Several theorists have contended that belief in a just world may be one way elderly rest home residents cope with anxiety, fear, and depression and thus maintain their well-being. In this study we explored belief in a just world and length of time elderly have been residing in rest homes in Lebanon in relation to their levels of self-rated quality of life. A sample of 354 cognitively able elderly people were selected from 36 nursing homes. Interview questionnaires including a translated and validated Self-beliefs in a Just World Scale (BJW-S; Lipkus, Dalbert, & Siegler, 1996) and the EuroQol Visual Analogue Scale (EQ-VAS; Brooks, 1996) that measures respondents’ quality of life on a 20cm visual analogue scale. The relationship between Arabic BJW-S scores and length of stay measured on the EQ-VAS was examined using analysis of variance. The findings showed significant main effects for belief in a just world on levels of EQ-VAS, but no significant effects of length of time in rest home on levels of EQ-VAS. Residents who had strong beliefs in a just world seem to have better abilities to cope with negative life events and better self-rated feelings of well-being than did residents who did not believe the world was just and who rated their own well-being lower.

Keywords: belief in a just world, well-being, rest home residents, length of stay, elderly.
The numbers of elderly people living in Lebanese rest homes has increased over the past decade. These elderly residents require living conditions that ensure their well-being and good quality of life, both physical and psychological (O’Boyle, 1997). Many elderly people employ various coping strategies to achieve successful health outcomes (Whatley, Foreman, & Richards, 1998) and have positive social and cognitive functioning, that reflect a positive acceptance of being elderly. Along with other researchers (Bègue & Bastounis, 2003) we have hypothesized that positive coping strategies may mitigate or dilute any stressful and unpleasant effects of rest-home living conditions and thus facilitate a better quality of life. Researchers have shown that those elderly nursing-home residents who do not cope well, experience sleeping disorders, anxiety, stress, guilt, psychosomatic symptoms, headaches, and fatigue, and generally have a much lower quality of life (Duner & Nordstrom, 2005; Schwarzer & Leppin, 1992). In prior work, the least studied etiology of well-being has been underlying psychological traits or characteristics of the person that can affect well-being, such as personality or specific behavioral characteristics, cognitive viewpoints, and/or characteristic ways of processing information that interact negatively or positively with life events (Nagase et al., 2009). In this context a negative interaction would generally have degenerative effects on well-being. In terms of this psychological factor, one promising coping mechanism is a person’s belief in a just world (see Nagase et al., 2009). However, we know of no study in which the relationship between rest home residents’ belief in a just world and their perceived and actual quality of life in their rest home (measured using the EQ-VAS; Brooks, 1996) has been examined. *Belief in a just world* is defined as a self-sustained belief (or illusion) in a just world to preserve one’s sense of cognitive balance while dealing with crisis (Lerner, 1978). This study, therefore, was the first step to answering the question of why some people aged 60 and above living in rest homes experience depression and other psychological conditions and why others in the same rest home are able to cope and maintain physical and psychological wellbeing in that environment.

The just world hypothesis is a theory that one’s belief in a just world (BJW) enables one to deal with unpleasant information and situations (Lerner & Miller, 1978). The origin of this theory is Lerner’s “self-justification (and validation) mechanism” by which it is proposed that people are prevented from changing their worldview or aspects of it in relation to a given situation in order to maintain a consistent sense of self (Jost & Hunyady, 2002). A strong BJW is correlated with positive feelings of competence and optimism about one’s future (Lerner, 1978) as well as positive feelings of physical and psychological (social) well-being. Those who have little control over their surroundings tend to have lower levels of just world belief (Ritter, Benson, & Snyder, 1990). Thus, the valence between control and perceived outcomes decides one’s degree of belief in a just world.
If people have control over their surroundings, they perceive the world as being more just than do those who have little such control (Lane, 2001). On the other hand, elderly people who are facing negative life events (such as accidents, death, or loss of income) are dealing with situations over which they have no control; they therefore tend to believe less in a just world than do those who are not facing these events. Doumit and Nasser (2008) found that elderly people living in rest homes usually have little control over life events. This lack of control, in turn, negatively impacts their sense of, and actual, independence (Cowan, Fitzpatrick, Roberts, While, & Baldwin, 2003), because of restricted movement both in and outside the care facility, restriction on freedom of communication and on decision making (Ferrell, 1991; Tobin, 1974; Tobin & Lieberman, 1976) and thus adversely affects both their psychological and physical well-being. This leads to anxiety, which intensifies over time and turns into both a self-perceived and actual negative state of well-being. However, belief in a just world may be an intervening variable and mechanism to prevent this spiraling cycle, thus delaying adverse health effects, and resulting in a much better state of well-being for the individual.

