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Original Article

Correlation between quality of life and spirituality in geriatrics

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Abstract

Aim: When tackling with human health, the elderly, one of the society's most vulnerable groups, must be analyzed in all its aspects. It was thought that spirituality had an important role in human health and fight against diseases. There is a scarcity of data reported from the literature on spirituality and health. Therefore, this study was undertaken to determine the impact of quality of life and spirituality on geriatrics.

Material and Methods: This research was made as descriptive research. The sample consisted of 368 individuals over 65 registered, who were being followed up at 10 Primary Care Clinics of Malatya province. Data were collected using an individual questionnaire, WHO QOL Instrument Elderly Module and Spiritual Orientation Scale.

Results: A statistically significant difference was determined between the income status, situations of living together, having support, having chronic illnesses and using devices and the spiritual orientations of the participants. When the sociodemographic characteristics and quality of life score averages of the geriatrics were compared, a statistically significant difference was determined between age, educational level, chronic illnesses, physical disability and using devices ($p<0.05$). When the ages of the geriatrics and their quality of life score averages are compared, it is seen that the sensory functions score of the elder individuals whose ages are between 85-94 is 10.69±2.17. It was determined that the men's quality of life subdimensions average score was higher than the women's. A significant difference was determined in the quality of life averages of the participants who did not have chronic illnesses. When the correlation between the total quality of life and their spirituality score averages was considered, a statistically significant correlation in the positive direction was determined ($r=.21$, $p=.000$).

Conclusion: Our results suggest that there was a positive correlation between the quality of life and spirituality in geriatrics and quality of life increased as the spirituality increased in geriatrics.

Keywords: Spirituality; quality of life; health professionals; elderly.

INTRODUCTION

The way which old age is perceived by the society is the elderly are as individuals who have become distant from their normal daily lives and the people they are always together with, briefly as are individuals whose quality of life has decreased. In fact, there are not only the negative aspects of old age but there are also positive aspects of it to live together with the next generation with the experience gained in years (1). Instead, the negative aspects of old age are emphasized by both geriatrics and society. Geriatrics accepts how the society regards the elderly person and he is abstracted from social life and accepts his pessimistic state and starts to retire from everything which makes his life a quality life (2). All factors affecting their daily life organization cause old individuals to live their lives more hardly. Living conditions getting worse may cause the individuals' quality of life to decrease. Quality of life is perceived differently at every age (3). Reasons such as the deterioration of health, the individual getting lonelier and having difficulties in fulfilling his daily needs in the individual whose living conditions get more difficult because of physical and social problems brought by old age can cause the quality of life to decrease. When it is considered from this point, it is possible to say that quality of life embodies many states of well-being (4).

One of the factors which affect the individual's quality of life in old age is spirituality. They can overcome the factors which make their lives difficult more easily with the help of their spiritual orientations (5). It is possible to perceive spirituality as a strength with this aspect of it. In elder individuals, clinging to life better and being happy with their time, thus, the situation of an increase in the

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quality of life can be experienced with belief (6).

While the elder individuals whose quality of life is lower are doing their daily activities, they and the other individuals in society have some difficulties. There is a very limited number of studies analyzing the correlation between the quality of life and spirituality in geriatrics. Although there are many studies analyzing the quality of life in geriatrics, there are few studies analyzing the spirituality in geriatrics. Bostancı et al (7) analyzed the spiritual orientation in geriatrics, Zincir et al (8) and Mendoza-Ruvalcaba et al (9) analyzed the correlation between health and quality of life in geriatrics in the studies they conducted.

Data on spirituality and health are limited in the literature. Therefore, this study was conducted to determine the relationship between quality of life and spirituality in the elderly.

MATERIALS and METHODS

Patients

This research was made as descriptive research. This research was conducted with the individuals over 65 who applied to the Primary Care Clinic in Malatya province center between September 2016 – November 2017. The population of the study consisted of 8,741 individuals over 65 years of age registered to 10 PCC's in Malatya. According to the power analysis, the sample of the study was determined as 368 elderly individuals with a power of 0.05 effect size and 98% universe representation power within the 95% confidence interval determined by 5% error level. Elderly individuals selected for the sample of the study, which were registered to the designated PCC's, constituted the sample of 368 elderly studies by simple random sampling method in parallel with the universe rate.

