RELATIONSHIP BETWEEN SOCIAL SUPPORT RELIGIOUS ORIENTATION AND QUALITY OF LIFE AMONG CANCER PATIENTS

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Abstract: This current study was devised to explore impact of social support and religious orientation of Pakistani cancer patients on their quality of life. For this purpose, a co-relational study was carried out with heterogeneous sample (N=50) comprising both males and females. Data was collected from hospitals in Rawalpindi providing oncology services. Psychometrically sound World Health Organization Quality of Life-BREF Scale, Social Support Scale and Religious Orientation Scale–Revised were used. According to the results of this current study, there was a positive relationship between QOL and social support at r = 0.42 and social support and religious orientation at r = 0.34. The study did not show any significant relationship between QOL and religious orientation. From the results, it was evident that there is a need to work more on the religious orientation and quality of life. The limitations of the research work were the limited time frame and small sample size due to which the results could not be generalized.

Key words: Social support, religious orientation and quality of life.

INTRODUCTION
Cancer caused 7.9 million deaths in 2008 and it is expected that it will rise up to 12 million by the end of 2030 (WHO, 2011). Pakistan shares a significant cancer burden and according to Bhurgri et al. (2006) from 1998 to 2002, the cancer burden in Pakistan was 179.0/100000 in males and 204.1/100000 in females. Cancer lays significant impact on individual’s quality of life (QOL). QOL is a multidimensional idea, taking in account the physical, psychological, social and emotional functioning of an individual to determine the quality of life through both objective and subjective perspectives. Objective perspective includes the level of income, social networks, friendships, standard of living, housing quality and access to health and other basic facilities. The subjective perspective includes the individual’s perception of his health status and life satisfaction which includes satisfaction from family, relatives, environment and his own perception of life and health (Zullig, Ward & Horn, 2006). Study of QOL is essential among cancer patients to understand the variables that can affect QOL and well being. Social support, partner support and optimism are found to be beneficial for QOL among cancer patients. Social support is associated with improved QOL in cancer. It is the support one gets from family, friends, and relatives and from community which can be in the form of financial assistance, material support, informational support and emotional support (Taylor, 2006; Gustavsson-Lilius, Julkunen, & Hietanen, 2007). Social support can either be actual or perceived however, perceived support is found to be more beneficial which is the person’s perception of being loved, cared, valued and esteemed. Social support can have uninterrupted or buffer affect on QOL of an individual. According to direct hypotheses, social support is beneficial in every life situation. According to buffer hypotheses it only becomes beneficial and act as a buffer against negative life events (Taylor, 2006).According to biopsychosocial pathway, there is a link between physical health, psychological functioning and social support as social support in stressful situation has shown decrease in levels of stress hormones and enhancement in the functioning of
immune system especially in a disease like cancer. In stressful and health threatening events, people think of the times when they got support from others and such interactions help people to get reaffirmation of their strengths in difficult times (Uchino, Uno & Holt-Lunstad, 1999; Pinquart & Duberstein, 2009).

Besides social support, belief system is one of the aspects of person’s life that can have profound impact on the QOL and adjustment to the disease. Religious orientation is an individual’s attitude towards the religion. Either intrinsic or extrinsic, both have the capacity to leave positive impact on individual’s life and control of life events (Spilka, Shaver, & Kirkpatrick 1985). Religiosity can be divided into four dimensions that are spiritual coping (personal prayer and contemplation), congregational coping (advice and information from the clergy and performance of rituals) spiritual support (perceived support from the God) and congregational support (perceived support from the clergy and people with whom one attends religious ceremonies). The religiosity and spiritual support play a stress buffering role in stressful events and lead to development of less negative emotions and enhanced QOL (Maton, 1989). Religion enhances QOL by establishment of personal relation with the God, adopting a religious lifestyle and understanding the meaning of self. Moreover, it also act as an social support mechanism when interaction with people is increased through participation in congregational activities (Ellison, 1991).

Main objectives of the research was to see relationship between social support, religious orientation and QOL among cancer patients. So, keeping in view the previously published literature following, hypotheses were devised:

- Cancer patients with high social support will have high QOL.
- Cancer patients with high religious orientation will have high QOL.
- Cancer patients with high social support will have high religious orientation.

For the collection of demographic data and responses of the patients for the study variables, following instruments were used:

**Demographic Data Sheet**

Demographic data sheet was used to collect demographic information which included age, marital status, socio-economic status and duration of treatment of all the respondents.

**World Health Organization Quality of Life -BREF**

World Health Organization Quality of Life -BREF Urdu version with twenty six items having likert type five response set categories were used in order to measure QOL among cancer patients. As this instrument takes physical functioning, psychological functioning, social relations and environment to determine QOL; it was a comprehensive instrument to be applied on to the cancer patients.

**Social Support Scale**

Social support was measured by Social Support Scale (SSS); a two part scale comprising of 31 likert type items. The first part comprises of 11 items which measure level of support provided by family, neighbors, friends, relatives and colleagues. The Second part comprises of 20 items which measure perceived social support by focusing on nurturance, attachment, reliable alliance, social integration and reassurance of worth.

