



RESEARCH ARTICLE

Examining the relationships between in-person and remote religious attendance and loneliness, quality of life, stress, and anxiety among older adults during COVID-19 in Ireland

[version 1; peer review: awaiting peer review]

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Abstract

Background

Religious attendance has been shown to have a positive effect on psychological health among the older people (Moon & Kim, 2013). Due to COVID-19 lockdown restrictions and precautionary health advice, many older adults struggled to attend service in-person. However, 87% of faith organisations provided a form of remote service between June and December 2020 (Ganiel, 2021).

Methods

Data were from Wave 6 (2021) of The Irish Longitudinal Study on Ageing (TILDA). Data were collected via telephone interview and self-completion questionnaires. The analysis sample was made up of 3,961 community-dwelling adults living in Ireland aged 60 years and older. To assess religious attendance, participants were asked about how often they attended in-person and how often they attended remotely using radio, television, or internet streaming. Relationships between religious attendance, Quality of Life (QoL), Loneliness, Stress, and Anxiety were modelled using linear regressions.

Results

The sample was 44.1% male and 55.9% female, with a mean age of 72.0 years. In-person religious attendance was positively related to

higher QoL [Beta=192.92, 95% Confidence Intervals (CI)=9.45, 376.39, $p<0.05$]. Remote religious attendance was positively related to higher anxiety [IRR=1.03, 95% CI=1.02, 1.04, $p<0.001$].

Conclusion

Results show that in-person attendance was positively related to QoL, while remote attendance was positively related to higher anxiety. This may be a result of the lack of social connectedness felt when practicing religion remotely or the higher level of anxiety during the COVID-19 pandemic. Future research should focus on social connectedness felt during in-person religious practice and during remote practice.

Keywords

Religion, COVID-19, Loneliness, Quality of Life, Older Adults, Stress, Anxiety

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Introduction

Traditionally, Roman Catholicism has permeated the culture in Ireland (Ingilis, 2017) with 81.6% of adults living in Ireland aged 60 and older identifying as Roman Catholic (CSO, 2023). In person religious attendance remains a highly prevalent activity among older people in Ireland, with over 50% of older adults reporting attending religious service at least once per week prior to the pandemic (Orr *et al.*, 2019). During the COVID-19 pandemic, older adults were advised to decrease social interaction, with those aged over 70 being advised to cocoon themselves, a form of extreme isolation (Health Service Executive, 2020). These restrictions combined with fear of contact with COVID made in person religious practice far less accessible during the pandemic period for older adults in Ireland. During the pandemic period, older adults in Ireland reported on average higher loneliness, depression, stress, as well as lower quality of life (QoL) (Pierce *et al.*, 2020; Ward *et al.*, 2021). In a study of 150 patients aged 70 and older who were in ambulatory hospital care, 40% reported lower mental health, 57% reported experiencing loneliness at least some of the time, and 50% reported a decline in QoL (Bailey *et al.*, 2021).

Religious participation has been shown to be associated with lower anxiety and stress and higher quality of life (Fernando & Berger, 2017; Kidwai *et al.*, 2014; Moon & Kim, 2013). It is associated with greater emotional support and thus lower loneliness (Krause, 2016). In-person religious attendance was associated with higher quality of life among older community dwelling adults (Moon & Kim, 2013). It has also been shown to encourage healthy coping practice during times of adversity (Fernando & Berger, 2017; Harris *et al.*, 2013; Kidwai *et al.*, 2014). It is therefore likely that in a time of adversity such as the pandemic, barriers to access would have hindered these positive effects.

At various points during the COVID-19 pandemic period, access to in person religious service was restricted by various levels of lockdown. Additionally, older adults were warned that they were at higher risk of complications from the virus and advised to practice extreme social isolation (HSE, 2020). These barriers to access may have led to an increase in remote religious attendance. Ganiel (Ganiel, 2021) surveyed 439 religious institutions in Ireland and found that 87% of them offered some form of online religious service during the pandemic. Kretzler (Kretzler *et al.*, 2023), also found that those who use online religious services tend to be older. Bentzen (Bentzen, 2021) found that Google searches for prayer increased by 50% in 98 countries including Ireland. This suggests that, as barriers to in person participation increased due to the COVID-19 pandemic, remote religious practice became more popular.

