



Investigating the Correlation Between Religious Attitudes and Quality of Life Among Medical Students at Abadan University of Medical Sciences

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Abstract

Background: Spirituality and coping strategies employed by an individual in their life are two significant factors in determining the quality of life (QoL).

Objectives: The present research aimed to investigate the correlation between religious attitudes and QoL among medical students at Abadan University of Medical Sciences.

Methods: The present research is a cross-sectional, descriptive-analytical study was conducted in 2023 - 2024 with the participation of 462 students from 11 different fields of study at Abadan University of Medical Sciences. Stratified sampling was employed, and the research instruments consisted of a demographic, questionnaire, the quality-of-Life Questionnaire, and the Religious Attitude Scale. Data analysis was performed using descriptive statistics, the independent *t*-test, and ANOVA and Pearson correlation test with SPSS 21 at a significance level of 0.05.

Results: The mean total score of QoL was 90.66 ± 16.02 , and the mean score of religious attitudes was 135.86 ± 37.26 . There was no statistically significant difference in the mean scores of QoL and religious attitudes among students from different fields of studying order ($P = 0.143$, $P = 0.791$). The results revealed a significant correlation between the total scores of QoL and religious attitudes ($P < 0.001$, $r = -0.431$).

Conclusions: The results of this study showed that religious attitude and QoL are two concepts that are correlated with each other. Given the impact of religious attitudes on QoL and the decline in scores for both variables in higher semesters and older age groups, the need to strengthen the religious dimension among students through developing cultural programs and providing necessary infrastructure in universities seems evident.

Keywords: Religion, Attitude, Quality of Life, Students

1. Background

Religion serves as a profound foundation for shaping human existence and fulfilling essential needs. The absence of genuine religious belief may lead to psychological distress, despair, and a sense of meaninglessness (1, 2). Throughout history, religion has been deeply embedded in human societies, influencing values, behavior, and emotional well-being. Religious

individuals often experience greater resilience, deriving comfort from faith, social and spiritual support, and a sense of belonging, which help them better manage life's challenges (3). As a comprehensive system of values, norms, and rituals, religion provides individuals and societies with a structured model for living and fosters creativity and adaptability in facing limitations (4). Many scholars view religion as an innate human inclination that satisfies fundamental emotional and

existential needs, explaining its persistence across time and cultures (5).

Research consistently indicates that religious people tend to report better mental health, including lower anxiety and depression levels, compared with their less religious counterparts (6). Medical students, however, represent a population particularly vulnerable to stress, anxiety, and depression due to academic pressure, long hours, and constant exposure to illness and suffering (7). In this context, religiosity has been identified as a potential coping mechanism. For example, studies among students in East Malaysia found that higher religiosity was associated with lower depression, anxiety, and stress (8), while Brazilian research reported links between intrinsic religiosity, spiritual peace, and greater happiness and optimism (7). Nonetheless, the relationship between religiosity and mental health is complex. Positive religious coping can act as a protective factor, whereas negative religious coping is linked to higher distress levels (9). Additionally, some studies have reported no significant association between religiosity and psychological disorders among medical students, underscoring the need for further investigation across different cultural and demographic contexts (10).

2. Objectives

Students are the main pillars of society and the future builders of the country, and having peace, health, and efficiency in various biological, physical, psychological, and social areas is essential for their success in life. Given the esteemed position of religion and spirituality and the importance of the quality of life (QoL) of university students, who are the nation's cultural and intellectual capital and play a crucial role in construction, religiosity, and social advancement, Also given that no research was conducted in this field focusing on medical students, the present research was conducted to determine the correlation between religious attitudes and QoL among students at Abadan University of Medical Sciences in 2024.

3. Methods

3.1. Study Design

The present study is a descriptive-analytical that was conducted in Abadan University of Medical Sciences in 2023 - 2024. The inclusion criteria included studying at Abadan University of Medical Sciences, studying in the second semester or above, and expressing a willingness

to participate in the study. The exclusion criteria were incomplete questionnaires and guest students.

