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Correlation of Spiritual Care and Quality of Life among Institutionalized Older People

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Abstract

Ensuring that Older People have good quality of life is one of the major goals of any caregiver. Caregivers, which includes nurses, must be holistic in their provision of care to meet such a goal. Since one of the dimensions of quality of life is spirituality, these researchers sought to describe if any relationship exists between the caregivers' spiritual care practices and the quality of life of the older people in their care. Institutionalized older people were surveyed using the Nurse Spiritual Care Therapeutics scale and WHO Quality of Life for Filipino Older People to measure the spiritual care practices of caregivers and the quality of life of Older People, respectively. Results show no significant relationship between the two variables, which may be due to the fact that quality of life is composed of several dimensions, in which spirituality is only one, and is multi-factorial in nature; suggesting that quality of life is influenced by several factors and how these factors interplay ultimately determine the quality of life of Older People. The researchers recommend that a mixed-method approach be used to further understand the lack of direct relationship between the two variables.

Keywords: Elderly, Older People, Quality of Life, Spiritual Care

Introduction

As health sciences progress, there are more Older People now than ever before with the previous century seen as a period of increasing life expectancy (Crimmins, 2015). It is estimated that there will be 1.2 billion people aged 60 or older by 2025, and considering that this is a global trend, it requires a change in focus towards the promotive/preventive aspects of healthcare and medical needs of Older People (Shrivastava, Shrivastava, and Ramasamy, 2013). One such focus is improving their quality of life.

Quality of life takes into consideration the well-being of a person, and its improvement or maintenance is no doubt the "ultimate goal" of care (Jacobs, 2009). The World Health Organization (WHO) defines it as "individual perception of his or her living situation, understood in a cultural context, value system and in relation to the objectives, expectations and standards of a given society." A person's health or well-being goes beyond the physical and includes other dimensions such as psychological, emotional, social, and spiritual with each having its own peculiar needs (Berman and Snyder, 2012). Compared to patients of a different age group, older adults (60 years of age and above) have a particular set of spiritual needs. They may be especially concerned about living a life with purpose or meaning, avoiding social isolation through maintaining relationships, and preparing for a good death (Berman and Snyder, 2012).

Quality of life is not only about the physical aspect of health but also includes other factors (Khaje-Bishak, Y., Payahoo1, L., Pourghasem, B., and Jafarabadi, M.A., 2014) like emotional, social, and spiritual. Spirituality is concerned with the person's view of life, his recognition and achievement of his life's mission, and/or belief in a higher power; it is a core human experience (Berman and Snyder, 2012). It is "that most human of experiences that seeks to transcend self and find meaning and purpose through connection with others, nature, and/or a Supreme Being, which may or may not involve religious structures of traditions" (Buck, 2006, as cited by Berman and Snyder, 2012).

Addressing spiritual needs is an important part of care; in fact, several studies, such as that of Chen, Lin, Yan, Wu, and Hu (2018), urge health professionals to provide spiritual care to clients. Spiritual care is considered vital in improving certain aspects of quality of life (Sahir and Ozdemir, 2016). It is not prescriptive, but rather descriptive (Berman and

Snyder, 2012), and focuses on interactions and relationships (Daaleman et al, 2008). Such care is said to be effective; in fact, a study by Walker and Breitmaster (2017) showed that spiritual care that is provided by nurses improves the psychosocial aspect of health among patients; a finding supported by another study by Matos et al (2017).

One barrier to providing spiritual care would be its performance by healthcare professionals. Provision of spiritual care depends on the healthcare provider's knowledge and preparation (Sahir and Ozdemir, 2016), and attitude and personal spirituality (Vance, 2001). Spiritual care practices therefore differ from one healthcare professional to another.

Unfortunately, there is a dearth of literature that directly correlates spiritual care practices of caregivers and the quality of life of Older People. This study is significant in that regard, in the sense that this study may be the first that will try to see a direct relationship between spiritual care practices and the quality of life of Older People. This is why the researchers chose to test the null hypothesis: there is no relationship between spiritual care practices of the caregivers and the overall quality of life of Older People who are living in an institution.

Conceptual Framework

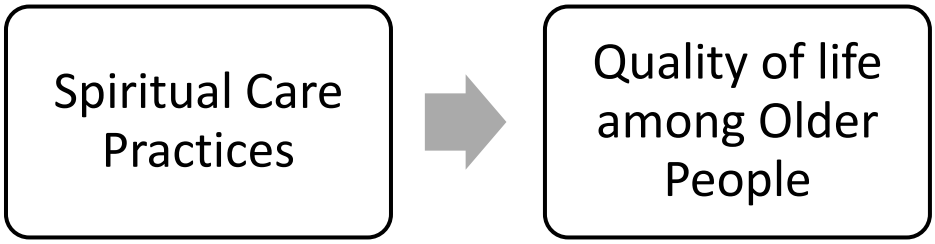

Figure 1. Conceptual framework

In this study, the researchers considered the level of Spiritual Care Practices as the independent variable and the Quality of Life among Older People as the dependent variable. The researchers analyzed if such a relationship exists between the two variables.

