CHAPTER 1

INTRODUCTION

Background and Significance of the Problem

The role of spiritual and religious factors in health, when viewed from a scientific perspective has raised interesting results, particularly so following the wide acceptance of the concept that the body works in close collaboration with the mind to influence health and disease (Thoresen, 1999). With transactional perspectives of health and disease in mind which view health as far more than just physiological matter, the recent interest in spiritual and religious factors in health and disease seems understandable (Thoresen, 1999).

Health has recently been viewed as a holistic aspect. Holistic health is a comprehensive view of person as a biopsychosocial and spiritual being (Potter & Perry, 2003). The American Holistic Nurses' Association recognizes that holism involves studying and understanding the interrelationships of the bio-psycho-social-spiritual dimensions of person, as an integrated whole interacting with and being acted upon by both internal and external environments (Dossey, 1995). Health is also seen in term of functioning. It is a concept that encompasses the effective total functioning of a person and refers to the ability of people to function physically, socially, psychologically, and spiritually (Maville & Huerta, 2002). The widely accepted health concept is that proposed by the World Health Organization (WHO), and has defined health as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity (Perry & Potter, 2005).

Spiritual or religious activities have been thought to have a positive effect on physical health. Levin and Schiller (1987) reviewed over 250 published articles and concluded from their investigation that religiosity appears to exert a salutary effect on physical health (Francis, Robbins, Lewis, Quigley, & Wheeler, 2004). It has been known for a long time that some religious groups such as Mormons and Adventists live longer with less chronic illness than non religious groups (Thoresen, 1999). This fact is supported by studies that found a positive association between religiosity and prolong survival or mortality risk (Blison, 2000; Helm, Hays, Flint, Koenig, & Blazer, 2000; Koenig, Hays, Larson, George, Cohen, McCullough, Meador, & Blazer, 1999; Oman & Reed, 1998; Zuckerman, Kasl, & Ostfeld, 1984). Francis *et al*. (2004) found that a positive attitude toward Christianity is associated with a higher level of self-reported general health.

The positive effect that religion operates on mental health has also been considered. Maselko and Kubzansky (2006) found that men and women who engaged in public religious activity at least once a week have lower psychological distress, greater happiness, and better self-rated health. Furthermore, Maselko and Kubzansky have noted that researchers who have explored the characteristic of "happy persons" found higher levels of religious engagement consistently demonstrated by those people when compared to their less happy counterparts. Another study showed that religious orientation was significantly related to well being outcomes (Dezutter, Soenens, & Hutsebaut, 2006).

Existing studies regarding religiosity found that the levels of religiosity show certain patterns among gender and age group. Women were more religious than men (Koenig, Kvale, & Ferrel, 1988; Koenig, George, & Siegel, 1988; Maselko &

Kubzansky, 2006) and in the age group, of older people higher levels of religiosity were found than in the younger (Holland, 2002; Taylor & Lockery, 1995).

The association between health and religion among various findings do, however, present inconsistent results. Some investigations found that there was no significant relationship between religiosity and health (O'Connor & Cobb, 2003; Yeager, Glei, Au, Lin, Sloan, & Weinstein, 2006). Maselko and Kubzansky (2006) did note a study that found religiousness was associated with poor mental health. A review of the literature regarding religiosity and health presents not much study found their negative link. However, Chatters (2000) proposes that religious involvement may emerge as a negative impact on health; such as religious beliefs and commitments may lead to patterns of behavior that are harmful to health, and religious groups may also discourage professional help-seeking behavior.

Yeager *et al*. (2006) have stated that to date nearly all the studies regarding religiosity and health have captured samples from Christian or Jewish population in the United States or Europe. The researcher has also found difficulties in examining studies regarding religion-health intersection in Muslim society, particularly in the Asian population. Islam is the second major religion of the world ranked by number of followers (Adherent, 2005; Maps of World, 2006; Wikipedia, 2005), and Indonesia has been identified as the world's largest Muslim population (Infoplease, n.d.).

Islam emphasizes and values health as important for its believers. It is taught that Islam is not considered to be a religion in the sense of something separate from the rest of life rather it is a complete system of life encompassing all existences (Hickman, 2006). The Islamic way of life is a system of divine principles and code of ethics to be

practiced in the daily life of an individual (Arafa, n.d.). Therefore, if Muslims follow the Islamic guidance they will be in their optimum health status.