The study population in this study comprised all students studying at Abadan University of Medical Sciences in 2023 - 2024. Using the formula and the MedCalc software, the sample size was calculated to be 385 with a 5% margin of error and a standard deviation of 0.1. To account for a 20% dropout rate, the final sample size was determined to be 462.

$$n = \frac{z_1^2 - \frac{\alpha}{2} \sigma^2}{d^2}$$

3.2. Participants

All students studying in 11 disciplines in Abadan University of Medical Sciences were considered as the research population. Using proportional stratified random sampling, 462 out of 1498 students from 11 different fields of study, including medicine (n = 177), nursing (n = 92), medical laboratory sciences (n = 31), operating room (n = 26), anesthesia (n = 30), public health (n = 17), environmental health (n = 21), occupational health (n = 17), health information technology (n = 18), librarianship (n = 13), and emergency medicine (n = 20), were included in the study.

3.3. Scales

Data were collected using three instruments: A demographic questionnaire, the Khodayarifard's Religious Attitude Scale (11), and the World Health Organization Quality of Life - Brief Version (WHOQOL-BREF) (12). The demographic questionnaire included items on age, gender, field and semester of study, academic level, parents' education, marital status, type of residence, satisfaction with the chosen field, and overall grade point average (GPA).

The Religious Attitude Scale, developed by Khodayarifard through a study of 4,000 university students, consists of 40 items across four subscales: Religious beliefs (12 items), religious emotions (12 items), religious behaviors (12 items), and social pretense (4 items) (11).

Responses are rated on a six-point Likert scale ranging from 0 ("never") to 5 ("always"), with total scores ranging from 0 to 200. Higher scores indicate stronger religious attitudes. The scale has demonstrated strong psychometric properties, with reported reliability coefficients of 0.96 and 0.94 in two separate studies, a test-retest reliability of 0.91, and a split-half

reliability of 0.82 based on the Spearman-Brown method.

The WHOQOL-BREF, a 26-item instrument developed by the World Health Organization, assesses overall QoL across four domains: Physical health (7 items), psychological health (6 items), social relationships (3 items), and environment (8 items), along with two general items on overall QoL and health. Each item is rated on a 5-point Likert scale, where higher scores reflect better QoL. The Persian version of WHOQOL-BREF has been validated in Iran by Nejat et al., demonstrating satisfactory test - retest reliability across all subscales (0.75 - 0.84) (12).

3.4. Data Collection

To collect data, questionnaires were administered in person to the research samples. After obtaining informed consent, participants were provided with detailed instructions on how to complete the questionnaires. Students were also assured that the responses would be analyzed confidentially and in general. Data collection was carried out between November 2023 and December 2024.

3.5. Data Analysis

After data collection, an analysis of demographic characteristics was conducted using descriptive statistics, including measures of central tendency and dispersion, as well as frequency and percentage. Independent *t*-tests and one-way analysis of variance (ANOVA) were employed to examine the relationships among each demographic variable and the scores of QoL and religious attitudes. Finally, Correlation test and regression analyses were conducted to analyze the correlations between the variables of religious attitudes and QoL by controlling for the effects of other variables. Data analysis was performed using SPSS version 21, with a significance level of 0.05. The power of the test in the study is 80%.

3.6. Ethical Consideration

The present study was conducted after obtaining the code of ethics from the Abadan University of Medical Sciences (code: [IR.ABADANUMS.REC.1401.110](#); No.: 1547). All participants entered the study with informed consent and were assured that the results would be reviewed confidentially and publish in general.

4. Results

The mean age of the participants was 21.88 years. Of the total sample, 52.5% were female and 95% were single.

Additionally, 61.7% were undergraduate students, and the mean overall GPA was 16.92. Most of the participants (87.7%) lived in dormitories, and 28.4% reported being fully satisfied with their field of study. The demographic characteristics of the participants are presented in Table 1.