Spiritual care is an expression of self (Berman and Snyder, 2012); in this case, it is the nurses or caregivers expressing themselves toward the Older People in their care. Spiritual care seeks to provide fulfillment of the spiritual needs of the Older People. The researchers assumed that when spiritual care practices are rendered, the spiritual needs of the Older People are addressed; subsequently, the patients' overall quality of life improves.

Theoretical framework

This study is guided also by Parse's Human Becoming Theory (Parse, 1999). There are three assumption**s** about human becoming (Berman and Snyder, 2012):

1. It is freely choosing personal meaning in situations in the intersubjective process of relating value priorities. This means that people deliberately determine the meaning of their experience based on their actions.
2. Cocreating rhythmic patterns or relating in mutual process with the universe is human becoming. This pertains to a person's adaptation to the environment; and
3. It is cotranscending multidimensionally with the emerging possibles.

Choosing personal meaning pertains to the patients' deliberate desire to determine the meaning of their experiences. Cocreating rhythmic patterns pertain to a person's adaptation to the environment. Contrascending is the process that pertains to the act of human becoming of the person in relation to the universe or environment (Parse, 1999, as cited by Berman and Snyder, 2012).

Simply put, the assumptions focus on meaning, rhythmicity, and cotranscendence. Meaning comes from the individual's interrelationship with the world or environment. Rhythmicity is shifting towards greater diversity of each person. Cotranscendence is reaching out beyond the self's previous capabilities. Parse believes that the clients, not the nurses,

are the authority and the central figures or decision makers (Berman and Snyder, 2012). The nurses' role is to assist the clients in choosing how to change his or her health processes by illuminating meaning for the clients, synchronizing rhythms, and mobilizing transcendence. Thus, the goal of nursing from the human becoming perspective is quality of life (Parse 2006, as cited by Berman and Snyder, 2012).

For this study, finding the meaning of life is part of someone's spirituality, and assisting in illuminating these meanings would be the nurses' job. In this case, we consider these tasks as spiritual care practices. While the goal of Parse's Human Becoming Theory for nursing is the quality of life, here, it is the dependent variable (Berman and Snyder, 2012).

Methodology

The researchers used descriptive correlational design using a survey method approach. Descriptive correlational research seeks to describe the relationship that exists between variables, but not to explain or understand the underlying causes of the variables (Polit and Beck, 2014). Although quality of life has many dimensions (Garcia and Navarro, 2018) and thus may be affected by a multitude of factors, only the relationship between the independent and dependent variables was analyzed by the researchers.

Data gathering for this study is cross-sectional. Cross-sectional designs are studies that collect data at one point in time (Polit and Beck, 2014).

The target population for this study was Older People at a certain institution. Purposive sampling, a method in which the researchers handpick the participants they deem to be knowledgeable (Polit and Beck, 2014), was used.

Participants were selected using the following inclusion criteria:

1. Must be 60 years old and above;
2. Must be able to read and understand Filipino and English; and
3. Must be able to perform activities of daily living without assistance, institutionalized or is living in a nursing home for at least a year.

Exclusion criteria include:

1. Presence of cognitive impairment or mental disorders
2. Presence of obvious disability (e.g. blind, crippled, etc.);
3. Inability to read both Filipino and English.

All twenty-six participants in the chosen institution matched the criteria and were thus included in this study therefore, the researchers did not need to determine the sample size.

The researchers used two instruments to measure the variables: the Nurse Spiritual Care Therapeutics Scale (NSCTS) by Mamier and Taylor (2014) to assess the spiritual care practices rendered to the participants, and the WHOQOL-BREF Fil OP, the Quality of Life instrument developed by WHO specifically for Filipino Older People.

The researchers requested permission from Dr. Elizabeth Taylor to use the NSCTS instrument. Permission was granted via email, and the researchers were given a copy of the instrument. Conditions for permission included proper citation of the authors and the non-alteration of the instrument.