The necessary written permissions were taken from Inonu University Health Sciences Board of Scientific Research and Publication Ethics, from Figen Kasapoglu who prepared Spiritual Orientation Scale, Malatya Provincial Directorate of Public Health and the responsible doctors at the 10 Primary Care Clinics determined. 8741 individuals over 65 registered at 10 PCCs in Malatya province center made the universe of the research. The sample consisted of 368 individuals over 65 registered, who were being followed up at 10 Primary Care Clinics of Malatya province.

Data Collection

The Personal Information Form prepared by the researcher consists of 13 questions asked to determine the age, sex, marital status, educational level and the income level of the participants. It also contains questions to learn if they have children and to learn the number of children they have. There are also questions to learn who they live with and if they are supported or not, their perception of own health status, if they have a chronic illness, if they have any disabilities and if they use any devices or ancillary types of equipment.

The questionnaire consists of 24 questions and 6 subfields determined by five-point Likert scale. These fields rank as sensory functions, autonomy, past, present, and future activities, social participation, and "to die" and death and attachment. Sensory functions and the effects of their loss on the quality of life are assessed with the "Sensory Functions" dimension. The "autonomy" dimension means independence in advanced age and it expresses the skill of living lonely. The "Past, Present and Future Activities" dimension indicates the satisfaction with the success in life and how the individual regards the future. The "Social Participation" dimension especially indicates being able to participate in the activities in the daily life. The "Death and to die" dimension is about the worries, concerns, and fears about death and to die. The "Attachment" dimension evaluates the skill for building personal and private relationships. The lowest possible score for each question is 1 and the highest score is 5. The possible dimension scores are in 4-20 range. The highest total score to be taken from the questionnaire is 12 and the lowest total score is 24. The quality of life gets better as the score increases.

The Spiritual Orientation Scale developed by Kasapoğlu (2015) was used for evaluating the spiritual orientations of the participants. The "Spiritual Orientation Scale" (SOS) consists of 16 questions determined by 7 points Likert scale. In this research, the scale questions were designed according to the perspective of believing in a transcendental power, and meaning and quest and prayer/meditation which are considered as among the basic criteria of spirituality. A high score taken from the scale indicates a spiritual orientation at a high level (10).

The SOS is a 7 point Likert scale and it grades the questions in the positive direction and 16 is the lowest score taken and 112 is the highest score taken as a result of it. The high score taken from the scale indicates a spiritual orientation at a high level.

Statistical Analysis

The data obtained from the research was evaluated at the SPSS 22 programme. Percentage distribution, mean and standard deviation values were used for the demographic characteristics and scale results. After the Kolmogorov-Smirnov test was applied in order to determine if the data were in the normal distribution range, variance analysis, t-test and Pearson Correlation test were used in the normal dispersion range. Mann-Whitney U and Kruskal Wallis tests were used for the data which do not conform to the normal dispersion range. The significance level was accepted as $p<0.05$ in the evaluations which were not statistical.

RESULTS

In this part of the study in which the correlation between the quality of life and spirituality in geriatrics is searched, there are the findings of the research.

The elder individuals' averages of quality of life are 72.57±10.06 and their spirituality averages are

92.86±12.17. When the averages of the subdimensions of quality of life are considered, it is seen that the sensory functions average is 12.68±2.54, the autonomy average is 12.22±2.46, the past and the present average is 11.98±2.95 and the social participation average is 11.01±2.77. The "to die" average is 11.88±3.26 and the attachment average is 12.76±2.88 (Table 1) (p<0.05).

When the ages of the geriatrics and their quality of life score averages are compared, it is seen that the sensory functions score of the elder individuals whose ages are between 85-94 is 10.69±2.17.

Their autonomy score is 11.61±1.85, their perception of past and the present score is 12.07±1.75, and their social participation score is 10.46±1.89.

Their"to die" score is 13.07±4.34. Their attachment score is 12.07±2.21 and their quality of life score average is 70.00±9.25.