There have been a number of studies carried out concerning the relationship between levels of well-being and BJW mostly among noninstitutionalized adults (see e.g., Dalbert, 1999). The main hypothesis in our study is that belief in a just world is a coping mechanism, both cognitively and affectively, among rest home residents. For example, just world belief has been found to be related to depression (Bègue & Bastounis, 2003; Ritter et al., 1990), life satisfaction (Dzuka & Dalbert, 2002), insomnia, and anger (Jensen, Dehlin, Hagberg, Samuelsson, & Svensson, 1998). More specifically and importantly, Ritter et al. found that older adults are less likely to believe in a just world than are younger adults. Dalbert (2002), on the other hand, found that rest home residents with low BJW reported lower self-esteem and increased levels of anger as compared to residents with high BJW.

Lipkus (1991) found a negative correlation between BJW and well-being. As a follow-up to this work, Lipkus, Dalbert, and Siegler (1996) became concerned with what they called the bidimensional (or bifurcated) character of BJW, and they extended and differentiated the concept into self-BJW (BJW-S) and other-BJW (BJW-O). Thus, Lipkus et al. recognized that two different types of belief in a just world might exist, with each type affecting how people cope with stressful situations differently. They also developed an instrument that differentiated between self and other types of BJW and using this they found that BJW-S correlated strongly with perceptions of psychological well-being, whereas BJW-O correlated weakly with self-report measures of psychological well-being, that were primarily made up of depression and stress indicators.
Quality-of-life factors of elderly people have obvious implications for their cognitive, affective, and functional abilities, which are significantly related to their overall self-perceived and actual well-being (O’Boyle, 1997). Some measures and indicators of life quality in old age can be used to detect emerging health-related problems that would otherwise quickly develop into disease or illness, and this well-established fact suggests that early physical or psychological screening can prevent illness. One goal that motivated us to carry out the current work, therefore, is ascertaining whether a strong or weak belief in a just world is an early and predictive indicator of rest home residents’ future psychological, physical, and social well-being. It was our view that those elderly people who did not have a strong belief that the world was just and who are placed in a rest home by relatives may feel unjustly placed, and, thus, may quickly become psychologically distressed, and may perceive their living conditions as less than ideal. Those who stay for a long period in a rest home may have a low BJW-S score, subsequently resulting in a low level of self-rated perceived and actual quality of life. On the other hand, those who have high BJW-S scores are generally healthy on entry to the rest home, potentially have high levels of self-rated quality of life over both short- and long-term periods, and have a greater level of self-rated perceived and actual quality of life. A strong belief in a just world (as indicated by a high BJW-S score) may therefore be an intervening variable and mechanism that inhibits the various deleterious effects of making a life transition to rest-home living and the effects (self-perceived and/or actual) of rest-home residence over time.

STUDY AIMS

The more recent just-world-belief research trends have been focused on exploring attribution of blame by victims of rape (Idisis, Ben-David, & Ben-Nachum, 2007; Sakallı-Uğurlu, Yaşan, & Glick, 2007), injustice to individuals whose life experiences are similar to the person doing the judging (Aguiar, Vala, Correia, & Pereira, 2008; Correia, Vala, & Aguiar, 2007), and perceptions of justice by low socioeconomic status defendants (Freeman, 2006). In the present study our aim was to add to knowledge of groups or individuals living in rest homes, who have a number of restrictions placed on them but in ways that are quite different from the typical victimology literature in that rest-home residents are in a custodial setting, in which their freedom to come and go to and from the home is limited. This study was specifically designed to find out if differences in BJW-S levels are related to differences in self-rated quality of life among old people living in nursing homes in Lebanon. The aim in recent international victimology literature as well as in earlier studies was to assess levels of global BJW in Japan (Mahler, Greenberg, & Hayashi, 1981),
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Taiwan (Ma & Smith, 1985), England (Furnham & Gunter, 1984), and Australia (Heaven & Connors, 1988). However, no studies on these variables have been carried out with Arab-speaking residents of rest homes in the Middle East, and no researchers have assessed the self-belief in a just world in the specific environment of rest home residents in relation to self-rated quality of life and length of time living in a rest home.

