Original Article

# Religious/spiritual coping in institutionalized elderly*

*Coping religioso/espiritual de idosos institucionalizados*

Coping *religiosos y espirituales de los ancianos institucionalizados*

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## ABSTRACT

**Objective:** To evaluate the spiritual/religious *coping* (SRC) of elderly of two institutions of long-stay for elderly, from two towns Pouso Alegre and Santa Rita in south of Minas Gerais state Brazil and to correlate the SRC with personal characteristics. **Methods:** The work is based on epidemiological and analytical cross-sectional design method with nonprobability sampling and sample of 77 elderly. The instruments used are characterization staff which consists of 15 multiple choice questions, scale of two dimensions SRC, SRC positive and SRC negative. **Results:** both groups were balanced between the sexes, by the average age of 76 years old, 81.6 % did not complete primary education and 96.1 % practiced a religion. There was a high use of the SRC total average use and showed higher scores with age and time of residence and SRC Total. **Conclusion:** final analyses of the data demonstrated that the elderly uneducated and with religion presented SRC strategies so high and positive.
**Keywords:** Aged; Homes for the aged; Spirituality; Religion and science

## RESUMO

**Objetivos:** *A*valiar o c*oping* religioso/espiritual (CRE) de idosos residentes em duas instituições de longa permanência; e correlacionar o CRE com características sociodemográficas e de saúde. **Métodos:** Estudo epidemiológico, analítico com desenho transversal, amostragem não probabilística e amostra de 77 idosos. Na coleta de dados, realizada entre junho e agosto de 2010, foram utilizados dois instrumentos: caracterização pessoal constituída por questões fechadas; e a Escala CRE com duas dimensões, CRE Positivo e CRE Negativo. **Resultados:** Os idosos apresentaram distribuição equilibrada entre os gêneros, média de idade 76,6 anos; 81,6% não possuíam Ensino Fundamental completo; 96,1% praticavam uma religião. Foi alta a utilização do CRE total e evidenciou maiores pontuações com as variáveis, idade e tempo de moradia e CRE Total. **Conclusão:** O mais velhos, sem escolaridade e com religião apresentaram estratégias do CRE de forma elevada e positiva para as adversidades vivenciadas no processo de institucionalização.
**Descritores:** Idoso; Instituição de longa permanência para idosos; Espiritualidade; Religião e ciência

## RESUMEN

**Objetivos**: Evaliar el *coping* religioso/espiritual (CRE) de los instituciones de ancianos em Pouso Alegre y Santa Rita do Sapucaí, Minas Gerais y correlacionar La CRE con características personales. **Metodos**: estudio epidemiológico, transversal analítico com El deseñ de muestreo no probabilístico y La muestra de 77 ancianos. Instrumentos: 1- caracterizacion 1) Caracterización del personal se compone de 15 preguntas de opción múltiple, 2) a gran escala con dos dimensiones CRE, CRE positivo y negativo. **Resultados**: Ambos grupos fueron equilibrados entre los sexos, con edad promedio 76,6 años, 81,6% no completó la educación primaria, el 96,1% practica una religión. Hubo un alto uso de la CRE Total y mostraron mayores puntuaciones con las variables edad y tiempo de residencia y cree total. Las variables correlacionadas con la escala y factores. **Conclusión:** Los mayores, sin educación y la religión se presentan las estrategias de CRE tan alto y positivo para las dificultades experimentadas en el proceso de institucionalización.
**Descriptores:** Ancianos; Hogares para ancianos; Espiritualidad; Religión y ciencia

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## INTRODUCTION

The rapid growth of the elderly population is a worldwide phenomenon, resulting in an increase in chronic diseases that impair the functional capacity of this population. With the change in family arrangements, some of these individuals increasingly require care in long-term care facilities (LTCF) for the elderly[1].

This change creates major alterations in the social, cultural, economic and institutional context; at the same time, Brazilian law demands that the care of dependent members is the responsibility of the families. The sharp decline in the fertility rate has reduced the availability of family caregivers, along with the recent effect of the demographic transition and growing integration of women into the labor market, who until that time had been the traditional caregiver figure[2].

The relationship between spirituality and health has become a clear paradigm to be established in the daily practice of health professionals, since religiosity and spirituality are strategies that older people use in their daily lives, to seek support in stressful situations related to one's finite nature, distance from family and their socioeconomic context, during the common health problems of daily life and their institutionalization. On the other hand, "spirituality, related or unrelated to religiosity, historically has been the point of satisfaction and comfort in different times of life, as well as a cause for discord, bigotry and violent clashes"[3]. It is observed that studies about stress and coping tend to reinforce the view that aging can lead to spiritual development[4].