The NSCTS instrument has 17 items written in a 5-point Likert scale format. This tool was used to rate the spiritual care practices rendered by caregivers to the Older People as perceived by the Older People. Psychometric properties show that the tool is valid and reliable (Mamier, I. & Taylor, E. J., 2015). Potential score ranges from 17 (lowest) to 85 (highest). High scores indicate frequent nursing therapeutics or activities supporting patient spiritual integration and low scores indicate nurse to infrequently provide spiritual care.

The WHOQOL-BREF Fil OP is an instrument to measure the quality of life of Older People. It was adapted for Filipinos and translated into the Filipino language. The researchers requested permission from the World Health Organization (WHO) via their website. WHO emailed the researchers a contract, which the latter signed and sent back to WHO. After some time, WHO emailed the researchers a copy of the instrument and a manual on how to use it. The tool is composed of 27 items in a 5-point Likert scale type of questionnaire. Items 3, 4, and 26 are reversed then total score will be computed. The higher the score, the better the overall quality of life.

Ethical clearance was obtained from the Arellano University Ethics Committee. A copy of the proposal was sent to the ethics committee, and after two weeks, an expedited review was rendered, and then the approval was given.

Officials of the institution where the study took place allowed the researchers to gather data on the condition that the institution, its employees, and its patients remain anonymous. The institution's staff assisted the researchers regarding patient schedules and availability. The staff also helped in identifying and screening of participants.

The participants were informed of the study's objectives and the potential risks and benefits of participation. They were given an opportunity to clarify matters or ask questions pertaining to the study. Securing verbal and written consent from the participants was done prior to data gathering. Participants were made aware that they could refuse to continue with their involvement at any time. Codes were used to conceal the identity of the participants. Participants were informed of the researchers' plan to disseminate and publish the study.

Data gathering took place from February 25 to 28, 2019. The researchers were supervised by the institution's staff. The caregivers were advised of the scheduled survey to ensure that the data gathering would not interfere with nursing care. Each participant took at most about 20 minutes, to answer both questionnaires. No participant dropped out during the conduct of the study.

Data gathered are confidential and are intended for use only in this study. No other person aside from the researchers have access to the collected data. Paper files, like documents and questionnaires, will be destroyed or shredded after 5 years, at most.

Data were collated and encoded immediately. Microsoft Excel was used to organize the collated data. No identifiers were encoded in the spreadsheet.

To analyze the relationship between the two variables, the researchers used inferential statistics. Specifically, Pearson r was used to determine if there was a significant relationship in the spirituality of the caregivers and the quality of life of the Older People. Jamovi 0.9.5.15 statistical software was used for data analysis. The p value was analyzed.

A p value of less than 0.05 would indicate a significant relationship between the variables. However, the analysis showed a value greater than 0.05, which means no significant relationship that exists between the variables.

Results and Discussion

Table 1.
Spiritual Care of caregivers and Quality of Life of Older People

Variable	Mean
Spiritual Care	4.13
Quality of life	3.71

Table 1 presents the mean values of the spiritual care of the caregivers and the quality of life of Older People. As evaluated by the participants, the spiritual care of the caregivers averaged a score of 4.13, and the Older People's quality of life averaged 3.62.

Results of the Pearson correlation indicate no significant association between Spiritual Care and quality of Life of Older People, ($r(26) = -.29$, $p = .151$). Pearson r analysis yields a p value of 0.151 which signifies that there is no significant relationship between the two variables. Thus, the null hypothesis is accepted.

Discussion

Quality of life is composed of several elements (Bai and Lazenby, 2015), of which spirituality is only one. Physical, social, emotional, psychological, and environmental elements or dimensions also exist (Bai and Lazenby, 2015). Literature suggests that any of these elements may influence each other and the overall quality of life, including spirituality and quality of life (Sawatzky, Ratner, and Chiu, 2005). The influence of the dimensions to each other and the overall quality of Life then implies that if a person's spirituality is high, the quality of life can be expected to be high as well.

Certain studies show that caregivers or nurses can affect their patients' level of spirituality depending on their own level of spirituality and on how they attend to the spiritual needs of their patients (Carpenter,

Girvin, Kitner, and Ruth-Sahd, 2008). If the caregivers' spirituality is high, then their spiritual care practices must also be high (Carpenter et al, 2008). In simple terms, the better the spiritual care practices rendered by the caregivers, the higher the patients' own level of spirituality as well, which in theory should increase the overall quality of life of the patients. This claim is supported by a meta-analysis done by Sawatzky, Ratner, and Chiu (2005), who found a correlation between the person's spirituality and overall quality of life to a varying degree, meaning the strength of relationship is not consistently high or low. Their study also found out that age, gender, ethnicity, and religious affinity may moderate the relationship of the two, though not much is known about how these exactly affect the relationship. This only shows that overall quality of life is can be influenced by many factors.