METHOD

INSTRUMENTS

Belief in Just World–Self  Sutton and Douglas (2005) conducted a factor analytical validity study of the questionnaire constructed by Lipkus et al. (1996) to measure BJW for others (eight items) and self (eight items). The varimax rotation mapped seven of the eight BJW-S items ($\alpha = .86$) into one factor and the rest of items into a second factor. All the BJW-S items used by Lipkus et al. were used in this study. These items are: 1) I feel that the world treats me fairly; 2) I feel that I get what I deserve; 3) I feel that people treat me fairly in life; 4) I feel that I earn the rewards and punishments I get; 5) I feel that people treat me with the respect I deserve; 6) I feel that I get what I am entitled to have; 7) I feel that my efforts are noticed and rewarded; and 8) I feel that when I meet with misfortune, I have brought it upon myself. Sutton and Douglas established the construct validity of the self and other types of BJW, with the data Lipkus generated in 1996.

The BJW-S was translated by a committee – or cross-translation – method widely used to translate an instrument from a source (English) to a target language (Arabic). Three translators were asked to translate the eight items and then the translations were validated by bilingual judges. The Cronbach’s alpha was $\alpha = .78$ across the eight items.

The Arabic version of the BJW-S (ABJW-S) response format consisted of five possible response selections with alternatives of 1 = strongly disagree, 2 = disagree, 3 = neutral, 4 = agree, and 5 = strongly agree. By using the option of scoring the ABJW-S as an interval scale (see Carifio & Perla, 2007 for details), it was possible to obtain a percentage of positive responses (i.e., a criterion-referenced score) as well as an average scale score that could also be reduced to a dichotomous variable using the median (i.e., a norm-referenced score) for analyses and interpretations. The ABJW-S was computed by adding the rating on each item and dividing it by the number of items. To obtain a mean score in this study we added the ratings of the eight items and divided it by eight. Based on the mean rating of the ABJW-S it was recoded into a 3-level variable: high, middle, and low. The ABJW-S variable was recoded based on the bottom 1/3 cumulative frequency as low, between ABJW-S values of 1/3 and 2/3 (inclusive) of the
cumulative distribution as middle, and above 2/3 (exclusive) as high ABJW-S. **Quality of Life Measure: EuroQol Visual Analogue Scale (EQ-VAS)** The EQ-VAS is a graduated 20cm scale ranging from 0 (worst possible state of health) to 100 (best possible state of health) and individual rates their quality of life through marking the scale. The EQ-VAS is part of EuroQol (EQ-5D; Brooks, 1996) composed of five elements or domains: mobility, self-care, usual activity, pain/discomfort, and anxiety/depression. As part of the EQ-5D, on the EQ-VAS people indicate their general health, using a visual analogue scale ranging from the worst imaginable state, rated as 0, to the best imaginable health state, rated at 100%. Scores are recorded as percentages. The validity and reliability of the EQ-VAS were verified by Brooks (1996) and the scale shows a strong correlation with the five dimensions of the EQ-5D scores.

**SAMPLE**

In 2011 there are 46 rest homes in Lebanon that provide elderly people with food, a place to live, and medical support. When this study was carried out, there were only 44 such homes. Field researcher staff for this study attempted to survey all rest homes but had access to only 36 of them. Five exclusion criteria were applied to the sample: 1) having been in a nursing home for less than three months; 2) suffering from a terminal disease; 3) being blind and/or deaf; 4) exhibiting cognitive impairment as measured by a score of 18 or less for the Arabic Mini-Mental State Examination (AMMSE1); and 5) being under 60 years of age. Elderly people who were not eliminated by these criteria were recruited for the study. Out of the 2,094 people living in the 36 rest homes, there were 354 who were eligible to participate in the study and who were recruited (age range from 60 to 94 years; average age, 76.84 years, $M = 77.45$ years). All the participants agreed to be part of the study and to provide candid and trustworthy responses to the measures. Participants were told that all individual level information will be kept confidential. Approximately two thirds of the sample were females (65.6%) and the rest were male (34.4%). Valid responses were received from 238 people.