Table 1. Demographic Characteristics of Students Participating in the Study

Demographic Variables	No. (%)
Field of study	
Public health	17 (3.7)
Occupational health	17 (3.7)
Environmental health	21 (4.5)
Health information technology	18 (3.9)
Librarianship	13 (2.8)
Medical laboratory science	31 (38.3)
Medicine	177 (38.1)
Nursing	92 (19.9)
Anesthesia	30 (6.5)
Operating room	26 (5.6)
Emergency medical	20 (4.3)
Academic semester	
2	152 (32.9)
3	71 (15.4)
4	79 (17.1)
5	63 (13.6)
6	72 (15.6)
7	13 (2.8)
8	3 (0.6)
9	3 (0.6)
10	3 (0.6)
11	3 (0.6)
Satisfaction with field of study	
Completely disagree	7 (1.5)
Disagree	45 (9.7)
Neutral	109 (23.4)
Agree	166 (35.7)
Completely agree	132 (28.4)
Gender	
Female	243 (52.5)
Male	219 (47.4)
Marital status	
Single	438 (95)
Married	23 (5)
Degree	
Bachelor	285 (61.7)
Doctorate	177 (38.3)
Type of residence	
With family	48 (10.5)
Dormitory	401 (78.7)
Rented	8 (8.1)
Father's education level	
Illiterate	18 (3.9)
Middle school	70 (15.2)
Diploma	104 (22.6)
Associate	47 (10.2)
Bachelor	132 (28.4)
Master	65 (14.1)
Doctorate	22 (4.8)
Seminary	2 (0.4)
Mother's education level	
Illiterate	30 (6.5)
Middle school	85 (18.5)
Diploma	157 (34.1)
Associate	52 (11.3)
Bachelor	79 (17.2)
Master	40 (8.7)
Doctorate	15 (3.3)
Seminary	2 (0.4)

The mean total score of QoL was 90.66 ± 16.02 (range: 30 - 130), while the mean total score of religious attitudes was 135.86 ± 37.26 (range: 0 - 200) (Table 2). The

Table 2. Means and Standard Deviations of Quality of Life and Religious Attitudes, and Their Subscales

Variables	Minimum Score	Maximum Score	Mean $\pm$ SD
QoL	30	130	90.66 $\pm$ 16.02
Physical health	7	72	23.95 $\pm$ 5.25
Mental health	8	30	21.79 $\pm$ 4.08
Social relationships	3	15	9.55 $\pm$ 2.63
Social environment	3	15	10.62 $\pm$ 2.63
QoL and general health	2	10	7.56 $\pm$ 1.74
Religious attitudes	0	200	135.86 $\pm$ 37.26
Religious belief	0	60	41.93 $\pm$ 13.12
Religious emotions	0	60	43.95 $\pm$ 10.26
Religious behavior	0	55	31.71 $\pm$ 13.86
Social pretense	0	20	15.24 $\pm$ 3.59

Abbreviation: QoL, quality of life.

normality of both variables was verified using the Kolmogorov - Smirnov test, confirming a normal distribution; therefore, parametric tests were applied.

Independent *t*-tests were used to compare the mean total scores of QoL and religious attitudes based on gender, marital status, and education level. The results showed a statistically significant difference in religious attitude scores by gender ($P = 0.025$), with female students reporting higher religious attitudes than males. No significant difference was observed between gender and QoL scores ($P = 0.479$). Similarly, marital status was not significantly associated with either QoL ($P = 0.945$) or religious attitudes ($P = 0.166$). Education level also showed no significant relationship with QoL ($P = 0.904$) or religious attitudes ($P = 0.45$).

One-way ANOVA indicated no significant differences in QoL ($P = 0.143$) or religious attitudes ($P = 0.791$) across fields of study. QoL scores did not differ significantly based on residence type ($P = 0.170$), mother's education level ($P = 0.692$), or academic semester ($P = 0.692$). Likewise, religious attitudes were not significantly affected by father's ($P = 0.661$) or mother's ($P = 0.579$) education levels (Table 3).