This research aims to assess the impact of both in-person and remote religious practice on loneliness, quality of life, anxiety, and stress. Specifically, we hypothesise that, because of the protective effect of religious practice and the healthy coping behaviours encouraged by religious practice, adults aged 60 and older who report higher in-person and remote religious attendance will have higher on average QoL, and lower on average stress, loneliness, and anxiety.

Methods

Criteria for inclusion in the sample were if participant completed the in person religious attendance and remote religious attendance questions as well as at least one of the measures for anxiety, stress, QoL, and loneliness. This left a sample made up of 3,223 people aged 60 or older living in Ireland. Data were from The Irish Longitudinal Study on Ageing (TILDA), a nationally representative, multidisciplinary, longitudinal study of the Irish population aged 50 and older and their partners of any age (Whelan & Savva, 2013). TILDA utilises a comprehensive nationally representative sampling frame system based on the Irish Geodirectory, a listing of all private residential addresses, allowing for a multi-stage sampling approach (Whelan & Savva, 2013). First, all residential addresses were grouped into clusters proportionate of socio-economic group, then a set of addresses within each cluster (n=50) were selected with 10 in reserve (Whelan & Savva, 2013). A total of 25,600 addresses were visited with 8,178 participants agreeing to participate in the study, achieving a response rate of 62.0% (Donoghue *et al.*, 2017; Whelan & Savva, 2013). Commencing in 2009, TILDA has collected data every two years, with a health assessment every four years (Donoghue *et al.*, 2017). A listwise deletion method was implemented whereby missing data were excluded from the model.

As of 2022, TILDA has collected six waves of survey data; the first five using computer assisted personal interviews (CAPI). During Wave 6, TILDA used computer assisted telephone interviews (CATI) in line with COVID-19 guidelines. Ethical approval TILDA for Wave 6 was granted on November 10, 2020 by the Trinity College Dublin College Research Ethics Committee (Wave 6 REC Ref: 190407). Explicit informed consent was obtained from all participants verbally via telephone due to COVID-19 restrictions and recorded electronically by the interviewer. Participants were provided with detailed information regarding the purpose of the study, their rights as participants, and the measures taken to ensure confidentiality and data protection in advance of participation. Participation was voluntary, and participants were free to withdraw from the study at any point. TILDA adheres to the 1964 Helsinki declaration and its later amendments.

Data used for the present study were from Wave 6. Data collection took place via CATI from January 2021 to January 2022. Data collection began roughly ten months after the first COVID-19 lockdown in Ireland. The data collection period included various stages of lockdown restrictions.

This study was done in adherence with STROBE guidelines (Elm *et al.*, 2007).

Key variables

Religious participation

In-person religious attendance was assessed using a single item measure as part of a Computer Assisted Telephone Interview (CATI). Participants who were affiliated with a religion were asked “About how often do you go to religious services?” Response options ranged between 1 (more than once per

week) and 6 (never/almost never). Remote religious participation was assessed with the following question: “How often do you participate in religion on radio, tv, or internet?” Response options ranged between 1 (more than once per week) and 6 (never/almost never).

For ease of interpretation, both religious participation items were reverse coded. Participants who reported having no religious affiliation were routed past this question. These participants were added back during the analysis and coded as 0. This made for a range of 0 (non-religious) to 6 (More than once per week).

Measurements of Anxiety, Stress, Loneliness, And QoL

Anxiety: Anxiety was measured using the Generalized Anxiety Disorder (GAD-7) (Spitzer *et al.*, 2006). The GAD-7 uses a four-point Likert format and includes seven items. It is an accessible and relatively quick measurement of subjective anxiety. Possible responses are 0 “not at all” 1 “several days” 2 “more than half the days” and 3 “nearly every day”. Scores from each response are summed for a total possible score ranging from 0–21, with higher scores representing greater levels of anxiety.

Loneliness: a modified version of the University of California Los Angeles (UCLA) Loneliness scale (Russell, 1996) was used to measure loneliness. This modified scale asks five questions: four positively framed, and one negatively framed question. The scale offers three response options: 0 (Hardly ever or never), 1 (Some of the time), and 2 (Often). The scale is summed, ranging from 0–15, with higher scores representing higher levels of loneliness.