Spiritual/religious *coping* (SRC) is the process by which an individual, through her spirituality, belief or religious behavior, attempts to understand and / or deal with important personal or situational challenges in her life. The presuppositions are: the existence of a stressful experience; assessment that the person makes about the situation – threat, harm or challenge; resources available to deal with stress, and responsibility in dealing with a particular experience[5,6]. In addition, several studies mention that there is consistent evidence of an association between quality of life and religiosity/ spirituality[7].

Therefore, the questions that guided this study were: What are the religious/spiritual *coping* strategies among institutionalized elderly? Do sociodemographic and health factors, controlled statistically, interfere with these perceptions?

The interest in investigating the aforementioned findings emerged based on the growth of institutionalization among the elderly in Brazil, and also the lack of studies of this nature in the national literature.

Based on these considerations, the present study aimed to evaluate spiritual/religious *coping* (SRC) of elderly residents in two long-term care facilities (LTCF) and to correlate CRE with sociodemographic and health characteristics.

## METHODS

This was a cross-sectional, analytical, epidemiological study, using a non-probabilistic sample. The study was conducted in two LTCF located in the extreme south of Minas Gerais; one in the city of Pouso Alegre with 53 seniors, and the other in Santa Rita do Sapucaí with 95, for a total of 148 seniors.

The final sample was 77 elderly, calculated using dimensional sampling of the elderly, with 41 in Santa Rita do Sapucaí and 36 in Pouso Alegre, with a maximum sampling error of 3% and a confidence interval of 97%. Inclusion criteria were: 60 years of age or older, and agreement to participate in the study.

The instruments used for data collection were: Socio-demographic and Health Characterization with 15 closed questions; and the religious/spiritual coping (RSC) instrument. This is a scale constructed, adapted and validated for Brazilian culture by Panzini [6] in 2005, based on the North American RCOPE scale, developed by Pargament, Koenig, Perez [5] in 2000.The scale consists of 87 items and two dimensions: the first indicates the level of positive CRE (CREP) obtained by the evaluation of the mean of 66 questions; and the second dimension establishes the level of negative CRE (CREN) obtained by the evaluation of the mean of 21 questions. The total CRE (CRETOT) indicates the total quantity of the CRE obtained by the evaluation of the mean between the CREP index, and the mean of the inverted responses of the CREN. Therefore CRETOT = Mean [CREP / Inverted CREN], a value located between a score of 1.00 to 5.00[6].

The parameters used for analysis of the values of the means of the CRE regarding its use by each respondent were: none or negligible: 1.00 to 1.50; low: 1.51 to 2.50; average: 2.51 to 3.50; high: 3.51 to 4.50; highest: 4.51 to 5.00[7].

The data were entered and confirmed by two technicians to minimize errors, into the *Statistical Package for Social Sciences* (SPSS) software, version 15.0. Possible associations were analyzed between the CRE scores and the following variables: age, length of residence in the LTCF, gender, education, children, religious practice, chronic illness, medication use, health self-assessment, health compared with the previous year, and health compared with other people of the same age. For analysis of quantitative variables, we used the Spearman correlation coefficient, analysis of variance – ANOVA for continuous data that had three or more categories, the Dunnett or Bonferrori tests for variables with multiple comparisons, and the Student's t-test for continuous

variables, conforming to parametric assumptions with the significance level of 5% ($p < 0.05$).

The classification of the magnitude of the correlations between variables was: 0.00 to 0.19 = absent or very weak; 0.20 to 0.39 = poor; 0.40 to 0.59 = moderate, 0.60 to 0.79 = strong, and 0.80 – 1.00 = very strong[8].

The research project was approved by the Committee of Ethics in Research of the Universidade Federal de São Paulo, SP – Protocol number 0443/10. Data collection was conducted between June and August of 2010, by the primary investigator and a nursing student, trained by the researcher. The Terms of Free and Informed Consent were read and signed by the institutionalized elderly study participants.