However, both QoL and religious attitudes demonstrated statistically significant differences across levels of satisfaction with the field of study ($P < 0.001$). Post hoc analysis revealed that students who were completely satisfied had significantly higher QoL scores compared to dissatisfied, moderately satisfied, and partially satisfied students (all $P < 0.001$). Religious attitudes also differed significantly among satisfaction groups, with completely satisfied students scoring higher than those who were dissatisfied or moderately satisfied ($P < 0.05$) (Table 4).

Moreover, religious attitude scores varied significantly based on residence type ($P = 0.011$), with students living with their families reporting higher scores. Quality of life scores were also significantly associated with father's education level ($P = 0.049$), being higher among students whose fathers had seminary education. A significant difference in religious attitudes was also observed across academic semesters ($P < 0.001$), with a slight decline as the semester advanced (Table 4).

Pearson's correlation analysis revealed significant negative correlations between age and GPA ($r = -0.261$, $P < 0.001$) and between age and QoL ($r = -0.08$, $P < 0.001$), indicating that as age increased, GPA and QoL tended to decrease. Grade point average was positively correlated with religious attitudes ($r = 0.255$, $P < 0.001$). Furthermore, religious attitudes were significantly correlated with all QoL domains – including physical health, psychological health, environment, and general health ($P < 0.05$) – except for social relationships, which showed no significant correlation with religious beliefs ($P = 0.16$, $r = 0.065$) or social pretense ($P = 0.423$, $r = -0.037$). Overall, the total QoL and religious attitude scores showed a significant positive correlation ($r = 0.431$, $P < 0.001$) (Table 5).

5. Discussion

The present study examined the relationship between religious attitudes and QoL among medical students at Abadan University of Medical Sciences. Findings revealed that religious emotions scored highest among the dimensions of religious attitudes, while physical health was the strongest dimension of QoL. A significant positive correlation was observed, indicating that students with higher religious attitudes

Table 3. Comparing Quality of Life at Different Levels of Demographic Variables

Demographic Variables	Mean $\pm$ SD	P-Value
Field of study		0.143
Public health	91.05 $\pm$ 19.06	
Occupational health	96.58 $\pm$ 11.66	
Environmental health	90.23 $\pm$ 14.02	
Health information technology	86.94 $\pm$ 14.48	
Librarianship	89.46 $\pm$ 16.63	
Medical laboratory science	88.70 $\pm$ 18.64	
Medicine	90.54 $\pm$ 16.76	
Nursing	91.57 $\pm$ 14.98	
Anesthesia	90.46 $\pm$ 17.46	
Operating room	83.65 $\pm$ 12.42	
Emergency medical	99.100 $\pm$ 11.01	
Academic semester		0.233
2	89.70 $\pm$ 15.43	
3	90.56 $\pm$ 13.43	
4	88.34 $\pm$ 16.64	
5	93.65 $\pm$ 14.42	
6	91.09 $\pm$ 19.06	
7	90.91 $\pm$ 12.43	
8	89.78 $\pm$ 15.23	
9	93.34 $\pm$ 14.53	
10	92.70 $\pm$ 18.44	
11	90.65 $\pm$ 16.02	
Satisfaction with field of study		< 0.001
Completely disagree	74.14 $\pm$ 15.64	
Disagree	85.20 $\pm$ 18.77	
Neutral	86.18 $\pm$ 14.28	
Agree	89.07 $\pm$ 14.11	
Completely agree	98.92 $\pm$ 15.42	
Gender		0.479
Female	90.16 $\pm$ 15.55	
Male	91.21 $\pm$ 16.55	
Marital status		0.945
Single	90.82 $\pm$ 16.36	
Married	90.59 $\pm$ 51.99	
Degree		0.904
Bachelor	90.82 $\pm$ 16.36	
Doctorate	90.59 $\pm$ 51.99	
Type of residence		0.170
With family	94.66 $\pm$ 14.52	
Dormitory	90.18 $\pm$ 16.29	
Rented	93.25 $\pm$ 11.52	
Father's education level		0.049
Illiterate	82.94 $\pm$ 16.75	
Middle school	91.51 $\pm$ 13.72	
Diploma	91.27 $\pm$ 16.31	
Associate	96.10 $\pm$ 14.49	
Bachelor	91.04 $\pm$ 15.85	
Master	87.26 $\pm$ 16.99	
Doctorate	86.40 $\pm$ 19.04	
Seminary	102.00 $\pm$ 24.04	
Mother's education level		0.692
Illiterate	88.86 $\pm$ 17.10	
Middle school	91.29 $\pm$ 13.63	
Diploma	91.19 $\pm$ 16.80	
Associate	90.07 $\pm$ 17.89	
Bachelor	91.41 $\pm$ 14.47	
Master	91.20 $\pm$ 14.47	
Doctorate	84.80 $\pm$ 18.29	
Seminary	75.50 $\pm$ 13.43	