Stress: Stress was measured using The Perceived Stress Scale-4 (PSS-4) (Mitchell *et al.*, 2008) (Cohen *et al.*, 1983). The PSS-4 is a four item, five-point Likert scale that is designed to be a short, reliable, and accessible measure of subjective stress. The scale is summed, ranging from 0–16, with higher scores representing higher levels of stress.

Quality of Life (QoL): The Control, Autonomy, Pleasure, and Self-Realization-12 (CASP-12) (Wiggins *et al.*, 2008) was designed to measure subjective quality of life in older people. This 12 item Likert scale is a highly reliable and valid and has been used previously in examining the older adults living in Ireland (Sexton *et al.*, 2015). The scale is summed, with scores ranging from zero to 36, and higher scores indicating higher levels of quality of life.

Control variables: Several known covariates of the dependent variables were controlled for, including age, gender (male, female), education (primary, secondary, third), self-rated physical health (Excellent, Very Good, Good, Fair, Poor), marital status (Married, Widowed, Divorced, Never Married) and living alone (Alone/Not Alone) (Herrera *et al.*, 2021; Kalpana & Srivastava, 2014; Purba *et al.*, 2021). Concern about COVID and having a disability were controlled for because it was assumed that these participants would be more likely to attend remotely.

To measure this, participants were asked whether illness or disability limit activities in any way. Response options were “Yes” or “No”. Concern about COVID was also controlled for by asking participants “Overall, how concerned are you about the COVID-19 pandemic?” Response options ranged from 1 (Least Concerned) to 10 (Most Concerned). Comorbidities were also controlled for. A variable was also derived from several variables asking about having any comorbidities. This new variable was coded 0 for no comorbidities and 1 for having a comorbidity.

Analytic strategy

Cross-sectional analytic framework was used to identify associations and test hypotheses. The choice of regression analysis was informed by the measurement type of each outcome variable. Ordinary Least Squares regression models were used to model the relationship between in-person and remote religious attendance and stress, and QoL. Prior to analysis model assumptions were tested using residual plots and histograms. Both the anxiety and loneliness variables were zero-inflated and approximated a Poisson distribution, and therefore, a Poisson regression was used for these two outcomes. The QoL variable was negatively skewed violating the assumption of normality so, prior to analysis, a cubic transformation was used to ensure the suitability of the variable.

Missing data were dropped using a listwise deletion method; any case with a missing value in one or more of the religion or psychological health variables were dropped. Statistical analyses were performed using Stata version 15.1 (RRID:SCR_012763) (Stata Corp, 2021). Copyright license was obtained for use by The Irish Longitudinal Study for use by all staff. All statistical methods can be replicated using open-source software such as R (RRID:SCR_001905) (R Studio Team, 2022). Statistical significance was set at $p < 0.05$.

For each of the Poisson models, results are presented with incidence rate ratios (IRR) and 95% confidence intervals (CI). This is a relative difference measure used to compare the incidence rates of an event and can be interpreted as plus or minus 1, with values below 1 indicating a negative relationship and values above 1 indicating a positive relationship.

Results

Table 1 describes the sample descriptives. 44.1% identified as male and 55.9% identified as female. 42.4% reported having at least a third level education while 18.2% reported having a primary school or lower education. 69.9% of the sample reported being married.

Table 2 describes the sample by religious affiliation, frequency of in person religious attendance, and frequency of remote religious attendance. The sample was overwhelmingly Roman Catholic (85.2%). 46.1% of the sample reported attending religious service in person at least once per week, while 43.1% reported attending religious service remotely via radio, television, or internet streaming.

Table 1. Sample descriptive statistics.

Sample Characteristic	Wave 6
Gender, %	
Female	55.9%
Male	44.1%
Marital Status, %	
Married	69.9%
Never Married	8.5%
Separated/Divorced	6.8%
Widowed	14.8%
Highest Level of Education %	
Primary/ None	18.2%
Secondary	39.4%
Third/Higher	42.4 %
Age (years), mean (SD)	72.0 (7.8)
Lives Alone, %	
Alone	23.53%
Not alone	76.47%
Long Term Illness, %	44.1%
Chronic Condition, %	60.3%
COVID Concern, mean (SD)	6.9 (2.4)
CASP Quality of Life Total Score, mean (SD)	27.7 (5.3)
GAD-7 Anxiety Score, mean (SD)	2.4 (3.9)
PSS Stress Score, mean (SD)	4.2 (3.0)
UCLA Loneliness Score, mean (SD)	1.8 (2.1)

Table 3 describes the results of the linear regression models. In-person attendance was positively associated with higher QoL [Beta(B)=192.92, 95% CI=9.45, 376.39, $p<0.05$].