## RESULTS

Regarding the profile of the elderly in the LTCF, the mean age was 76.6 years (SD ± 9.5) with an amplitude of 43 years of age. The mean time that the elderly had resided in the LTCF was 9.3 years (SD = 10.6). There was practically no difference between men and women (49.4 and 50.6%, respectively) because of institutional policies to maintain gender balance. A little less than half of the participants had no children (49.4%). In terms of education, 81.6% reported that they had not completed primary education or had no schooling. As for religious practice, 96.1% professed a religion; 74.0% had a chronic disease and 77.9% used some medication regularly.

Regarding health status self-assessment, 72.7% evaluated it from good to great. Regarding the perception of health compared to the previous year, 39.0% reported that their health was currently better or much better. Also, 75.0% affirmed that their current state of health was better or much better than other elderly.

**Table 1.** Assessment of positive, negative and total religious/spiritual *coping* (RSC), of elderly in two LTCF, Minas Gerais – 2010 (n = 77)

| RSC Outcome Scale | Mean (± SD) | Median | Amplitude |
|---|---|---|---|
| PRSC * | 3.38 (± 0.6) | 3.4 | 1.4 – 4.7 |
| NRSC ** | 2.1 (± 0.5) | 2.0 | 1.3 – 3.9 |
| TRSC *** | 3.6 (± 0.3) | 3.7 | 2.3 – 4.2 |

*PRSC – positive religious/spiritual *coping*; **NRSC – negative religious/spiritual c*oping*; ***TRSC – total religious/spiritual c*oping*

**Table 2.** Assessment of religious/spiritual *coping* (RSC) factors of the elderly of two LTCF, Minas Gerais – 2010 (n = 77)

| Factors of the PRSC and NRSC | Mean (± SD) | Median | Amplitude |
|---|---|---|---|
| **PRSC** | | | |
| Transformation of yourself and / or your life | 3.7 (± 0.6) | 3.8 | 1.8 – 5.0 |
| Actions in search of spiritual help | 3.0 (± 0.7) | 2.9 | 1.2 – 5.0 |
| Offer to help others | 3.3 (± 0.8) | 3.3 | 1.1 – 4.9 |
| Positive positioning in front of God | 4.2 (± 0.6) | 4.3 | 1.5 – 5.0 |
| Personal quest for spiritual growth | 3.1 (± 0.7) | 3.2 | 1.4 – 5.0 |
| Actions in pursuit of another institution | 3.1 (± 0.9) | 3.1 | 1.1 – 5.0 |
| Personal quest for spiritual knowledge | 1.8 (± 0.8) | 1.6 | 1.0 – 4.0 |
| Separation from God, religion and / or spirituality | 3.7 (± 0.6) | 3.8 | 1.7 – 5.0 |
| **NRSC by factors** | | | |
| Negative revaluation of God (questioning) | 1.8 (± 0.6) | 1.6 | 1.0 – 4.1 |
| Negative positioning in front of God | 3.0 (± 0.8) | 3.0 | 1.0 – 5.0 |
| Negative revaluation of meaning | 2.3 (± 0.9) | 2.2 | 1.0 – 4.4 |
| Dissatisfaction with the other institution | 1.7 (± 0.7) | 1.5 | 1.0 – 4.0 |

SD – standard deviation; PRSC – positive religious/spiritual *coping* ; NRSC – negative religious/spiritual c*oping*

**Table 3.** Spearman correlation between the scores of the factors and Total RSC with the variables of age and time of residence of elderly in two LTCF, Minas Gerais – 2010 (n = 77)

| Total RSC and factors | Variables | | | |
|---|---|---|---|---|
| | Age | | Time living in LTCF | |
| PRSC | 0.520 | (0.019)* | 0.812 | (0.212) |
| NRSC | -0.014 | (0.412) | -0.328 | (0.008)* |
| TRSC | 0.780 | (0.301) | 0.693 | (0.010)* |

*Significant correlation P <0.05 *;* PRSC – Positive spiritual/religious *coping*; NRSC – negative spiritual/religious c*oping*; TRSC – total spiritual/religious *coping*