It is observed that there is a decrease in the score averages of the subdimensions of quality of life. It has been determined that there is a significant difference between the ages and quality of life subdimensions of the elder individuals (Table 2) (p<0.05).

When the correlation between sex and quality of life subdimensions was analyzed, a statistically significant difference was determined between the autonomy subdimension (t=2.28, p=.002) and sex. It was determined that the men's quality of life subdimensions average score was higher than the women's. When the quality of life is regarded with its subdimensions, it is seen that the averages of the married participants are higher than the single one (Table 2) (p<0.05).

The quality of life score increases as the educational level increases. It is seen that the quality of life averages of the participants who have children are higher than the averages of the participants who don't have children. A statistically significant difference was determined that the quality of life average increased as the income level increased. The quality of life average of the participants who live together with their spouses and children are higher than the others' (Table 2) (p<0.05).

A statistically significant difference was determined between the subdimensions of having support and quality of life and the subdimensions of sensory functions (t=3.79, p=.000) and attachment (t=5.22, p=.000). It was determined that the participants who did not have support had the higher quality of life averages when compared to the participants who had support (Table 2) (p<0.05).

It was determined that the quality of life score averages of the participants who perceived their health as good were higher than the averages of the participants who perceived their health as bad. A significant difference was determined in the quality of life averages of the participants who did not have chronic illnesses. They were higher than the quality of life averages of the participants who had chronic illnesses. A statistically significant difference was determined in the participants who had social security. They had a higher quality of life when compared to the participants without social security (Table 2) (p<0.05).

A statistically significant correlation was determined in the participants without physical disabilities. They had the higher quality of life averages when compared to the participants with physical disabilities (Table 2) (p<0.05).

A statistically significant difference was determined in the participants who did not use devices. They had the higher quality of life averages when compared to the participants who used devices (Table 2) (p<0.05).

When the comparison of the informative characteristics and the SOS score averages of the participants are considered, it is 93.40±12.23 of the participants between 65-74 age range. The men's score is 93.35±10.25, the married participants' is 93.35±10.25 and the literate participants' is 93.89±12.85.

The score of the participants with high-income levels is 95.13±13.26 and the score of the participants who live with their spouses and children is 96.15±11.96 (Table 3) (p<0.05).

It is 94.01±12.01 according to their status of having support, it is 94.80±11.42 according to the status of chronic illnesses and it is 93.53±14.51 in the participants with physical disabilities (Table 3) (p<0.05).

A statistically significant difference was determined between the participants' income levels (KW=9.01,

Table 1. Mean Scores of Quality of Life and Its Subdimensions and Spirituality

	Number	Mean and Standart Deviation	Minimum	Maximum
Quality of Life	368	72.57±10.06	46.00	108.00
Sensory Function	368	12.68±2.54	6.00	33.00
Autonomy	368	12.22±2.46	6.00	20.00
Past / Present	368	11.98±2.95	5.00	42.00
Social Participation	368	11.01±2.77	4.00	19.00
To Die	368	11.88±3.26	4.00	20.00
Attachment	368	12.76±2.88	7.00	20.00
Spirituality	368	92.86±12.17	33.00	112.00

Table 2. Comparison of the Informative Characteristics of the Participants and the Mean Scores of Quality of Life