There was also a trend with in-person attendance being negatively related to Loneliness [IRR=0.99, 95% CI= 0.99-1.00, $p=0.050$], however this did not reach statistical significance. Remote attendance was not significantly associated with QoL, Stress, or Loneliness, but was significantly related to higher Anxiety [IRR=1.03, 95% CIs= 1.02, 1.04, $p<0.001$]. Prior to cubic transformation, in-person attendance was also significantly associated positively with QoL [B=0.19, 95% CI=0.10,0.29, $p<0.001$].

To further examine potential differences between in-person and remote religious attendance on psychological health, a

Table 2. Sample broken down by religious affiliation and frequency of attendance.

Variable	%
Religious Affiliation	
Roman Catholic	85.2
Anglican/ Church of Ireland	2.9
Other	2.8
Non-religious	8.3
Remote Attendance (Those who have religious affiliation)	
Never/ Almost Never	28.6
Once or Twice a Year	11.9
Every Few Months	6.6
Once or Twice a Month	6.6
Once a Week	36.1
More than Once Per Week	10.0
Remote Attendance (Those who have religious affiliation)	
Never/ Almost Never	44.2
Once or Twice a Year	3.4
Every Few Months	3.1
Once or Twice a Month	5.9
Once a Week	26.1
More than Once Per Week	17.0

sensitivity analysis was conducted to first model this relationship while excluding participants who reported never attending in-person, and subsequently model the relationship with participants excluding those who reported never using remote services. The results of the sensitivity analysis are described in **Table 4**. In-person attendance was still associated with lower anxiety when participants who also reported using remote services at least once per month were removed [IRR=0.98, 95% CI=0.96, 0.99, $p<0.05$]. Remote religious practice was also still found to be associated with higher anxiety when participants who had reported attending religious service in-person at least once per month were removed [IRR=1.03, 95% CI=1.01, 1.05, $p<0.001$] (**Table 4**).

Discussion

This research examined the relationship between religious attendance and loneliness, QoL, stress, and anxiety during a period of great adversity and social isolation: the COVID-19 pandemic. Results provided evidence of a positive relationship between in-person attendance and QoL. Loneliness was also shown to trend downward despite not reaching statistical significance.

Table 3. Results of multiple linear regression models.

	QoL		Anxiety		Stress		Loneliness	
	B	95% CIs	IRR	95% CIs	B	95% CIs	IRR	95% CIs
In-person Attendance	192.92*	9.45, 376.39	1.01	0.99, 1.02	-0.01	-0.04, 0.06	0.99	0.97, 1.00
Remote Attendance	12.17	-161.44, 185.78	1.03***	1.02, 1.04	0.04	-0.02, 0.08	1.00	0.99, 1.01

Models controlled for age education marital status sex self-rated physical health Covid Concern Limiting Disability, and comorbidity.

*Indicates p value less than 0.05

**indicates p value less than 0.01

***indicates p values less than 0.001

Table 4. Sensitivity analysis results.

	QoL		Anxiety		Stress		Loneliness	
	B	95% CIs	IRR	95% CIs	B	95% CIs	IRR	95% CIs
In-person Attendance Without Participants who Reported engaging in Remote Religion	590.99***	242.07, 939.92	0.98*	0.96, 0.99	-0.10*	-0.19, -0.00	0.96***	0.94, 0.98
Remote Attendance Without Participants who Reported Attending in-person	-76.25	-316.63, 164.12	1.03***	1.01, 1.04	0.02	-0.04, 0.09	0.99	0.98, 1.01

In-person religious attendance has already been shown to have a beneficial effect on psychological health (Fernando & Berger, 2017; Kidwai *et al.*, 2014; Moon & Kim, 2013) and loneliness (Krause, 2016). It has also been shown to encourage healthy coping behaviours (Fernando & Berger, 2017; Harris *et al.*, 2013; Kidwai *et al.*, 2014). Thus, during the COVID-19 pandemic, a time of uncertainty and adversity, those who were able to attend in-person may have been able to cope with anxiety better than those who could not.