**RESULTS**

The raw ABJW-S scores of the participants were divided into low, medium, and high scores using the 33rd and 67th percentile scores from the three levels. The first analysis crossed ABJW-S levels with length of stay in rest home levels from the EQ-VAS. The length-of-stay measure provides a sense of decline in

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*1 The AMMSE is a 30-item cognitive scale that tests orientation, attention, and immediate and longer term recall through verbal instructions (Folstein, Folstein, & Fanjiang, 2001).*
well-being (measured through self-rated quality of life) over time, but it should be clearly noted that this decline is a confounded composite of factors and care at the residents’ rest homes, physical health and psychological histories of each participant, and other factors such as if the person was visited regularly by her or his family. In addition, it was not uncommon for participants to report a strong feeling of neglect and a sense of being victimized by their family and by society. This was not unexpected because Lebanon is a country where close-knit and extended family structure is strong.

To see whether a higher ABJW-S was related to the length of stay in rest homes in terms of higher and positive self-rated quality of life measures, we examined length of stay in rest homes crossed with ABJW-S levels in relation to EQ-VAS scores. We expected that a lower ABJW-S would produce lower EQ-VAS ratings at each of the time intervals examined. A lack of an interaction between ABJW-S and EQ-VAS would support the model and theory that a strong belief in a just world would give the elderly people a preventative mechanism that would temper the health and well-being effects of the transition to a rest home and the subsequent residence at the home.

The length of time spent at the rest homes was verified from the resident dossier. We obtained the date of arrival at the rest home and subtracted from that the date when the elderly person was interviewed for/responded to the ABJW-S. This was recorded in days and was then recoded into a three-category scale based on sample distribution. The short-stay classification was 0 to 763 days (the bottom third of the length-of-stay distribution); the medium stay period was 764 to 1,576 days (the middle third of the distribution); and the long-stay period was 1,577 to 9,338 days (the top third of the distribution). The length-of-stay distribution was
positively skewed and, because the data are cross-sectional, there were mortality effects across the categories, which is not necessarily a weakness of the study or design but rather a strength given the hypotheses and theory being examined and the fact that this was an exploratory study.

**TABLE 2**

<table>
<thead>
<tr>
<th>Self-belief in a just world</th>
<th>Length of stay</th>
<th>M</th>
<th>SD</th>
<th>n</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low ABJW-S</td>
<td>Short</td>
<td>55.80</td>
<td>26.366</td>
<td>25</td>
</tr>
<tr>
<td></td>
<td>Medium</td>
<td>56.46</td>
<td>25.891</td>
<td>26</td>
</tr>
<tr>
<td></td>
<td>Long</td>
<td>68.64</td>
<td>29.877</td>
<td>25</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>60.25</td>
<td>27.687</td>
<td>76</td>
</tr>
<tr>
<td>Middle ABJW-S</td>
<td>Short</td>
<td>67.52</td>
<td>18.414</td>
<td>21</td>
</tr>
<tr>
<td></td>
<td>Medium</td>
<td>55.90</td>
<td>20.409</td>
<td>20</td>
</tr>
<tr>
<td></td>
<td>Long</td>
<td>63.37</td>
<td>23.781</td>
<td>24</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>62.42</td>
<td>21.331</td>
<td>65</td>
</tr>
<tr>
<td>High ABJW-S</td>
<td>Short</td>
<td>66.91</td>
<td>22.280</td>
<td>80</td>
</tr>
<tr>
<td></td>
<td>Medium</td>
<td>67.95</td>
<td>24.046</td>
<td>65</td>
</tr>
<tr>
<td></td>
<td>Long</td>
<td>75.32</td>
<td>25.086</td>
<td>77</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>70.06</td>
<td>24.021</td>
<td>222</td>
</tr>
</tbody>
</table>