	Features	N	Sensory Function (X±SS)	p value	Autonomy (X±SS)	p value	Past / Present (X±SS)	p value	Social Participation (X±SS)	p value	To Die (X±SS)	p value	Attachment (X±SS)	p value	Total (X±SS)	p value
Age	65-74	286	13.03±2.48		12.53±2.48		12.24±3.09		11.37±2.76		11.92±3.22		12.98±2.94		74.08±10.04	
	75-84	69	11.63. ±2.41	.000	11.05±2.12	.000	10.89±2.21	.000	9.65±2.53	.000	11.52±3.17	.000	12.01±2.57	.045	66.78±8.04	.000
	85-94	13	10.69±2.17		11.61±1.85		12.07±1.75		10.46±1.89		13.07±4.34		12.07±2.21		70.00±9.25	
Sex	Female	139	12.49±2.47		11.84±2.27		11.63±2.39		10.69±2.72		11.62±3.25		12.62±2.67		70.92±9.66	
	Male	229	12.80±2.58	0.26	12.44±2.54	.002	12.20±3.22	0.70	11.20±2.79	0.08	12.04±3.26	.022	12.85±3.00	.450	73.56±10.19	.010
Marital Status	Single	127	70.61±10.51		12.10±2.54		11.75±2.60		10.97±2.91		10.96±3.26		12.62±2.94		70.61±10.51	
	Married	241	73.60±9.68	.007	12.28±2.42	0.49	12.10±3.11	0.27	11.03±2.70	0.84	12.37±3.15	.000	12.84±2.84	.470	73.60±9.68	.007
Education Level	Literate	112	12.16±2.48		11.77±2.29		11.87±2.36		10.70±2.91		11.65±3.50		12.79±2.67		70.96±9.78	
	Primary School	197	12.71±2.57		12.21±2.30		11.87±3.17		10.89±2.52		11.81±3.16		12.50±2.87		72.01±9.25	
	Lycee and Over	59	13.61±2.30	.002	13.10±3.02	.004	12.57±3.14	0.24	12.01±3.09	.008	12.57±3.07	0.19	13.61±3.16	.030	77.49±11.74	.000
Having Children	Yes	333	12.69±2.58		12.30±2.50		12.07±3.04		11.03±2.84		11.84±3.28		12.93±2.89		72.88±10.31	
	No	35	12.57±2.15	0.77	11.45±1.89	0.05	11.14±1.711	0.07	10.85±2.04	0.72	12.34±3.02	0.38	11.17±2.24	.001	69.54±6.74	.060
Income Status	High	56	13.87±2.68		14.33±2.53		13.89±2.22		13.89±2.22		11.85±2.95		14.55±2.33		81.55±9.79	
	Moderate	284	12.59±2.44	.000	11.86±2.20	.000	11.71±2.96	.000	11.71±2.96	.000	11.97±3.22	0.404	12.55±2.85	.000	71.93±9.05	.000
	Low	28	11.53±2.47		11.60±2.75		10.96±2.58		10.96±2.58		11.03±4.09		11.32±2.68		66.57±10.17	
Status of Living Together	Singly	66	12.68±2.45		12.33±2.73		12.48±4.67		11.66±2.40		11.48±3.87		12.03±3.07		72.68±11.726	
	Children	79	11.59±2.37		11.77±2.37		11.59±2.30		10.65±3.08		10.84±3.17		12.75±2.67		9.22±9.96	
	Spouse	176	13.23±2.59	.000	12.23±2.44	.167	11.82±2.48	.146	10.93±2.64	.165	12.50±2.98	.001	12.68±2.88	.002	73.43±9.47	.006
	C. and S.	47	12.48±2.15		12.76±2.18		12.53±2.25		11.00±3.10		11.89±3.00		14.12±2.52		74.80±8.80	
Status of Having Support	Yes	230	12.30±2.72		12.12±2.23		11.96±2.42		10.83±2.92		11.73±3.28		13.35±2.72		72.32±9.77	
	No	138	13.32±2.07	.000	12.39±2.80	0.31	12.01±3.67	0.88	11.31±2.47	0.10	12.13±3.22	0.25	11.78±2.87	.000	72.97±10.56	.540
Perceiving Health	Good	55	14.63±3.56		13.96±2.47		13.27±2.32		12.58±2.80		12.23±2.91		14.36±2.81		81.05±10.91	
	Moderate	251	12.79±1.89	.000	12.15±2.32	.000	12.05±3.14	.000	11.14±2.73	.000	12.27±3.08	.000	12.62±2.89	.000	73.04±8.49	.000
	Low	62	10.51±2.15		10.95±2.10		10.56±1.91		9.11±1.65		10.03±3.64		11.93±2.35		63.11±7.18	
Chronic Illness	Yes	228	11.94±2.25		11.92±2.42		11.92±3.18		10.78±2.85		11.48±3.57		12.87±2.94		70.94±9.84	
	No	140	13.89±2.52	.000	12.70±2.45	.003	12.09±2.52	0.58	11.38±2.61	0.04	12.55±2.54	.002	12.60±2.77	.370	75.22±9.90	.000
Social Security	Yes	356	12±2.56		12.20±2.45		12.01±2.97		11.03±2.79		11.95±3.17		12.81±2.89		72.73±10.06	
	No	12	12.16±1.89	.246	12.75±2.73	.489	11.00±1.85	0.174	10.33±2.01	0.40	9.91±5.10	0.07	11.41±2.19	.070	67.58±9.19	.040
Social Security	Yes	97	11.16±1.96		11.94±2.41		11.56±2.37		9.72±2.71		11.49±3.88		12.92±2.80		68.82±9.50	
	No	241	13.23±2.50	.000	12.32±2.47	0.20	12.13±3.12	0.10	11.47±2.65	.000	12.02±3.00	.16	12.71±2.91	.520	73.91±9.94	.000
Using Devices	Yes	116	11.43±2.02		11.75±2.41		11.71±3.69		10.00±2.73		11.24±3.71		12.17±2.84		68.32±9.63	
	No	252	13.26±2.55	.000	12.43±2.46	0.01	12.11±2.53	0.230	11.48±2.66	.000	12.18±2.99	0.01	13.04±2.86	.007	74.52±9.67	.000