**Table 4.** Distribution of means of the socioeconomic and health variables, conforming to the total RSC among elderly in two LTCF, Minas Gerais – 2010 (n = 77)

| Total RSC and factors | | Variables | | | |
|---|---|---|---|---|---|
| | | Having children | Religious practice | Having disease | Use of medication |
| **PRSC by factors** | | | | | |
| P4: Positive positioning in front of God | Yes | 3.2(±1.1) | 2.2(±2.5) | 2.2(±0.6) | 2.9(±1.6) |
| | No | 2.2(±0.3) | 4.1(±2.1) | 4.4(±0.9) | 4.1(±0.9) |
| | p-value | 0.141 | 0.508 | 0.200 | 0.043* |
| P5: Seeking personal spiritual growth | Yes | 4.1(±1.7) | 3.7(±1.9) | 3.7(±0.9) | 4.0 (±0.7) |
| | No | 3.5(±0.7) | 3.6(±1.2) | 4.5(±1.3) | 2.8(±1.2) |
| | p-value | 0.896 | <0.001* | 0.218 | 0.096 |
| P6: Actions in pursuit of another institution | Yes | 2.2(±0.7) | 2.9(±2.1) | 3.8(±2.7) | 4.1(±1.5) |
| | No | 3.3(±1.9) | 2.5(±1.1) | 4.3(±1.1) | 3.8(±0.7) |
| | p-value | 0.863 | 0.044* | 0.695 | 0.703 |
| P8: Separation from God, religion and / or spirituality | Yes | 3.1 (±1.1) | 3.3(±1.3) | 2.2(±1.0) | 3.9(±1.5) |
| | No | 4.4(±1.3) | 2.2(±1.7) | 3.5(±0.4) | 2.1(±0.7) |
| | p-value | 0.032* | 0.057 | 0.934 | 0.805 |
| **NRSC by factors** | | | | | |
| N4: Dissatisfaction with the other institution | Yes | 1.5(±0.8) | 2.8(±1.2) | 3.8(±1.9) | 1.9(±0.8) |
| | No | 2.1(±1.3) | 1.9(±2.9) | 2.9(±2.9) | 3.3(±0.4) |
| | p-value | 0.992 | 0.956 | <0.001* | 0.091 |

*Significance p <0.05 *,* PRSC – positive spiritual/religious c*oping*; NRSC – negative spiritual/religious c*oping*

**Table 5**. Multiple comparisons of interest in the self-assessment of health status and TRSC factors of elderly in two LTCF, Minas Gerais – 2010 (n = 77)

| TRSC by factors | Variable: self-assessment of health status | | |
|---|---|---|---|
| | Much better X Better | Much better X Worse | Better X Worse |
| PRSC | 0.248 | 0.017* | 0.298 |
| NRSC | 0.325 | 0.449 | 0.748 |
| TRSC | 0.867 | 0.043* | 0.155 |

*Significance p <0.05 *;* PRSC – positive religious/spiritual c*oping*; NRSC – negative religious/spiritual *coping*; TRSC – total religious/spiritual c*oping*

## DISCUSSION

The use of TRSC by the elderly participants was classified as "high" (3.6). The older group presented more significant religious behaviors and attitudes than the less elderly, therefore valuing spirituality. These factors are seen as stabilizing the aging process[6]. The researcher responsible for the RSC scale validation for Brazilian culture found evidence of religion in the face of crisis situations in the aging process[7]. Analyzing the index encountered in this study, it was observed that the elderly felt comfortable in their use of religious/spiritual beliefs and behaviors, as a support in the resolution of their problems, and to prevent potential negative emotional consequences and stressors in their daily lives in the LTCF.

In this research, the PRSC was considered to be "average" in terms of its use by the institutionalized elderly (3.38). In a study of 551 critically ill elderly, the PRSC domain presented the highest use[6]. The same author affirmed that mental health was related with greater use of the PRSC and associated with less depression and better quality of life. Corroborating this assertion, the PRSC reveals a greater sense of attachment and confidence in the higher power, thus, levels of comfort, support and security are presented by people with greater use of the PRSC [9].

Among the PRSC factors, the factor *positive positioning in front of God* had the highest mean (4.2), ranked as "high" in its utilization. This factor encompasses self-directed strategies and the search for spiritual support from God, which tends to offer a perception that God grants skills to the individual to deal with the situation on one's own, or that support is given, without, however his intervening in the problem[10].

All behavior with the use of the RSC exposes a personal position in front of God in relation to situations that may manifest themselves through many styles of RSC, which provide religious boundaries, seeking support in God, more connection with Him and / or positive revaluations through Him. Attitudes are revealed such as to count, collaborate, supplicate, approach and / or rely on God, or even in individual actions independent of divine help[7]. This result may be related to the beneficial influence that religiosity and spirituality present on the coping process experienced by the elderly in LTCF.