**Religious Orientation Scale: Revised**

Religious orientation was measured by Religious Orientation Scale: Revised developed by Gorsuch & McPherson in 1989. Urdu version of the scale was used which was adopted and translated into Urdu by Ghaus in 2003. The scale measures religiosity in the domains of intrinsic, extrinsic social and extrinsic personal religious orientation. It is a 14 item, likert type scale having five response set categories ranging from one (strongly disagree) to five (strongly agree).

**Participants**

The research locale was Rawalpindi and data was collected from Benazir Bhutto Shaheed Hospital, Combined Military Hospital, Holy Family Hospital and National Cancer Institute Rawalpindi. The heterogeneous (both males and females) sample size of 50 patients was taken with the age above 20 years (M = 0.62, S.D. = 0.49). Patients who were not able to read were taken as the subjects.
along with the literate patients due to the limited number of available cancer patients. Purposive sampling was used because patients who were severely ill were not included into the study as they were not able to communicate.

RESULTS
The findings of the sample were achieved by using correlation test, t-test, ANOVA, chi square and alpha reliability on the scales used in the study. Statistical Package for Social Sciences (SPSS 13) was used to calculate the outcomes of the research sample.

The correlation showed a significant relationship among quality of life and social support (Table 1). So according to the results, people who had high level of social support enjoyed high level of quality of life. The relationship between quality of life and religious orientation was negative but non-significant. The relationship between social support and religious orientation was substantial, showing that individuals with great level of social support enjoyed high level of religious orientation as well.

Table 1: Correlation matrix between World health Organization Quality of Life-BREF, Social Support Scale and Religious Orientation Scale-Revised

<table>
<thead>
<tr>
<th></th>
<th>WHOQOL-BREF</th>
<th>SSS</th>
<th>ROS-R</th>
</tr>
</thead>
<tbody>
<tr>
<td>WHOQOL-BREF</td>
<td>-</td>
<td>-0.02</td>
<td>0.42*</td>
</tr>
<tr>
<td>SSS</td>
<td>-</td>
<td>-</td>
<td>0.34**</td>
</tr>
<tr>
<td>ROS-R</td>
<td>-</td>
<td>-</td>
<td></td>
</tr>
</tbody>
</table>

*p < 0.05, **p < 0.01

While analyzing the study variables with demographic variables, non-significant relationship of gender with QOL, social support and religious orientation was seen as the significance level was greater than 0.05 (Table 2). On QOL females score was higher than that of males and males score recorded was higher than females on social support and religious orientation. This implies that male patients received more social support and had more religious orientation as compare to female patients but females had better QOL.

DISCUSSION
As the current research work was devised to study the connection between QOL, social support and religious orientation among cancer patients, the hypothesis was devised that “cancer patients will have high social support with high QOL” and present study succeeded in validating the hypothesis by showing a positive relationship between both the variables. It showed that people who had greater level of social support also had greater level of quality of life. These findings are consistent with Melin-Johansson, O’Diling, Axelsson, and Danielson (2008), which supported that patients with their families and significant others enjoy high quality of life with increased sense of security and experience ease in their suffering. High social support enhances ability to perform daily activates due to enhanced physical and psychological well being (Sherbourne, 1992).

The present study did not support the hypotheses that “cancer patients with high religious orientation will have high QOL”. It rather showed a non significant inverse relationship between both the variables with participants scoring high on quality of life but low on religious orientation. Sherman and Simonton (2001) reported that many studies have shown a significant increase in quality of life as a consequence of increased religious orientation but it is not always true as many studies have shown the negative relationship between both variables as well such as Gall (2004) presented a insignificant association between the negative view of God and the well being and quality of life of the patients. Thune-Boyle, Stygall, Keshtgar, and Newman (2006) in a systematic review of literature reported that out of seventeen reports, three reports showed the negative consequences of religious orientation and seven showed no significant relationship between religious orientation, adjustment with the cancer and enhancement of quality of life. Sometimes people blame God for their chronic and life threatening illness and in such situation they cannot continue...
with their religious practices and rituals as well as cannot enhance their faith so ultimately their health and illness condition goes critical day by day and that’s why they do not show significant enhancement in their quality of life. Sample understudy in the present research showed decline in religious orientation while their QOL increased which can be the consequence of the social support they received as the present study showed positive relationship of QOL and social support.

The present study validated the hypothesis that “cancer patients with high social support will have high religious orientation”. Ellison and George (1994) reported that individuals who attended holy ceremonies and congregations had huge social networks and received more social emotional and instrumental social support. Besides this they also experienced high feelings of love, care and nurturance and they felt themselves as a part of a social group. The reason for increased religiosity among patients can be high social support and social interactions which encourage them to participate in congregational religious activities or these actives bring opportunities for them to develop relationships which lead to increased social support.

CONCLUSION
Through the results of the present research it is evident that social support has the capacity to affect the QOL but religiosity leaves no significant impact on the QOL. Even in the era of globalization when the social values have changed but still social support is one of major pillars of our society that can bring constructive change in the lives of cancer patients. Religiosity being the integral part of Pakistani society has no significant relation with the well being of cancer patients but many people develop their hopes with the religion and the God and religious healing is one of the most prevalent alternative healing systems. So there is need to further study the religiosity and its impacts on lives of people suffering from cancer.

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