C. and S. =Children and Spouse , SD= Standart Deviation

p=0.01), their status of living together (F=2.89, p=0.03) and having support (t=2.34, p=0.02). Their chronic illness (t=2.40, p=0.01) and their spiritual orientations (p<0.05) (Table 3) were also included.

A statistically significant correlation in the positive direction was determined between the elder individuals' quality of life and their spirituality score averages (r=.21, p=.000). The correlation between the quality of life subdimensions and spirituality score averages was also considered. A statistically significant positive correlation was determined in these subdimensions: sensory functions (r=.190, p=.000), autonomy (r=.103, p=.004), "to die" (r=.178, p=.001) and attachment (r=.173, p=.001) (Table 4) (p<0.05).

Table 3. Comparison of the Informative Characteristics of the Geriatrics and Their SOS Mean Scores

Features	Number	Spiritual Orientation (X±SD)	Statistical analyses and p value
Age			
65-74	286	93.40±12.23	KW=5.36
75-84	69	91.77±11.76	p=0.06
85-94	13	86.92±11.91	
Sex			
Female	139	92.07±14.81	t=0.97
Male	229	93.35±10.25	p=0.32
Marrital Status			
Single	127	92.04±14.15	t=0.93
Married	241	93.30±10.99	p=0.34
Education Level			
Literate	112	93.89±12.85	F=0.62
Primary School	197	92.56±11.73	p=0.53
Lycee and Over	59	91.94±12.38	
Income Status			
High	56	95.13±13.26	KW=9.01
Moderate	284	93.00±11.41	p=0.01
Low	28	86.92±15.60	
Living Together			
Singly	66	90.53±14.99	F=2.89
With Children	79	91.00±12.67	p=0.03
With Spouse	176	93.70±10.53	
With Children and Spouse	47	96.15±11.96	
Having Support			
Yes	230	94.01±12.01	t=2.34
No	138	90.96±12.24	p=0.02
Having a Chronic Ilness			
Yes	228	91.68±12.49	t=2.40
No	140	94.80±11.42	p=0.01
Physical Disability			
Yes	97	93.53±14.51	t=0.62
No	271	92.63±11.24	p=0.52

Table 4. Comparison of the Participants' Mean Scores of Quality of Life and Mean Scores of Spirituality

	Mean Scores of Quality of Life						
	Sensory Function (r and p value)	Autonomy (r and p value)	Past and Present (r and p value)	Social Participation (r and p value)	To Die (r and p value)	Attachment (r and p value)	Total Mean Scores (r and p value)
Mean Scores of Spirituality	r=.190 p=.000	r=.103 p=.004	r=.083 p=.011	r=.030 p=.568	r=.178 p=.001	r=.173 p=.001	r=.213 p=.000

DISCUSSION

The findings of the research made in order to determine the correlation between the quality of life and spiritual status of the geriatrics were discussed within the frame of the literature and the studies conducted on this topic. Since there is a limited number of studies analyzing the correlations between quality of life and spirituality in geriatrics, studies conducted in order to determine the correlations between the quality of life and spirituality of the individuals in different age groups were also included in the discussion.