The least significant factor in the use of the PRSC was a *personal quest for spiritual knowledge*, with a classification of "low" (1.8), which was related to the demand for greater spiritual knowledge. The objectives of raising spiritual knowledge can be various, such as: spiritual strengthening in relation to a problem, to the world and / or to the divine design, increase in religious practice or of their own attitudes, seeking help for dealing with and / or for understanding the situation, or even the simple addition of intellectual pursuit. This factor has a dimension of individualized personal quest of spiritual knowledge, which is no stranger to the institution, as the data show the relationship between the factor *personal quest for spiritual knowledge* and church attendance[7]. This is accomplished, mainly, by reading the Bible and other books with spiritual approaches. Experience in the LTCF suggests that reading and intellectual development may be compromised by the high percentage of illiterate elderly, especially among the most elderly. This is a characteristic that compromises the use of this factor.

As already noted, the NRSC used by the elderly was considered "low" (2.1) and the NRSC strategies showed a moderate level of correlation with a lower quality of life (QoL) and greater levels of depression. The NRSC collaborates in declining health as in the limited spiritual outcomes and increased dysfunction in the activities of daily living[5].

The low mean achieved in the NRSC, and the great influence of the PRSC benefits, allowed the attribution of meaning to the events, that nothing happens by chance and that events are determined by a higher power. Thus, these events can also lead to personal growth, such as wisdom, balance and maturity[5]. For these authors, the NRSC and PRSC factors explain the existing correlations, because the more intense and the greater the faith, understanding, or acceptance of events throughout life, it arouses motivation to face the events and live with more intensity, making life more satisfactory.

The factor that contributed most negatively among those of the NRSC was: *negative positioning in front of God* with the use of "average" (3.0). The same thing occurred in validation of the RSC scale for the Brazilian culture[6]. It was observed that this factor was related to delegating and passive *coping* strategies in which the person ceases to act on his own, to then be directed by a transcendent force. The individual who exercises this *coping* style may distort reality and present difficulties in successfully confronting the problem[5]. The factor *negative positioning before God* is a behavior of religious and spiritual *coping,* in which a person transfers the responsibility exclusively, or simply waits for God to act, without her participation, expressing herself by means of the passive religious delegation *coping* style[7]. Many elderly use their trust in God to justify submission.

The delegating modalities are more related to events that are beyond their control, such as chronic diseases and their own finite nature. People with lower competencies and abilities tend to prefer an omissive style due to the belief and support they receive from the divine force[5]. Many of the elderly in LTCF have difficulty facing the institutionalization process, because of physical limitations, medication control and fear of relapse, remaining passive,

limiting their self-care; delegating their state of health only to God and their beliefs. The competence of the elderly can be inhibited or stimulated, depending on the modality of RSC practiced.

The factor that contributed least to the NRSC was: *negative revaluation of God* (1.7) that consists of a cognitive reappraisal of the idea that the individual constructed of God in which, through his behaviors, he questions his own will and that of God. This is evidenced by the questions of the existence, power, love, protection, responsibility, desire, acts and / or punishments of God. Generally, this occurrence is accompanied by the expression of unfavorable feelings, such as: revolt, guilt, helplessness and sorrow[7].

The Brazilian religious tradition, especially among the elderly, is based on presence and fidelity to God[10]. The elderly person realizes that God is seen as the one who gives the ability and the independence to act, making sustenance available, but without direct intervention, granting freedom and strategies for individuals to direct their own lives. This does not mean anti-religious behavior, but the use of the liberty that God offers.

The positive correlation between the variable of age and the PRSC factor means that the higher the age, the higher the score on the PRSC factor. Old age is considered by many as the final stage of life, in which there are more reflections with respect to death, and more so, to what is beyond it. These considerations inevitably strengthen the larger religious approach by the elderly[11]. That said, the oldest participants especially used more positive religious and spiritual *coping* strategies, making them more adaptable and secure for facing adversity at this stage of life.

Regarding the length of residence in the LTCF, the study showed that the longer a person lived in the LTCF, the lower the NRSC factor scores. The TRSC presented a strong positive correlation in the variable time of residence in the LTCF, which means that the longer the duration of residence, the higher the TRSC score. These results are explicable, because the TRSC is the result of the mean between the PRSC index and the mean of the inverted responses of the NRSC. Therefore, the lower NRSC scores reflect on the favorable TRSC scores[7,11]. The TRSC is the set of faith strategies people use to cope with stress factors, that emphasize faith, religion, spirituality and personal beliefs[12,13].

