Clinical Research

Assessment of the Spiritual Well-Being and Quality of Life of the Older Adults

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ABSTRACT

Objective: This study aimed to evaluate the factors affecting the spiritual well-being and quality of life of older adults living in nursing homes.

Material and Method: This cross-sectional study involved 188 older adults living in nursing homes in Manisa province.

Results: The mean total spiritual well-being of older adults was 30.86 ± 6.70. A statistically significant difference was found between the EQ-5D quality of life scale, mobility, self-care, usual activities, pain/discomfort, anxiety/depression sub-dimensions, and general health perception.

Conclusion: It was determined that the poor health perception of the elderly negatively affects their quality of life and spiritual well-being.

Keywords: Aged, Spirituality, Quality of life

ÖZ

Yaşlı Bireylerin Manevi İyi Oluşunun ve Yaşam Kalitesinin Değerlendirilmesi

Amaç: Bu çalışmada huzurevinde yaşayan yaşlı erişkinlerin ruhsal iyilik hallerini ve yaşam kalitelerini etkileyen faktörlerin değerlendirilmesi amaçlandı.

Gereç ve Yöntem: Kesitsel tipte olan bu çalışma Manisa il genelindeki tüm huzurevlerinde yaşayan 188 yaşlı ile gerçekleştirilmiştir.

Bulgular: Yaşlı yetişkinlerin manevi iyilik hali toplam refahı ortalaması 30,86 ± 6,70 idi. EQ-5D yaşam kalitesi ölçeği, hareket, öz bakım, olağan aktiviteler, ağrı/rahatsızlık, anksiyete/depresyon ve genel sağlık algısı alt boyutları arasında istatistiksel olarak anlamlı fark bulunmuştur.

Sonuç: Yaşlıların sağlık algılarının kötü olmasının, yaşam kalitelerini ve manevi iyilik hallerini olumsuz etkilediği belirlendi.

Anahtar Sözcükler: Yaşlı, Maneviyat, Yaşam Kalitesi

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Aging is a process that should be evaluated based on its physical, psychological, and social dimensions. While the physiological measurement of aging expresses changes seen with chronological age, its psychological size refers to changes in one's capacity to adapt regarding perception, learning, psychomotor, problem-solving, and personality characteristics as chronological age progresses. Projections made by assuming the continuation of current demographic trends, the 21st century for Turkey, in line with expectations worldwide, suggest the old age century (1,2).

Expressions of spirituality and spiritual care are inherently abstract concepts in the structure of people. Spirituality allows people to understand themselves, compare themselves and others, and maintain respect. Spiritual care can help patients find meaning and purpose and discover effective coping strategies for their diseases (3). Spiritual well-being is often sought in the face of troubles experienced by older individuals (3, 4). Spiritual care is also needed for spiritual goodness. It is based on unconditional love, affirming one's unique value, and being influenced by spiritual and cultural beliefs, physical conditions, emotions, thoughts, and cultural connections. Self-spiritual care is the essential mental-based experience of behaviors people show to feel better in the face of illness (4).

Many studies document meaningful relationships between spirituality and mental, physical, or functional health in adults with chronic diseases (5, 6). It has been shown that spiritual care can help patients improve their physical discomfort, reduce anxiety levels, and increase their hopes for the future (7, 8). In addition,

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spiritual practices serve as coping mechanisms, improve pain management, improve surgical outcomes, and minimize depression, substance abuse, and suicidal behaviors (9). Most studies have shown the relationship between spirituality and quality of life (10, 11).
Spirituality in the nursing discipline has grown in popularity in recent years. Studies on spiritual care in health professionals in our country are limited. It was concluded that health professionals needed to adequately grasp the importance of spiritual care and receive sufficient information about it throughout their education, and the spiritual needs of their patients were neglected (12). This study aims to evaluate the spiritual well-being and quality of life of older adults in nursing homes and some socio-demographic factors that affect it.

MATERIAL AND METHOD

Study Design

This cross-sectional study's population consisted of elderly individuals living in all nursing homes in Manisa. 0.80 power and 0.05 margin of error were used to evaluate whether there was a moderately positive linear relationship (H0:r=0.30, H1:r=0.50) between the Spiritual Well-Being Scale score and Quality of Life Scale scores in elderly individuals living in nursing homes. Considering the sample size calculation, it was determined that 139 patients should be included in the study. The sample size calculation was made with the G*Power 3.1.9.7 program.
The data was collected from voluntary participants using the non-probable sampling method (n =188). 139 involuntary residents diagnosed with advanced cognitive dysfunction (e.g., Alzheimer's disease, dementia), could not answer the questionnaires due to communication problems, did not score adequately in the Mini-Mental Test, and needed advanced care were excluded from the study.
The inclusion criteria were as follows: 65 years of age or older, no language problems, no diagnosis of dementia/psychiatric illness/mental retardation, and volunteering. As a data collection tool, the Socio-demographic Information Form (e.g., gender, age, education level, marital status, income status), the Spiritual Well-Being Scale (Facit Sp-12), the Quality-of-Life Scale (EQ-5D), and a Mini-Mental Test were used.