also reported better QoL. These results align with previous research showing similar associations in various populations. For instance, Babapour et al. found a positive link between religiosity and QoL in cancer patients, and Hasanvand Amoozadeh reported comparable findings among Welfare Organization beneficiaries (1, 13). Likewise, Bashirian et al. demonstrated that enhanced religious attitudes

improved students' mental health (14), and Shakournia and Baniasad identified a significant correlation between religiosity and self-esteem among medical students (15). Other studies have reinforced these results, highlighting positive associations between religiosity, meaning of life, spiritual health, and social well-being (16-19).

Table 4. Comparing Religious Attitudes at Different Levels of Demographic Variables

Demographic Variables	No. (%)	P-Value
Field of study		0.791
Public health	136.28 ± 35.89	
Occupational health	134.23 ± 17.40	
Environmental health	134.31 ± 09.92	
Health information technology	139.28 ± 55.04	
Librarianship	140.34 ± 38.50	
Medical laboratory science	132.43 ± 96.83	
Medicine	137.37 ± 22.59	
Nursing	134.41 ± 31.92	
Anesthesia	139.44 ± 80.11	
Operating room	140.36 ± 69.30	
Emergency medical	140.24 ± 45.01	
Academic semester		0.233
2	89.15 ± 70.43	
3	90.13 ± 56.43	
4	88.16 ± 34.64	
5	93.14 ± 65.42	
6	91.19 ± 09.06	
7	19.90 ± 12.43	
8	89.15 ± 78.23	
9	93.14 ± 34.53	
10	92.18 ± 70.44	
11	90.16 ± 65.02	
Satisfaction with field of study		< 0.001
Completely disagree	113.30 ± 42.06	
Disagree	113.38 ± 60.63	
Neutral	131.32 ± 33.56	
Agree	134.38 ± 66.47	
Completely agree	150.33 ± 13.85	
Gender		0.025
Female	139.37 ± 54.25	
Male	131.38 ± 75.82	
Marital status		0.166
Single	136.37 ± 39.48	
Married	125.32 ± 34.47	
Degree		0.45
Bachelor	134.37 ± 82.36	
Doctorate	137.37 ± 51.59	
Type of residence		0.011
With family	149.39 ± 60.60	
Dormitory	134.36 ± 65.85	
Rented	117.26 ± 12.78	
Father's education level		0.661
Illiterate	125.33 ± 83.71	
Middle school	136.39 ± 11.25	
Diploma	136.35 ± 72.57	
Associate	143.36 ± 44.11	
Bachelor	134.38 ± 17.48	
Master	133.37 ± 86.43	
Doctorate	24.38 ± 36.141	
Seminary	109.13 ± 50.43	
Mother's education level		0.579
Illiterate	131.40 ± 50.07	
Middle school	141.34 ± 50.07	
Diploma	13.40 ± 45.35	
Associate	138.30 ± 55.37	
Bachelor	133.36 ± 40.43	
Master	140.37 ± 72.12	
Doctorate	128.38 ± 26.94	
Seminary	117.24 ± 00.04	

