Association between Quality of Life and Spiritual Well-Being in Community Dwelling Elderly

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Abstract: Spiritual Well-Being is one of the influencing factors on quality of life. The current study has been carried out to assess the relationship between quality of life and Spiritual Well-Being among elderly living at homes. A descriptive - analytical study was conducted on 200 community dwelling elderly in north of Iran. Data was collected using Demographic, quality of life and Spiritual Well-Being questionnaires. The average quality of life and Spiritual Well-Being were 53.52± 19.38 and 94.40±14.03, respectively. The Pearson correlation coefficient showed a significant positive association between Spiritual Well-Being scores and quality of life of the elderly (P=0.003, r=0.21). In addition, all aspects of quality of life had significant relationship with the Spiritual Well-Being, except the physical functioning and general health domains. Therefore, it is crucial for health care providers to notice to the importance of spiritual aspects of life in elderly and attempt to improve it. However, further studies on the relationship between different aspects of quality of life and Spiritual Well-Being seem to be essential.

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Introduction

According to Hudson (1999), who declared that in 2000 the population of people over 60 would be 35 million people and noted that in 2030 this number would reach 21% of the total world population(Strydom, 2005). A census in the United State in 1998 predicted a 20 percent increase in people aged over 65years by 2050 AD(Bryant, Corbett, & Kutner, 2001). In England, it was estimated that by the year 2036, the population of people over 70 years old will be up to 10.9 million and 2.1 million people will be over 85 years old(Shin, Kim, & Kim, 2003). In addition, according to estimations, about the year 1410 in Iran, aging explosion phenomenon will occur and 20- 25% of population will be over aged 60 years(Foroughan, 2001).

Aging and the aging process is often associated with increase of chronic diseases and a wide range of complications, symptoms and harmful challenges for health status and welfare. It seems that inactivity and general weakness are parts of the aging process. Most of these difficulties lead to other problems such as social isolation, disability, functional loss, economic loss and depression(Easley & Schaller, 2003); this period of life is associated with chronic stress and increase of needs(Caldas & Bertero, 2007).

The results of a study revealed that as elderly spend the aging process, they experience loss of confidence, feeling of isolation, alienation, worthlessness, and progressive physical, mental, psycho- social and spiritual problems(Chung et al., 2008). Furthermore, researchers in a study expressed perception of insufficient income, low religiosity, Spiritual Well-Being, functional ability and loneliness are the barriers to manage the elderly stress and ultimately to achieve a successful aging and a good quality life (Traynor, 2005). Therefore, the above mentioned factors can lead to changes in various aspects of health and low Quality of Life (QOL) in the elderly.

Health, as defined by World Health Organization is composed of physical, mental, social and spiritual dimensions. Some authors believe that spiritual dimension of health is the most important one and requires serious attention. Some studies indicate that without Spiritual Well-Being, other biological

aspects of life such as psychological and social cannot act properly or may not reach to their maximum capacity and the highest level of QOL will not be accessible(Omidvari, 2008). QOL is a criterion for measuring of the best energy or force that makes a person tolerate challenging situations successfully(Jadidi, Farahaninia, Janmohammadi, & Haghani, 2011). In order to pass this period of life, elderly apply a series of problem-oriented and emotion-oriented strategies. One of these emotion-oriented coping strategies is attention to spirituality and Spiritual Well-Being (SWB). Thus, SWB is a result of using adaptive coping skills, which help the elderly to spend a good QOL in this period(Bagheri-Nesami, Rafii, & Oskouie, 2010).
According to the results of several studies, spirituality and practice of faith has been developed with the process of aging in the elderly (Ravanipour, Salehi, Taleghani, Abedi, Schuurmans et al., 2008; Roelofs, 1999; Shin et al., 2003; Tornstam & T¨ornqvist, 2000; Vaillant & Mukamal, 2001). Thus, trust in God and saying prayers is an emotion-oriented strategy used in the same direction of spirituality, helping elderly in coping with changes of aging process(Bagheri-Nesami et al., 2010). Based on findings of previous studies, aging provides more opportunities for attention to spirituality (Bagheri-Nesami et al., 2010; Habibi Sola, Nikpour, Sohbatzadeh, & Haghani, 2008; Ravanipour, Salehi, Taleghani, Abedi, Schuurmans et al., 2008; Roelofs, 1999; Shin et al., 2003). Furthermore, the results of some studies indicated a decrease of QOL in elderly as well (Habibi Sola et al., 2008; Heydari, Khani, & Shahhosseini, 2012; Jadidi et al., 2011; Jafarzade, Behnam Vashani, & Vahedian Shahroudi, 2010). Since one of the most important factors influencing QOL is SWB and limited available database about relationship between QOL and SWB in elderly, the current study aims to evaluate the relationship between QOL and Spiritual Well-Being in the elderly living at homes. We hope that the results of this study could provide teaching strategies to increase the SWB and improves the QOL of elderly to achieve a successful aging.