In today rush societies, some Muslims underestimate and ignore the principles and teachings of Islam. Those who are exposed with secular though may value materialism and rationalism more than they do belief and spiritual values, which is essential to Islam. On the other hand, many of Muslims have knowledge of Islamic teachings but do not realize them in daily life practices. Based on the investigator's lived experience, in Indonesia which includes religion in an individuals' residence identification card some Muslims tend only to view religion as an important part of their identity card. Some other Muslims understand Islam only as a way of how human connect to Allah (God) instead of as a way of life. Therefore, it is not surprising if the attachment of Muslims to Islam might vary in terms of level and might also do in its impact on Muslim's daily lives, especially on their health status.

Considering those phenomena, the researcher was interested in conducting a study examining the relationship between religiosity and health status from an Islamic perspective. It is expected that this study will provide a data base related to religiosity from an Islamic perspective and its relationship with health status to support existing studies and for advanced exploration. It would enrich nursing science and practice with regard to health maintenance and health promotion, since nurses work with patients and their families from certain backgrounds by which religion, beliefs, and culture may have an influence on the individual's thinking and actions.

Objectives of the Study

1. To determine the levels of religiosity among middle aged male Muslims in Jakarta, Indonesia.

2. To determine the levels of health status among middle aged male Muslims in Jakarta, Indonesia.
3. To investigate the relationship between religiosity and health status among middle aged male Muslims in Jakarta, Indonesia.

Research Questions

1. What are the levels of religiosity of middle aged male Muslims in Jakarta, Indonesia?
2. What are the levels of health status of middle aged male Muslims in Jakarta, Indonesia?
3. Is there a relationship between religiosity and health status among middle aged male Muslims in Jakarta, Indonesia?

Conceptual Framework

The construction of the conceptual framework was based on a literature review and previous studies regarding religiosity that employed the concept of religious orientation by Allport and Ross (1967). Religion is proposed as an organized social entity in which individuals share some basic beliefs, practices, rituals, and symbols to facilitate relationship to God, to oneself, and to others (Haris, Thoresen, McCullogh, & Larson, 1999; Holt, Haire-Joshu, Lukwago, Lewellyn, & Kreuter, 2005; Thoresen, 1999). Religion has relevance for health by reason of its prescriptions and restrictions in shaping an individual's health perceptions and health attitudes, as well as affecting psychological and personality characteristics of individuals (Lindeman & McAthie, 1999). The extent to which religion affects an individual's health based on the level of religious involvement, which is the adherence of an individual to religion (Lindeman & McAthie), or others is termed religiosity (Paek, 2006).

Religious involvement or religiosity is conceptualized as distinguishing between behavioral and subjective dimensions (Chatters, 2000). The behavioral dimension pertains to individual characteristics and activities that reflect organizational or public religious expression (e.g. religious-service attendance) and non-organizational practices such as private prayer, reading religious materials. In this study, it referred to the practice of Islamic teachings. Whilst, the subjective dimensions include attitudes, beliefs, experiences, and self-perceptions and attributions that involve religious or spiritual content (*e.g.* feeling of closeness to God) (Chatters). The subjective dimension of religiosity in this study was the attitude toward religion which employed the concept of intrinsic religious orientation proposed by Allport and Ross (1967). Intrinsic religiosity (IR) considers religion as a master motive in life (Dezutter *et al*., 2006) and as the framework which shapes a person's goals and decisions (Berndt, 1999). It is described as a wholly committed to religious beliefs and the influence of religion is evident in every aspect of individual's life (Maltby & Day, 2002).

Health status in this study referred to the health that encompasses aspect of physical functioning, role physical, role mental, mental health, social functioning, and spiritual health.

Definition of Terms

1. Religiosity refers to the religious attitude dimension which is intrinsic orientation and the dimension of religious behavior that is the daily practice of Islamic teachings. Religiosity was measured using the Islamic Involvement Questionnaire; adopted and modified from the existing religiosity measurement of the Religious Orientation Scale (Allport & Ross,

1967) and the Sahin-Francis Scale of Attitude toward Islam (Sahin & Francis, 2003).

2. Health status is subjective feelings encompass general health perceptions, physical functioning, role physical, role mental, mental health, social functioning, and spiritual health. The Health Status Questionnaire was employed to measure this variable. It was a modified measurement adopted from the Health Status Questionnaire (Yeomans, 2000) and Self-assessment (Dossey *et al*., 2005).

Scope of the Study

This study was conducted in a city in Jakarta, Indonesia and used middle aged male Muslims who were stay in that city.

Significance of the Study

1. Provide baseline data regarding health status and religiosity from the Islamic perspective for further exploration.
2. Provide supporting evidence regarding the relationship between health status and religiosity from the Islamic perspective in order to enrich nursing science and in turn facilitate the performance of appropriate nursing interventions for Muslim patients; particularly male patients.