Spirituality appears to function as an important coping resource, facilitating resilience and adaptive strategies in the face of stress. According to Pargament, individuals who engage in positive religious coping perceive divine support during difficulties, experience feelings of intimacy and understanding from a higher power, and receive unconditional acceptance, all of which contribute to personal growth and endurance

(20). Consistent with this study, Mahboobi et al. and Shakournia and Baniasad reported that religious emotions were the most prominent component of religious attitudes (6, 15), although Javadi et al. found belief to be the dominant dimension, suggesting that variations in demographics, culture, and measurement tools may account for differences (21).

Table 5. The Results of Correlation Coefficients Between Quality of Life and its Subscales and Religious Attitudes and its Components

Variables	QoL	Physical Health	Mental Health	Social Relationships	Social Environment	General Health
Religious attitudes						
r	0.431	0.278	0.417	0.105	0.428	0.373
P	< 0.001	< 0.001	< 0.001	0.024	< 0.001	< 0.001
Religious belief						
r	0.387	0.253	0.377	0.065	0.393	0.347
P	< 0.001	< 0.001	< 0.001	0.16	< 0.001	< 0.001
Religious emotions						
r	0.382	0.212	0.384	0.092	0.376	0.381
P	< 0.001	< 0.001	< 0.001	0.049	< 0.001	< 0.001
Religious behavior						
r	0.400	0.291	0.366	0.139	0.383	0.274
P	< 0.001	< 0.001	< 0.001	0.003	< 0.001	< 0.001
Social pretense						
r	0.293	0.128	0.325	0.037	0.301	0.375
P	< 0.001	0.006	< 0.001	0.423	< 0.001	< 0.001

Abbreviation: QoL, quality of life.

Gender differences were also observed, with female students exhibiting higher religious attitudes, consistent with prior research indicating that women generally demonstrate stronger religiosity, possibly due to greater time allocated for spiritual activities (6). However, some studies, such as Hasanvand Amoozadeh and Mahdavinoor et al., reported no significant gender differences, reflecting contextual and cultural variability (1, 22).

Additionally, higher religious attitudes were associated with greater satisfaction with one's field of study, higher GPAs, and living with family, suggesting that religiosity may serve as a motivational and supportive factor. Notably, both religious attitudes and QoL tended to decrease with advancing academic semesters and age, consistent with earlier findings (6, 15). These patterns indicate that although religiosity contributes positively to well-being, its expression may be influenced by educational progression and life stage. Overall, these findings reinforce the significance of integrating spiritual dimensions into student support programs to enhance coping and QoL.

5.1. Limitations of the Study

Among the limitations of this study is that the research sample was selected only from among students of Abadan University of Medical Sciences. Therefore, it is suggested that such research be conducted in other universities to increase the generalizability of the results. The participation of students from all majors studying at Abadan University of Medical Sciences was

used in the present study. However, given that the amount of stressors varies across different departments at the University of Medical Sciences, this was considered a confounding factor and relevant statistical tests were used to control it.

5.2. Conclusions

Based on the findings of this study, which revealed the correlation between religious attitudes and QoL among students, it can be concluded that there is a correlation between the two concepts of religious attitude and QoL. Considering that the 11 fields studied at Abadan University of Medical Sciences have differences in terms of environmental stress factors, it is recommended to conduct more research focusing on these factors in order to further generalize the results. Also, the necessity of strengthening the religious dimension among students through the implementation of cultural programs and the provision of necessary infrastructure in universities is self-evident.

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Footnotes

Authors' Contribution: Study concept and design, drafting of the manuscript: M. B.; Critical revision of the manuscript for important intellectual content, study supervision: A. A.; Drafting of the manuscript, administrative and technical support: S. M.; Acquisition of data: H. E.; Analysis and interpretation of data, statistical analysis: F. M.

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