The recoded time of stay at the ENH was crossed with ABJW-S levels in a 3 x 3 analysis of variance (ANOVA) with EQ-VAS as the dependent variable. There was a significant main effect for ABJW-S level, \((F(2, 213) = 3.62, p = .028)\), but there was no statistically significant main effect for length of stay in the rest home \((F(2, 213) = 2.66, p = .06)\) using the conventional .05 level of significance, although the difference was close and manifested itself in the trends across the three data points. Those with low scores on the ABJW-S also had lower scores on the EQ-VAS than did those who gained high scores on the ABJW-S. No significant conventional ANOVA design interaction effects were found for ABJW-S levels by length of stay at the rest home as measured on the EQ-VAS \((F(4, 213) = .94, p = .44)\). Specifically, those who had high ABJW-S were found to have lived for (survived) a longer time in the rest home and they had higher and fairly constant EQ-VAS rating across the three time periods compared to those who had lived there for a shorter period. However, it should be noted that from these results for the short-stay period, the medium and high ABJW-S group had similar EQ-VAS scores. The medium ABJW-S group’s EQ-VAS scores were significantly lower for the medium-stay period then moderately increasing for long-stay residents. On the other hand, the low ABJW-S group had low EQ-VAS scores for short-stay residents that remained the same at a medium length of stay and then decreased at the long-stay period. The residents who scored low
on ABJW-S also scored low on self-rated quality of life (EQ-VAS) and these scores became even lower, the longer residents had lived in a rest home (see Table 2 and Figure 1). Therefore, the self-rated quality of life of high ABJW-S participants was initially high and remained fairly constant across the three periods examined for length of stay, whereas the self-rated quality of life of low ABJW-S participants was initially significantly lower than that of high ABJW-S participants and became worse as length of stay increased. The medium ABJW-S residents had high self-rated quality of life scores, when they had lived for only a short time in the home but this dropped sharply at the middle length-of-stay time period, and then increased only moderately for long-stay residents. The substantive and fine-grained differences then were in the trend patterns of these three groups across the three periods of residence examined. The interaction, therefore, is not in the design but in the differing trends between ABJW-S levels in our quasi, rather than true, repeated measures design. We further broke down our analysis to find out whether the length of stay as an intervening factor had the same effects over a shorter period of time.

Because the time of stay extended to 3,859 days, older residents’ health could have deteriorated naturally because of their age. Thus, a reanalysis was carried out for a shorter period of residence. We reasoned that a shorter time period would possibly bring out some of stress of living in a custodial setting, which could diminish with adjustment over a longer period of living in a rest home. We reclassified the criterion for a long time of stay from 3,493 days to 1,200 days and this resulted in a sample half the size of the original one. We then formed three classifications based on the cumulative frequency distributions of the sample constituting the bottom one-third of the cumulative frequency; medium-stay period between one- and two-thirds; and long stay above the two-thirds, at a maximum length of 1,200 days. Choosing this half of the sample would guarantee that enough people would be in each of the cells of the factorial design (a 3 x 3, length of stay x ABJW-S) for appropriate analyses. In addition, the ratios of each of the classification to the total number of participants were comparable to the ratios of the three classifications of the original data set to its total (3,493 days). We ran a 3 x 3 ANOVA (ABJW-S x length of stay) on EQ-VAS. Results showed a significant effect of ABJW-S, $F(2, 105) = 3.08, p = .05$. No main effects were found for length of stay, and no interaction effects were observed. Figure 2 shows the behavior of each of the low, medium, and high BJW levels. The difference between the 1,200 and 3,493 days data sets is that in the low ABJW-S and medium ABJW-S groups of the 1,200 data set there was a more pronounced significant reduction in the self-rated quality of life between medium and long length of residence at a home. All of the effects and trends reported above were more pronounced in the 1,200 day data set than in the 3,493 day data set (see Figures 1 and 2). Specifically, for those who had low and medium ABJW-S
levels, a significant reduction in EQ-VAS was observed as residence at the home became longer. Of particular interest is the result that the medium-ABJW-S group showed a moderate decline in EQ-VAS from short- to middle-stay, then a sharper downtrend for the long. On the other hand, those who scored high for ABJW-S increased in EQ-VAS as the length of period of residence increased. Generally, for the 3,493 day data set, the high ABJW-S group reported a constant level of self-rated quality of life with a very slightly lower score at medium time of stay and a similar slight increase in score for short length of stay. The low and medium ABJW-S groups had EQ-VAS scores that decreased from short- to medium-stay then increased from medium- to long-stay.