Material and methods

The current descriptive - analytical study was conducted on 200 communities dwelling elderly resident at homes in Sari, Iran. Initially, a list of elderly was provided by 20 health care centers in the city and stratified random sampling method was used. After obtaining the permission from the ethic committee of Mazandaran University of Medical Sciences and in coordination with each health care official authors and obtaining necessary licenses, based on the number of households, the researchers referred to homes of the elderly; after obtaining written consent from the participants, they completed the questionnaires. Those who were unwilling to participate in the study were excluded and the nearest household's number was selected to complete the questionnaires. Demographic information was recorded in a questionnaire. Short form questionnaire (SF-36) of QOL and SWB questionnaire designed by Ellison and Paloutzian has been used. SF36 is a standard short questionnaire, which is very suitable for the elderly living in the community(Haywood, Garratt, & Fitzpatrick, 2005). The SF36 is a questionnaire with 36 items, measuring eight multi-item variables including general health, physical functioning, role limitations due to physical problems, role limitations due to emotional problems, social functioning, pain, mental health and vitality. The scores were ranged from minimum score of 0 (worst possible health state) to the maximum of 100 (best possible health state). Likert scale (very high, high, moderate, modest and not at all) was used to measure the responses. In positive questions score 1 indicates an unfavorable condition and score five was an ideal condition. In negative questions, scoring system was reversed. Then all scores were summed. Validity and reliability of the questionnaire was confirmed. Validity was confirmed by known and Convergent groups and reliability by internal reliability and Cronbach's Alpha equal to 0.90-0.77 in all aspects of QOL, except for vitality, which was equal to 0.65(Montazeri, Goshtasebi, Vahdaninia, & Gandek, 2005). The SWB Scale, developed by Paloutzian and Ellison, measures religious well-being (RWB), which is the individual's beliefs and relationship with God, and existential well-being (EWB), being individual's sense of meaning and purpose in life. Each of these 2 subscales contains 10 items, individually measured on a 6-point Likert scale, ranging from "strongly agree" to "strongly disagree". The items are scored from 1 to 6, with 6 indicating a greater well-being. Possible SWB scores range from 20 to 120. The total scores can be classified as follows; Low spiritual well-being scores 20-40 and scores of 41-99 and 100-120 indicates moderate to high spiritual well-being, respectively. Ellison and Paloutzian reported Cronbach's alpha coefficient equal to 0.93 for the total scale. AllahBakhshian et al., has reported the alpha coefficient of 0.82 for the Farsi translated version of SWB scale and validity of the questionnaire was confirmed by content validity study(Allahbakhshian, Jaffarpour, Parvizy, & Haghani, 2010). Collected data were analyzed using SPSS 16 statistical software and descriptive statistics tests, ANOVA, T-independent, Pearson correlation coefficient and chi-square tests.

Results

Among 200 elderly participants, 61% were female. Sixty-six percent were married, 1.5% divorced, 1% single, and 31.5% were widowed. Fifteen percent

were literate, 36.5% illiterate, 22.5% primary education, 8.5% were in high school education levels and 5.5% had higher education level. In addition, 57.5% were retired, 8.5% worker, 4.5% businessman, 12% unemployed and 17.5% were employed.

The Mean of QOL was 53.52± 19.38. The mean and standard deviation of various aspects of QOL are presented in Table 1. The average of all dimensions of QOL expect general health and limitations to play an emotional role were more than 50. Social function and general health aspects of QOL had the highest and lowest average, respectively.

The Average of SWB score of elderly was 94.40±14.03. None of elderly had SWB scores lower than 20-40, but moderate SWB namely scored between 41 to 99 was seen in age groups; 60-64, 65-69, 70-74 and ≥75 years old and high SWB scored between 100 -120 observed in age groups; 60-64, 65-69, 70-74 and ≥75 years old are summarized in Table 2. There was no significant relationship between SWB in age groups, gender, education, marital status and occupation (P> 0.05). Mean of SWB of elderly based on all domains of QOL has been shown in Table 3. Pearson correlation coefficient has shown a significant association between SWB scores and total score of the elderly QOL (P=0.003, r=0.21). Except physical function and general health domains, Pearson correlation coefficient has shown significant association between other domains of QOL and SWB (Table 4).