It was determined that the quality of life score averages of the married participants were higher than the quality of life score averages of the single participants. Moreover, a statistically significant difference was determined between income, educational level, living together, perceiving health, having chronic illnesses, having social security, physical disabilities and using devices and quality of life.

In the study conducted by Altuğ et al analyzing the factors affecting the elder individuals' quality of life, a statistically significant difference was determined in the individuals' quality of life. They were individuals who had social

security, who were satisfied with the environment they lived in and who did not have chronic illnesses, similar to the findings of this research (3). According to these findings, it is seen that the elder individuals' having an adequate income level, a regular family structure, social security and relatives to care them and no situations such as loneliness and illness which will make their lives difficult increase their quality of life.

When the comparison of the participants' informative characteristics and spiritual orientation score averages was considered, it was determined that the spiritual orientation averages of the participants who were between 65-74 age range, male and married and literate were higher. They were participants also who had children and lived with their spouses and children, who took support, who perceived their health as good and who had social security, who had physical disabilities and who did not use devices.

In the study they conducted to determine the effects of spirituality on the illness, Bostancı et al. determined that there was an important correlation between spiritual orientation and the patients' positive developments. They emphasized that the spiritual dimension should not be neglected in individuals with illnesses and an approach to individuals with spiritual orientation would provide positive developments in the patients (7).

When the correlation between the total quality of life and their spirituality score averages was considered, a statistically significant correlation in the positive direction was determined (r=.21, p=.000). According to these findings, it was determined that the quality of life score averages increased as the spirituality score averages increased. In the correlation between the subdimensions of quality of life and spirituality, there is a significant correlation in the positive direction in the subdimensions of sensory functions, autonomy, to die and attachment (Table 4).

In the studies conducted to determine the correlation between quality of life and spirituality, it is argued that there is a correlation in the positive direction between the individuals' qualities of life and their spirituality situations. It is also argued that spiritual orientation effects the quality of life in a positive direction (1,11-13).

In the study they analyzed the correlation between the quality of life and spirituality of the individuals with chronic illnesses, Bekelman et al determined a significant correlation between quality of life and spirituality in the individuals with chronic illnesses, similar to the results of this research. They determined that the quality of life score averages increased as the spirituality increased (4). In the study they analyzed the spirituality status in elder individuals, Rahimi et al determined that spirituality was a basic element in the geriatrics' adaptation to daily living conditions (11). Improvement of the daily life conditions is provided with the individual's quality of life's being high and spirituality has an important effect on this topic. In the study they conducted on the correlation between spirituality and quality of life in patients who had stem cell transplantation, Leeson et al determined that there was a statistically significant correlation between spirituality and quality of life. They determined that spirituality was an important factor in treatment (12). In the study they conducted on patients with HIV, Brown et al determined that there was a statistically significant correlation between spirituality and quality of life, similar to the findings of this research. They determined that spirituality decelerated the advance of the HIV disease and increased the HIV patients' quality of life (5). In the study they conducted to determine the correlation between pain and pain management and spirituality, Dedeli and Kaptan determined that spirituality was an important factor in overcoming pain and a decrease in pain increased the quality of life (13).

In this research, it was determined that the male and married participants with high educational levels and high-income levels who lived with their spouses and children had a higher quality of life and spiritual orientation score averages. They were the participants who did not have chronic illnesses and physical disabilities and who had children.

A positive correlation was determined between the quality of life and spirituality in geriatrics ($p<0.05$). It was determined that the quality of life increased as spirituality increased. It was determined that the quality of life increased as the geriatrics' age and income levels increased and it decreased in case the educational level decreased or a physical disability existed. It was determined that spirituality decreased as the age and educational levels increased and it increased as the income levels increased.

All health personals should evaluate the older individuals with a holistic approach and with all aspects of theirs and they should take the dimension of spirituality which enhances the quality of life and helps to cure the health situations carefully. It is recommended that the all health personals should not ignore that spiritual orientation is important for enhancing the quality of life during their work with geriatrics.

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