However, the results of this study did not show any significant relationship between the spirituality of the caregivers and the quality of life of Older People. It may be possible that the influence of the caregivers' spirituality is not enough to elevate the overall quality of life of the Older People because the quality of life of Older People is influenced more by other factors.

Quality of life is multi-factorial and multi-dimensional (Garcia and Navarro, 2018), with many variables that may improve or worsen it depending on the traits of an individual. De Araujo, Barbosa, Menezes, Medeiros, de Araujo, and Medeiros (2015) identified factors that negatively influence the quality of life of institutionalized Older People. In their study, Depression was identified as the major factor; low socioeconomic conditions, unsatisfactory family assistance, and occurrence of comorbidities also decreased the quality of life of the Older People. The participants of their research scored low on the questions related to health, indicating they had multiple visits to a healthcare provider for the past two weeks due to health concerns.

These findings are also supported by the study of Khaje-Bishak, Payahoo, Pourghasem, and Jafarabadi (2014), who noted a significant decrease in quality of life in Older People who had cardiovascular, respiratory, and gastrointestinal diseases, as well as sensory deficiencies. The researchers made illnesses part of the exclusion criteria to decrease the extraneous variables affecting the study results.

Of all the factors and different aspects that may be considered, the health aspect of quality of life also seems to have a greater impact on institutionalized Older People, along with other factors such as the ability to perform daily activities and family and social network (Fernandez-Mayoralas, et al., 2015). Pinkas et al. (2016) noted a similar decrease in quality of life when the Older Person was sick or had decreased social interaction. On top of that, chronic pain can also decrease the quality of life (Pinkas et al, 2016).

Age and gender do not seem to affect the overall quality of life of Older People (Khaje-Bishak, Payahoo, Pourghasem, and Jafarabadi, 2014), although age may affect the social aspect of the quality of life (Alemida-Brasil, et al., 2017). To a certain degree, age and gender can be considered as moderators of the relationship between spirituality and quality of life (Sawatzky, Ratner, and Chiu, 2005).

It appears that spirituality is a distinct dimension of quality of life that is separate from the physical, social, emotional, and functional (pertains to everyday activities). Although many studies show a positive correlation between spirituality and quality of life, spirituality is only one of the factors that influence quality of life (Bai and Lazenby, 2015). The association is relative and not absolute; hence, high spiritual care does not necessarily translate into a high overall quality of life (Chen, Lin, Chuang, and Chen, 2017), particularly on institutionalized Older People.

Spirituality is also personal, suggesting that one's own disposition and other internal factors affect one's spirituality rather than other people's. For example, a person's faith indirectly influences the functional (pertains to everyday activities) quality of life (Canada, Murphy, Fitchett, and Stein, 2015), but faith is a personal trait. Although some authors cite a strong correlation between high quality nurse-patient interaction and spirituality of institutionalized Older People (Haugan, 2013), the exact reason for the correlation is not identified. And despite these interactions, there is a discrepancy between how the patients assess themselves and how health providers assess their patients (Jacobs, 2009).

Despite the identified factors that directly affect quality of life being unmodifiable to a great extent, healthcare providers cannot underestimate their impact on the patients they care for because they are part of the environment the patients are in. One of the least satisfied aspects of quality of life among institutionalized Older People is the

environment, signaling the need for caregivers to focus on this as well (Moreira, Roriz, Mello, and Ramos, 2015).

Almeida-Brasil et al. (2017) noted that Older People who live in a community had lower quality of life (environment dimension) than those residing in an institution. Their study noted that Older people's environmental aspect of quality of life is lower due to social and health related factors. Nurses and other caregivers are primarily involved in this area of care, their role cannot be undervalued.

It is not appropriate to separate spiritual care from other forms of nursing (e.g., physical, social, and psychological) (Goldberg, 2002). It is part of their duty that they provide nursing care, regardless of their own spiritual care practices or level of spirituality.

Conclusions

The researchers conclude that the spiritual care rendered by caregivers has no direct relationship on the overall quality of life of Older People. Because quality of life is multi-factorial; other factors need to be analyzed as well.

The researchers recommend that future researchers use a mixed-method approach, specifically sequential explanatory design, to explain the lack of direct relationship between the spiritual care rendered by caregivers and the quality of life of Older People. This is because of the dearth of information on the connection between the two variables.

Spiritual Care is part of holistic nursing care and despite the absence of correlation between Spiritual Care Practices and overall quality of Life, nurses and caregivers cannot ignore the importance of Spiritual Care Practices.

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THAT IN ALL THINGS GOD MAY BE GLORIFIED

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