Spiritual Well-Being Scale (Facit Sp-12)

For Turkish society, its validity and reliability were done by Ay et al. The scale consists of 12 expressions and has three sub-dimensions: 1) meaning (items 2,3,5 and 8; between 0-16 points); 2) peaceful (items 1,4,6 and 7; between 0-16 points); 3) faith (items 9,10,11, and 12; between 0-16 points). The sum of the scores obtained from the sub-dimensions determines the individual's total score on the scale. The highest score that can be obtained is 48. A high score indicates an individual's spiritual well-being is in good condition (13).

Quality of Life Scale (EQ-5D)

The Quality of Life Scale is a self-report scale developed by the Euro-QoL group, a research community on Western European quality of life. The Turkish version's validity and reliability were measured (14).
The five dimensions of the EQ-5D scale are evaluated with one question each. These five dimensions are mobility, self-care, usual daily activities, pain/discomfort, and anxiety/depression. In terms of the answers to each dimension, there are three options, including "no problem," "some problem," and "major problem." An index score ranging from 0.59 to 1 is calculated from the five dimensions of the scale. The higher the scale score, the higher an individual's quality of life.
In addition, there is also the Visual Analogue Scale (VAS), with responses ranging from "worst imaginable health condition" to "best imaginable health condition," for which individuals give values between 0 and 100 regarding their current health status, marking it on a thermometer-like scale. Quality of life scores range from 0 to 100 on this scale.

Research Ethics

The research permission was obtained from the local Ethics Committee and the Provincial Directorate of Family, Labor, and Social Services (No: 20478486-050.04.04). Before applying the questionnaire, the individuals were informed about the research, and verbal consent was obtained via an informed, voluntary consent form. In addition, this research was supported by the local University Scientific Research Project.

Statistical analysis

SPSS 15.0 software was used for data entry and statistical analysis. Descriptive statistics (number, percentage distribution), the quality-of-life scale, and the relationship between the Spiritual Well-Being Scale and specific socio-demographic characteristics were evaluated via univariate analysis (e.g., Student's t-test and Kruskal Wallis test, ANOVA) and multiple linear regression analysis. Significance was accepted as $p < 0.05$.

RESULTS

Of older adults who participated in the research, 66.5% were male, the average age was 76.56 ± 8.44 (min: 65, max: 98), 41.0% were primary school graduates, 92.0% were single, 69.1% had children, and perceived income perception 33.0% income less than expenditure, and the general health perception was 37.2. The total mean score of the participating elderly individuals on the Spiritual Well-Being Scale was 30.86 ± 6.70 (Table 1).

Table 1. *Distribution by sociodemographic characteristics (n=188).*

Variables	n	%
Age 76.56±8.44 (min: 65, max: 98)		
Gender		
Male	125	66.5
Famale	63	33.5
Education		
Illiteracy	43	22.9
Literacy	25	13.3
Primary school	78	41.0
Secondary school	18	9.5
High school	15	8.2
University	9	5.1
Marital status		
Married	15	8.0
Single (widow and divorced)	173	92.0
Income		
less than expense	62	33.0
equal to expense	85	45.2
more than expense	41	21.8
General health perception		
Low	81	37.2
Middle	62	38.9
High	45	23.9

The mean scores of the sub-dimensions of the scale were: meaning of life 8.79 ± 2.75, peaceful 9.56 ± 2.84, and faith 12.50 ± 3.54. It was determined that the Spiritual Well-Being Scale received the highest scores in the faith dimension and the lowest score in the meaning dimension.

Older adults reported that 9% of their quality of life was abysmal, according to the EQ-5D scale. The EQ-5D index score of the elderly individuals was 0.68 ± 0.35 (median 0.78), and the EQ-VAS score was 62.61 ± 20.88. Regarding the sub-dimensions of the EQ-5D scale, 43.6% for the basis of the action, 64.9% for the self-care dimension, 64.4% for the usual activities dimension, 59.0% for the pain/discomfort dimension, and 61.2% for the anxiety/depression dimension reported that they did not have any problems (Table 2).

