study [14], in which the use of adaptive defence mechanisms was a predictor for subjective appreciations of health status – but not for the objective, physician-assessed health status – we find a strong connection between the perception concerning one's own health status and religious faith. The faith that God 'watches' and 'gives a cross to bear to those who can bear it' rather than as a form of punishment, cause the individuals in late adulthood to accept their lack of autonomy as a gift: "*There is a very strong connection between the experience of faith and health status, meaning that God gives you everything you need. If you do not have faith, you can't bear the suffering, either. If you do have faith, you combine faith with trouble and cope more easily*." (female, 68, urban environment resident)

When there is a childhood illness, the concern becomes constant, and involves a transition through several separate stages: hope, trial, then success; or: hope, trial, error, rebellion or resignation; or: hope, lack of trial, resignation.

Hope is manifested in the faith put in God's help and in the success of the reparatory medical act. The decision of trying a treatment, of undergoing a procedure subjects the individuals to a process in which they assume they do not have enough power. Hence, one of the results of our study: God is invoked as an authority in the decisions concerning an individual's health, as an investor in somebody who promises to be a better person or, in other situations, as a protector accompanying the individuals throughout their lives: "*Who knows what my situation might have been?! If I had been healthy what would have become of me, where I'd have been? Who knows what my situation might have been? Maybe I'd have lost my soul, this I cannot know, only He knows. And since he's given me this illness, I received it with resignation. I am content in my heart, I have no lack of contentment. I'm happy the way things are*. (female, 68, urban environment resident).

It is interesting how a person who has reached this life stage attempts to balance the aspects concerning individual responsibility for health with the power of divine decision: "*God never wants to harm us. Man is the guilty one. We're the guilty ones: our negligence, our foolishness... and so many accidents happening... God is never to blame for somebody's accident! No! They're caused by carelessness, fatigue, drinking...*" (female, 68, urban environment resident).

When the health of someone dear is (irremediably) damaged, or when someone dear is lost, the result of the aforementioned 'partnership' is rebellion. Rebellion, followed by periods of mistrust, is psychologically one of the crisis cycles [16] maintaining the same features in the situations of the interviews discussed here: "*I used to believe, but since my boy died, I don't know what to say*."

A source or cause of illness that is not clarified may be a reason for discontent throughout an individual's life. An assumption concerning her conception after her father came back from the war, with tuberculosis, causes a 66 year old woman to exclaim: "*I still believe that my father – may the Lord rest him! – came home from the war with tuberculosis. I was born in 1946, after he came back from the war. He was already ill. Very ill! And I think I inherited something. That's what I keep thinking... My brother is four years older than me and I don't remember him ever having problems with his legs. Never! He's never been poorly, whereas I...*" (female, 66, rural environment)

Throughout the interview, this person seldom mentions religious faith. She mentions religious practices – going to Mass on Sunday and for religious holidays –, but the focus is, to a great extent, on the material shortages of her childhood and youth, of her struggle for economic security, on the joy provided by the pay received for her work. In relation to the institution of the Church, she only mentions her fear of being blamed for the inappropriate behaviour her children have during services. She has not understood, nor accepted the difficulties caused by her precarious health in childhood. In the absence of other social services and of psychological support, in the absence of a relation with the religious values most accessible to her, she presents her life as a continuous struggle.

After analysing the attitudinal aspects present in the interviews carried out, we can say that the impairment of autonomy, of functional status, may hurry and support reflection and adaptive mechanisms or coping strategies. When the individuals are functionally autonomous, they make decisions without concern for their health status. *I would never think about that* – says one person who now, in late adulthood, makes great efforts to walk on her own. The recourse to support forms based on religious faith takes place in the early stages of crisis and later on, as an adaptive mechanism. Adaptation, however, requires a time of reflection and investment in the relationship with the divinity.

Indirect results of this study also appeared among the interview operators who say: "*... I admit that the story of her life (the life of the respondent), expressed in simple terms, had a very strong effect on my life, and thus I took some time afterwards and I meditated on the way we understand and live our lives, on the important values we build our lives on and – last but not least – on the way we understand to look after ourselves. I can say that this opportunity turned to be a life lesson for me.*"

4. Conclusions

We believe that the concern for health is similar to aging: it has an individualised character, based on the state of functional autonomy, on life experiences, and on that *wisdom* described by Erikson [9] – accepting the integrative ego, past years' achievements and failures.

The social status of old age is no longer just an approach of representation, but instead an approach that includes the relations between the mechanisms of consumption, production, between the perception of usefulness and uselessness. Interesting differences can be found between the stories of individuals living in the rural and in the urban environment, between the stories of those who had to cope with shortages and difficulties in childhood and youth and the stories of those who were able to find material stability. Uselessness is perceived more acutely by the individuals in the rural environment who in the past had work as a point of reference and crucial value. The usefulness of dialogue, usefulness though social relationships is felt more intensely by the individuals in the urban environment, who also found time to reflect, including in their relationship with divinity.

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