Remote religious practice, however, was found to be significantly associated with greater anxiety, even when concern over covid was controlled for. This result is similar to the results found in a study examining the relationship between religious involvement and anxiety among older adults in Ireland whereby frequency of prayer outside of religious service was found to be positively related to higher anxiety (O'Maoileidigh *et al.*, 2022). These results may be reflective of the social isolation experienced by older adults during the pandemic, meaning that anxiety was being driven by the social isolation that people who were using remote attendance experienced rather than the concern over the pandemic. Older adults were advised to avoid socialization and practice extreme isolation (Health Service Executive, 2020) which meant staying isolated from friends and family, restricted access to social activities and clubs, and even shopping at special times to avoid the general population.

These results may also be indicative of the missing social benefit found from attending in person (Krause, 2016; Orr *et al.*, 2019). Older people experienced many barriers to in person social activities, including a religious community that could be interacted with in person.

It should also be noted that the sensitivity analysis, which separated participants who only attend in person and those who only attend remotely, held the same result that remote religious attendance is significantly positively related to greater anxiety. In person religious attendance became significantly related to lower anxiety and lower loneliness when those who used remote attendance were removed.

Data was also collected at various points throughout the pandemic, thus participants who were interviewed during higher levels of restrictions may have been feeling more anxious while at the same time being unable to attend in person religious service. Vaccinations were also not available for the entirety of data collection and participants who may not have had one when they were interviewed may have reported more anxiety.

What's more, when those who attended religious services online at all were dropped, in person religious participation predicted significantly lower anxiety. When those who had attended in person were dropped, remote attendance was still associated with higher anxiety.

This study had several limitations. First, the use of cross-sectional survey data made measuring the change in religious practice and stress, loneliness, QoL, and anxiety over the COVID-19 pandemic impossible. Data was collected between January 2021 and January 2022, and while COVID was present throughout the entire time period, there were varying levels of lockdown restrictions throughout the year. Second, the use of single item responses to measure attendance rather than comprehensive scales. These items did not allow for the measurement of the complexities of religious participation such as spirituality, social benefit, or meaning and purpose. In addition, these measures fail to account for spirituality and intrinsic religious practice, which has been shown to have a positive effect on anxiety and stress (Vitorino *et al.*, 2018).

This study also has several strengths. The use of a large nationally representative sample made for more accurate and generalizable results with smaller margin of error. Additionally, the use of data collected during a unique point in time; the COVID-19 pandemic period.

Future research should include comprehensive spirituality measures as a dependent variable to capture the complex intrinsic facets of religious practice and spirituality as these facets of religious practice may be more protective against negative mental health outcomes than simple attendance alone. Future research should also focus on social connectedness felt during in-person and remote religious practice as this study could only measure social connectedness.

Conclusion

During the COVID-19 pandemic, older Irish adults were advised to socially isolate. This limited social participation in many

ways, including in-person religious attendance. This study set out to examine whether religious attendance, both in-person and remotely, had a positive effect on stress, loneliness, QoL, and stress among older adults living in Ireland during the COVID-19 pandemic period. While in-person attendance was shown to have a beneficial effect on QoL, remote religious practice was shown to have a negative effect on anxiety.

Ethics and consent

Ethical approval TILDA for Wave 6 was granted on November 10, 2020 by the Trinity College Dublin College Research Ethics Committee (Wave 6 REC Ref: 190407). Explicit informed consent was obtained from all participants verbally via telephone due to COVID-19 restrictions and recorded electronically by the interviewer. Participants were provided with detailed information regarding the purpose of the study, their rights as participants, and the measures taken to ensure confidentiality and data protection in advance of participation. Participation was voluntary, and participants were free to withdraw from the study at any point. TILDA adheres to the 1964 Helsinki declaration and its later amendments.

Data availability

The first five waves and COVID-Sub study of TILDA data are available from the Irish Social Science Data Archive (ISSDA) at www.ucd.ie/issda/data/tilda/. To access the TILDA survey data, please complete an [ISSDA Data Request Form for Research Purposes](#), sign it, and send it to ISSDA by email (issda@ucd.ie). The present work uses data from Wave 6 of TILDA which, as of the time of submission, is being prepared for deposit to ISSDA. Access can be requested via the TILDA on-site hotdesk facility (<https://tilda.tcd.ie/data/accessing-data/hotdesk/>).

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