At the beginning of institutionalization, the elderly go through acute changes in which their daily life is marked by a new routine with new rules, schedules, lack of flexibility, being quite different from the familiar environment[14]. These factors potentiate the dissatisfaction with the institutionalization, making the adaptation process more difficult and, consequently, less use of religion and spirituality in coping leads to the attribution of lower scores to the TRSC. However, with the passage of time and greater adaptation to the changes, with an increase in the bond with other elderly, professionals and a new autonomy, the elderly of the LTCF used more strategies of the TRSC. This can be explained by their greater adaptation to dealing with the adversities of daily life in this phase of life.

By comparing the RSC scale with personal, family, social, economic and health characteristics, the *elderly with children* had a higher correlation with the factor "*Separation* (from the stressful situation they experienced in the LTCF) *from God, religion and / or spirituality*". The person does not deny nor try to escape the situation, he just searches for relief with the help of spirituality and religiosity[7]. It is believed that older people with more children use this factor to positively address the process of institutionalization, because, in some way, they feel the lack of a family support network in the case of their children.

The elderly who practiced religion had a higher correlation with the positive factor *"personal search for spiritual growth"* and "*actions in pursuit of another institution*". These factors are associated with search and personal growth with God and the approximation of religious institutions and their leaders, respectively[7]. In religious practice, the elderly of the LTCF develop their spirituality and stronger links with the religious institution, favoring the coping practices.

The elderly with chronic diseases presented a correlation with the negative factor "*Dissatisfaction with the other institution*", showing that they were more dissatisfied with the other religious institution[7]. This result contradicts the literature, because spirituality / religiosity collaborate in the process of acceptance of chronic diseases, confronting the pain better. Chronic diseases have negative influences in the physical and psychological aspects attributed to the aging process, which can affect in a peculiar manner the process of confronting adversities, such as institutionalization. Thus, the most probable dissatisfaction of the majority of the elderly was with the religious representative.

The systematic use of medications by the elderly presented as related to the PRSC factor of "*positive positioning in front of God*". This factor, in short, characterized a greater connection to and seeking support from God[7]. The use of medications increases considerably in this age group, where there are a number of factors, among these the higher morbidity[15]. Thus the institutionalized elderly have a high prevalence of chronic diseases that requires daily medication for treatment. However, they also draw nearer to God to seek better physical and mental health.

Elderly people who considered their health much better had higher scores on the TRSC and PRSC in relation to those who considered it worse. The TRSC was predictive of changes in mental/ physical health,

and in a study of 268 hospitalized elderly patients, the PRSC was associated with better QoL assessments, greater social support and lower rates of emotional and behavioral problems that reflected on the health and human relationships[6,16]. The best self-assessments of health conditions were reinforced by the TRSC and PRSC in the elderly, because they presented better perceptions of their health status in general, which positively influenced coping strategies in the process of institutionalization as compared to older people who were dissatisfied with their health.

Studies of this nature have substantial implications for professional practice in the health area, and suggest the training of those involved with the institutionalized elderly, so they can develop an understanding of and listen for conflicts of a spiritual and religious nature, as well as the factors involved with QoL, to provide better adaptation, adjustment and maintenance of their health conditions.

## CONCLUSION

Most elderly people who were participants of the research practiced some religion and used CRE strategies of an elevated form for the adversity experienced in the process of institutionalization, and what contributed satisfactorily to this result were the PRSC strategies used.

Elderly people who are continually confronted with religious / spiritual issues, were particularly at risk to their health due to the use of the NRSC and, as a result, the development of depression and other illnesses.

For the elderly, faith collaborated in the healing, that is, in control of chronic diseases and / or improved functional capacity in activities of daily living. Undoubtedly, the CREP is essential for the elderly in LTCF.

The oldest elders, with religion, more time living in the LTCF and better perception of health used more strategies of the TRSC and PRSC. The elderly with more children approached religion / spirituality to depart from stressful situations such as institutionalization, because in some way, they lacked the support of their children. Many elderly had chronic diseases and presented some dissatisfaction with the representative of the religious institution, while those who used medications systematically were closer to God.

Studies of this nature possess a strong implication to the practice of the professional in the health area and suggest the training of those involved with the institutionalized elderly, so they can develop an understanding of and listen for conflicts of a spiritual and religious nature, as well as the factors involved with QoL, to provide better adaptation, adjustment and maintenance of health conditions.

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