**Figure 1:** EQ-VAS self-ratings based on short, medium, and long periods of residence and ABJW-S over a period of 3,493 days.

**Figure 2:** EQ-VAS self-ratings based on short, medium, and long periods of residence and ABJW-S over a period of 1,200 days.
DISCUSSION

This study is the first of its kind in which belief in a just world is related to overall health of rest home residents, and gives a longer view of BJW than that seen in other studies. Our findings reflect some of the current and previous results of research in which BJW has been examined in relation to well-being, and also adds significantly to this literature in terms of both theory and generalization with a population that has previously been neglected in studies. There are several possible explanations for the association of self-rated quality of life with ABJW-S in the elderly people we studied. First, the association between ABJW-S and EQ-VAS showed a moderate and positive correlation ($r = .22, p < .05$). Those who scored low on ABJW-S also scored low on the EQ-VAS. Lipkus et al. (1996) found that those who strongly believe in a just world were generally more satisfied, less lonely, and had low scores on various measures of isolation, alienation, and powerlessness (see also Ma & Smith, 1985, cited in Bègue & Bastounis, 2003). Thus, people’s self-beliefs about justice tend to be reflected in their wellbeing.

The only significant effect on self-rated quality of life scores for our participants was the level of ABJW-S, and it was highly significant across all of the analyses carried out, even when factoring out the variance of age based on the concept that as people get older there is a natural decline in health and well-being, reinforced if the old people feel they are being victimized. To test this particular proposition we ran an analysis of covariance on the 3,493 data set, using age as the covariate and ABJW-S and length of stay as the fixed factors on EQ-VAS. We found that only the ABJW-S had a significant effect $F(2, 209) = 3.44, p < .05$, so that age did not alter significantly the effects of ABJW-S. This suggests that self-belief in a just world is a preventive mechanism that enables those who have this belief to cope better in a living environment that they have not chosen and, thus, to have a greater sense of wellbeing when living in those circumstances. Furthermore, we expected that length of stay in the rest home would be related to self-rated health. However, we found no main significant effect for length of stay or technical design-related interaction because the effects of length of stay on self-rated quality of life affected each level of belief in a just world differently. Each ABJW-S level had a different pattern for self-rated quality of life across the three length-of-stay time periods. Level of ABJW-S, therefore, significantly mediated self-rated quality of life for the rest home residents in our study. The trend finding also indicated that in the short term residents who did not have a strong belief that the world is just had low self-rated quality of life, which decreased substantially as length of residence increased. Some form of intervention program/treatment at admission could be valuable for low ABJW-S people.
When they had lived at a home for a long time, the low and medium ABJW-S people felt their health improved, particularly those who scored at what might be called the borderline or threshold value for high and preventative ABJW-S; that is, medium ABJW-S. So why then for the medium ABJW-S participants, was there a general dramatic reduction in score for short-term residents but over a longer period a dramatic increase in self-rating of health? One possible explanation is that the total dataset marked true effects and that the data set is not organized by levels of ABJW-S. While belief in a just world is one factor that helps elderly people in rest homes to preserve their sense of well-being, this belief must be quite strong to carry them through their initial transition to living in the rest home. Thus, those who do not have a strong belief in a just world, and who are cognitively capable and agile, may be particularly aware of, and dwell upon, all of the changes that are being made to their lives. They may also feel more intensely the difficulties in the necessary transition in their early days at the rest home with no countervailing events or mechanisms and thus their sense of well-being decreases dramatically if they have low ABJW-S or decreases sharply initially and then decreases even further if they are middle level ABJW-S. As the length of residence for these two groups gets longer, their sense of both injustice and justice diminishes and they accept their conditions as *fait accompli* and thus their self-rated adjustment and well-being increase. By comparison, those who have a perception of little justice become quite depressed, and they do not cope easily with associated psychological symptoms and problems and this inhibits their ability to regain a sense of wellbeing.