Table 2. *The distribution of the mean scores of the EQ-5D Quality of life scale (n = 188).*

Dimensions	No problem		A few problems		Serious problem	
	n	%	n	%	n	%
Mobility	82	43.6	93	49.5	13	6.9
Self-Care	122	64.9	50	26.6	16	8.5
Ordinary activities	121	64.4	54	28.7	13	6.9
Pain / Discomfort	111	59.0	66	35.1	11	5.9
Anxiety / depression	115	61.2	60	31.2	13	6.9

As a result of the univariate analysis between the EQ-5D quality of life scale and certain socio-demographic variables, it was determined that there was a statistically significant difference between the variables of general income perception (for good ones) and education level. Its perceived income (pensioners are good) is based on the total EQ-5D point average (p 0.05). A statistically significant difference was found between the EQ-5D quality of life scale, mobility, self-care, usual activities, pain/discomfort, and anxiety/depression sub-dimensions and the general health perception (for good ones) variable ($p < 0.05$).

Similarly, when the relationship between the total Spiritual Well-Being Scale (Facit-Sp-12) total score average and certain socio-demographic variables was analyzed via univariate analysis, a statistically significant difference between educational status and the Spiritual Well-Being Scale (FacitSp-12) as well as its meaning sub-dimension was found ($p < 0.05$; Table 3).

Table 3. *The distribution of the mean scores of Spiritual well-being scale (FACIT-Sp-12) and its sub-dimensions (n = 188).*

Scale and Sub-dimensions	IQR	Mean	SD
Meaning dimension	4.00	8.79	2.75
Meaning dimension	4.00	9.56	2.84
Faith dimension	5.00	12.50	3.54
Spirituality Wellbeing Scale (FACIT-Sp-12)	9.00	30.86	6.70

Table 4. *It is seen that the subscales and total scores of the Facit sp 12 were compared based on the socio-demographic characteristics.*

Features	***Meaning*** Mean ± SD	***Peaceful*** Mean ± SD	***Faith*** Mean ± SD	***FACIT-Sp-12*** Mean ± SD
Age				
65-74	8.70±2.79	9.54±2.69	12.05±3.78	30.30±6.41
75-84	8.83±2.75	9.48±2.64	13.04±3.18	31.36±6.47
≥85	8.80±2.76	9.77±3.57	12.40±3.67	31.05±7.82
Gender				
Female	8.96±2.62	9.69±2.51	12.12±3.52	30.79±5.93
Male	8.70±2.82	9.49±3.00	12.69±3.56	30.89±7.07
Having a child				
Yes	8.96±2.77	9.60±2.89	12.36±3.78	30.93±6.90
No	8.39±2.70	9.46±2.74	12.82±2.96	30.68±6.28
Continuous drug use				
Yes	8.76±2.85	9.44±2.78	12.70±3.49	30.91±6.71
No	8.87±2.53	9.85±2.98	12.00±3.65	30.72±6.73
Chronic disease				
Yes	8.38±2.60	9.35±3.14	11.89±3.37	29.64±6.77
No	8.89±2.79	9.61±2.76	12.66±3.58	31.12±6.66
Perceived income				
Few	8.03±3.29*	8.72±3.03*	12.61±3.45	29.37±7.58
Average	8.98±2.46	9.78±2.76	12.67±3.53	31.44±6.30
High	9.53±2.16	10.36±2.42	12.00±3.76	31.90±5.79
Perception of health				
Good	9.16±2.65*	10.23±2.67*	12.63±3.25	32.03±6.10*
Bad	8.29±2.82	8.67±2.84	12.33±3.91	29.30±7.16
Marital status				
Married	9.00±2.47	8.73±2.34	11.00±4.78	28.73±8.00
Single	8.77±2.78	9.63±2.87	12.63±3.40	31.04±6.57
Education				
Not literate	8.48±2.95	9.29±2.73	12.51±4.08	30.29±7.25
Literate or primary school	8.73±2.94	9.61±3.03	12.87±4.08	31.22±6.69
Minimum high school	9.20±2.05	9.68±2.53	11.66±4.01	30.55±6.27
Eq5D				
Good	9.26±2.45	10.41±2.77*	12.75±2.88	32.42±5.46*
Bad	8.59±2.86	9.20±2.80	12.40±3.80	30.19±7.07

* Significance level p <0.05

There was a statistically significant difference between the total mean score of the Spiritual Well-Being Scale, the mean score for peaceful and meaning, and the general perception of health ($p<0.05$). It was determined that there was a statistically significant difference between perceived income and the mean scores of meaning and peaceful ($p<0.05$; Table 4).

Multiple regression analysis was performed by modeling participant education status, general health perception, perceived income status, and income, which had a statistically significant relationship with the total score average of the Spiritual Well-Being Scale (Facit-Sp-12). When the regression coefficients were examined (β), general health perception was determined to be an independent explanatory variable for the total Facit score (Table 5; $p<0.001$). For meaning subscore; Eq5D, perceived income, and general health perception were independent explanatory variables for peaceful subscore.