Discussion

According to the results of the present study, the average QOL of elderly people in the community was moderate. Similarly, in another study conducted on 410 elderly in Iran, the QOL was expressed moderate using Short Form (SF12) questionnaire(Habibi Sola et al., 2008). In addition, the results of study performed on 1,920 Korean elderly showed that the QOL was at moderate levels(Orfila et al., 2006). However, the studies were reported lower QOL in elderly(Jafarzade et al., 2010). These differences could be due to differences in sample size.

In the current study, expect in the domains of general health and emotional role limitations, the elderly had average more than 50 in other aspects of QOL. In a similar study(Jafarzade et al., 2010) on 304 elderly patients with the standardized questionnaire SF-36, the lowest QOL was reported in general health domain (39.2±19.7). It seems that, low general health scores could be due to more development of chronic diseases and more involvement with conflicts of common stressors in the elderly. However, these factors can also affect other aspects of their QOL (Chen, 2003; Eliopoulos, 2010; Fiksenbaum, Greenglass, & Eaton, 2006; Proctor, Hasche, Morrow-Howell, Shumway, & Snell, 2008; Wadensten & Carlsson, 2003). The current study has found that among all domains of QOL, social functioning had the highest averages. Nevertheless, Jafarzade et al., reported the highest QOL to be related to vitality, power and energy (50.6±0.5)(Jafarzade et al., 2010). It seems that the higher social function domain is more related to cultural structure in northern Iran, which there is more social and family relationships among the peoples.

Similar to previous studies, the QOL of elderly in our study was significantly associated with gender(Jadidi et al., 2011; Orfila et al., 2006). In this regard, other studies showed that physical pain was significant difference between elderly men and women, as pain in women was reported to be more than men(Jafarzade et al., 2010; Ordu Gokkaya et al., 2011).

In the present study, the mean of SWB in elderly was 94.40± 14.03. None of the elderly had SWB lower than 20-40. Similarly, the results of another study showed that the average of SWB domain of elderly people in nursing homes was 96.26±17.93. Moreover, they have reported none of the elderly having lower SWB domain(Jadidi et al., 2011). This issue can be due to religiosity of Iranians that religion and spirituality play an important role in all stages of their life including aging. Several studies have also emphasized the role of spirituality in this period of life (Bryant et al., 2001; Easley & Schaller, 2003; Wadensten & Carlsson, 2003).

According to the results of a similar study(Jadidi et al., 2011), we found no significant relationship between SWB and other demographic variables such as gender, marital status, education and occupation, which could be due to the small sample size in both studies. Age range in elderly is one of these demographic variables, which does not have any relationship with SWB. However, the average of SWB in older age groups was higher, but the difference was not significant. The results of our study are supported by recent theories of aging known as Gerotranscendental theory that was initially expressed in 1994 by Tornstam. According to this theory, the term Gerotranscendental refers to changing in elderly view and a shift in meta-perspective, from a materialistic and rational view to a more cosmic and transcendent one. Gerotranscendental vision proposes transcend developmental dynamic perspective in elderly(Eliopoulos, 2010; Mauk, 2006). In contrast to materialist theory, this theory believes that people have less attention to material aspects of life by increasing age and become more interested to spirituality, meaningful life and more willing to communicate with others(Eliopoulos, 2010). According to this theory, all people are prone to be wise and mature and crises of life speeds the evolution of gerotranscendental. The Tornstam

theory has new insights related to aging changes. In this theory, cultural values, expectations and attitudes in community have been stated as facilitator or inhibitor agents in Gerotranscendental process. Tornstam has stated Western culture is one of these obstacles (Tornstam & T¨ornqvist, 2000; Wadensten & Carlsson, 2001).

In the current study, similar to other studies(Elizabeth Rippentrop, Altmaier, Chen, Found, & Keffala, 2005; Jadidi et al., 2011), there was a significant relationship between score of SWB and total scores of all domains of QOL of elderly. In addition, there was a significant relationship between SWB and all aspects of QOL expect for physical function and general health dimensions. In a similar study(Jadidi et al., 2011) with the exception of physical function and mental health, a significant association was reported between SWB and other aspects of QOL. However, the result of one study has shown that SWB is concerned with all aspects of quality of life(Johnson et al., 2007). Based on the results of a study, SWB can be an important indicator of QOL(Daaleman & Frey, 2004). Moreover, results of a study had indicated that spirituality help to an adaptive coping and preparation for the Hereafter in elderly. In addition, religion and prayers helps self-report and higher QOL including physical, psychological and social health(Williams, Keigher, & Williams, 2012).