To summarize, the elderly people in our study with medium-level ABJW-S showed a pronounced dramatic decrease in self-rated quality-of-life scores after 18 months of living in rest homes, which should be of great concern to providers and caregivers. In the people with medium ABJW-S, the significant decrease followed by increase may show some resilience, which, over time, may help old people cope better with the living conditions in rest homes. Only those people with initially high levels of ABJW-S had consistently high levels of self-rated quality of life scores over both the 3,493-day and the 1,200-day timeframe of analysis. Elderly people who had these consistent high scores should be studied more closely and may be an unrecognized resource for improvement of quality of life for all in rest homes through their participation in further research.

Given the data in this study, it would seem warranted as an exploratory assertion to say that ABJW-S is associated with – or part of – a strong coping mechanism for dealing with a highly limiting or custodial setting such as rest-home living. This coping mechanism also affects levels of self-rated health. Other factors might be in play, as pointed out above, and, specifically, understanding differences between males and females would help shed light on other factors needing study in this area. Generally, elderly women in Lebanon are
accustomed to a patriarchal close-knit society where there is a strong traditional and conventional role for them with clear and assigned duties that they must see to daily. Elderly Lebanese women used to this traditional role may feel confined in rest homes where they have little to do or little sense of purpose, and where they are less mobile and not involved in activities, and this situation may, in turn, lead to psychological health problems that will be reflected in their self-rated of quality of life (Rejeski & Mihalko, 2001).

A number of researchers have shown the effects of coping on psychological well-being. Ritter et al. (1990) showed that locus of control was not related to belief in a just world. Other factors such as neurotransmitter abnormalities, disturbed sleep patterns, gender hormone imbalance, use of medication, chronic illness, stressful life events, lifestyle, and premorbid personality (Ebmeier, Donaghey, & Steele, 2006; Tamres, Janicki, & Helgeson, 2002) have been found to be related to psychological illness. Studies on the beliefs of older people and the impacts of these beliefs on coping and overall health and how they can adversely affect thinking, motivation, and behaviors are rare. It has been suggested that the relationship between coping and psychological illness may be a vicious cycle because the elderly do not cope well with new living conditions in custodial care and do not regain their sense of well-being in the rest home environment (Nagase, et al., 2009). However, elderly people who believe in a just world rationalize their living conditions and may apply reason about their status to make the best of their situation. The results of this study reinforce the BJW-S theory, in which it is suggested that those with high ABJW-S experience less psychological discomfort than do people with low ABJW-S, and high BJW acts as a mechanism that diminishes this. Retrospective clinical studies are needed to both confirm and better understand this process and mechanism. As predicted by Carifio (2005), this preventative BJW mechanism is probably related to the resilient personality, and this ability to be resilient should be investigated as it is known that resilience is trainable (Reivich & Shatté, 2002).

CONCLUSION AND LIMITATIONS

The results in the present study add to knowledge of custodial or restricted groups or individuals who may be unnecessarily constrained in rest homes, but in ways that are quite different from the typical victimology literature. The uniqueness of this study is the suggestion that the subjective belief in a just world of 354 elderly people who were rest home residents is a strong intervening variable that affects the individual sense of well-being as evidenced by self-ratings of health. We believe that our findings will help researchers in the field to understand how people cope subjectively with what they perceive as injustice in relation to their psychological well-being. The findings may also help
to develop a set of skills that could be taught to people suffering various kinds of injustices to help them preserve their psychological well-being.

This study has some limitations that need to be addressed in future studies. Firstly, self-rated quality of life is a subjective measure and, thus, a very broad measure of psychological as well as physiological health. Future researchers could use assessment instruments that specifically screen and/or assess psychological or physiological conditions that have adverse consequences on the health of old people. Such an attempt is currently being undertaken by the authors by investigating the relationship between belief in a just world and depression through the use of the Geriatric Depression Scale (Sheikh & Yesavage, 1986).

REFERENCES


BELIEF IN A JUST WORLD AND WELL-BEING