Table 5. *Multivariate analysis of spiritual well-being scale (Facit-Sp-12) scale and some socio-demographic variables*.

Scales and subscales	**R^2**	**β**	**p**
FACIT-Sp-12	0,086		
Constant			,000
Eq5D (For every 1 unit increase)		,887	,136
Perception of health (1 = Those with bad perception)		,537	**,005**
Meaning	**0,055**		
Constant			,000
Perceived income (1 = Those with few income)		**-,132**	**0,016**
Perception of health (1 = Those with bad perception)		-,175	0,070
Peaceful	**0,123**		
Constant			**,000**
Eq5D (For every 1 unit increase)		**-,146**	**0,039**
Perceived income (1 = Those with few income)		**-0,170**	**0,016**
Perception of health (1 = Those with bad perception)		**-0,219**	**0,002**

DISCUSSION

The increase in the elderly population worldwide and Turkey has also increased the proportion of people living in nursing homes. In this context, besides the emerging health problems of older adults, evaluating their spiritual well-being and quality of life has become an essential requirement (15). This study examined the relationship between spiritual well-being and HRQL in a group of functionally independent older adults without cognitive impairment.

The total score average of the Spiritual Well-Being Scale for older adults was 30.86 ± 6.70. This finding is similar to a study conducted with older adults in Switzerland, which indicated that the participant's level of spiritual well-being was moderate (29.6 ± 7.8) (16). The mean score of the faith sub-dimension of the spiritual well-being scale was higher than in the Swiss study (12.50 ± 3.54). It has been evaluated that this situation may be due to a slightly different perception of spirituality in our country.

Health-related quality of life is a broad concept that includes many directly or indirectly related to health. It shows a lower quality of life than the EQ-5D index score in the study conducted with adults in Spain (17), but it is similar to the Australian outcomes (18). As a result of this study, it was determined that most of our elderly participants reported a moderate quality of life (61.2%).

In the literature, many studies in nursing homes have reported that socio-economic factors (such as education and income) impact the quality of life of older adults (19-21). In this study, the average EQ score was 62.61 ± 20.88. This result was found to be lower than the study carried out with older adults (69.8) in Spain (17) and higher than the study (59.2 ± 14.7) in Australia (18).

In this study, there was a statistically significant difference between educational status and the average scores of the life quality sub-dimensions of self-care, ordinary activities, pain/discomfort, and anxiety/depression. This refers to those with low educational status having more psycho-somatic complaints, with less or little pain due to longer training time. However, someone with a higher education level is expected to be more active socially. Similar results were found in the following studies in 10 European countries (22), Singapore (23), and France (24).

In this study, the perceived income status of older adults and the Spiritual Well-Being Scale scores affected the meaning and peaceful sub-dimensions. The quality-of-life scale score average was higher among those who earned their income from pensions, those with excellent general health perception, and those with high school or higher education levels.

Our results showed that the QOL of those with low perceived income levels was lower in this study. Similarly, studies among older adults reported that the quality of life decreased in those of a low socio-economic level (19, 25). In a study conducted among adults, low socioeconomic status and quality of life were negatively related (17).

The perception of health is based on one’s general health status assessment. It is a simple yet powerful indicator that reflects the multidimensionality of a person's health and biological, mental, and social status. It has been shown that there is a strong relationship between a person’s quality of life and their having an excellent general health perception (11, 26, 27).

In this study, multivariable analyses showed that the general health perception of the elderly participants was the most crucial factor affecting their quality of life and spiritual well-being. It was also determined that those who perceived their health as very good

reported a high quality of life. Anxiety about the health of older adults also affects the quality-of-life scale and the sub-dimensions of mobility, self-care, usual daily activities, pain/discomfort, and anxiety/depression.

Conclusion

Nursing homes will become more critical as the population ages worldwide. From this point of view, attempts to improve the life quality and spiritual well-being of older adults in nursing homes will reduce their problems and make nursing homes a better housing option. While healthcare professionals provide care to the individuals they serve using holistic approaches, they must have sufficient knowledge regarding spirituality and spiritual care to meet their patients' spiritual care needs.

Limitations

The most notable strength of this research is that it was conducted on nursing home residents. Besides that, there are some limitations. This research was carried out in only one province in Turkey. In addition, it was carried out on older adults who could participate in the study mentally and spiritually. Therefore, the generalizability of the data is open to discussion.

Implications for Nursing Practice

Spiritual care, one of the essential components of holistic care, should be considered more significantly in older adults and in institutions such as nursing homes where the fragile population is relatively high, and this service should be given with care. Alternative methods of gaining practice on this issue should be developed in the elderly population and all areas of education for health professionals.

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