Furthermore, another research finding has indicated that the three dimensions of physical, mental and spirituality are for healthy and successful ageing. They also reported that positive attitude and adaptive strategies are often used to compensate the physical injuries. In addition, in the former study, the elderly had much emphasis on psycho- social factors as a key element of successful aging, while had less emphasis on genetic factors, life expectancy, lack of disease, disability and employment(Reichstadt, Depp, Palinkas, Folsom, & Jeste, 2007). It seems that contrary to most of studies, this study has also emphasized the psychological health aspect of aging and mentioned it as an integrated part of successful aging and QOL. However, further studies on the relationship between QOL and SWB seem to be necessary.

Some studies have also shown that in addition to be a factor for integrating and meaningful life, spirituality and religion are expressed as a factor for mental and physical health, and the requisite of life satisfaction and successful ageing(Nagalingam, 2007). Paying attention to spirituality and religion are supporting and welfare factors for aging life continuity(McCann Mortimer, Ward, & Winefield, 2008). In addition, it was reported that religiosity decreases fear of death and future and makes geriatric accept death easier (Caldas & Bertero, 2007; McCann Mortimer et al., 2008). Another study has expressed spirituality is a supportive system and a power factor for elderly(Ravanipour, Salehi, Taleghani, Abedi, & Schuurmans, 2008). Similarly, the results of a qualitative study announced that one of coping methods used by African American older adults is relying on God(Loeb, 2006). Therefore, spirituality and spiritual health lead to better acceptance of challenges of life and improve the QOL.

In the present study, possessing of SWB in elderly and its relationship with QOL indicates that this component can improve QOL and is effective on coping with problems of aging period. Therefore, it is necessary for health care providers to consider \ the importance of the spiritual dimension of elderly life and try to promote it.

Conclusion

The findings of the current study added to the knowledge of gerontology. Presenting these findings to physicians, nurses, Policy makers, psychiatrics, psychologist and other health care providers help to these in elderly management. Comparsion of association between quality of life and Spiritual Well-Being in community dwelling elderly is needed through cross-cultural researches.

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References

Allahbakhshian, M., Jaffarpour, M., Parvizy, S., & Haghani, H. (2010). A Survey on relationship between spiritual wellbeing and quality of life in multiple sclerosis patients. *Zahedan Journal of Research in Medical Sciences*, *12*(3), 29-33.

Bagheri-Nesami, M., Rafii, F., & Oskouie, S. F. H. (2010). Coping strategies of Iranian elderly women: A qualitative study. *Educational Gerontology*, *36*(7), 573-591.

Bryant, L. L., Corbett, K. K., & Kutner, J. S. (2001). In their own words: a model of healthy aging. *Social science & medicine*, *53*(7), 927-941.

Caldas, C. P., & Bertero, C. M. (2007). Living as an oldest old in Rio de Janeiro: the lived experience told. *Nursing science quarterly*, *20*(4), 376-382.

Chen, Y. M. (2003). The Meaning of Health and Health Promotion Practices of Taiwanese Elders with Chronic Illness. *Care management journals 15*(6), 505-510.

Chung, Y. G., Kim, K. H., Choi, K. S., Kwon, H. J., Park, K. S., Choi, M. H., et al. (2008). Korean older adults' perceptions of the aging process. *Journal of gerontological nursing*, *34*(5), 36-44.

Daaleman, T. P., & Frey, B. B. (2004). The Spirituality Index of Well-Being: a new instrument for health-related quality-of-life research. *The Annals of Family Medicine, 2*(5), 499-503.
Easley, C., & Schaller, J. (2003). The experience of being old-old: life after 85. *Geriatric nursing 24*(5), 273-277.
Eliopoulos, C. (2010). *Gerontological nursing*. 7 th ed: Lippincott Williams & Wilkins pp. 14-20, 35-36.
Elizabeth Rippentrop, A., Altmaier, E. M., Chen, J. J., Found, E. M., & Keffala, V. J. (2005). The relationship between religion/spirituality and physical health, mental health, and pain in a chronic pain population. *Pain, 116*(3), 311-321.
Fiksenbaum, L. M., Greenglass, E. R., & Eaton, J. (2006). Perceived social support, hassles, and coping among the elderly. *Journal of applied gerontology, 25*(1), 17-30.
Foroughan, m. (2001). *Iran and the world's first congress on aging issues*. Tehran: ketab Ashena.
Habibi Sola, A., Nikpour, S., Sohbatzadeh, R., & Haghani, H. (2008). Quality Of Life in elderly people of west of Tehran. *Iranian Journal of Nursing Research, 2*(7), 29-35.
Haywood, K. L., Garratt, A. M., & Fitzpatrick, R. (2005). Quality of life in older people: a structured review of generic self-assessed health instruments. *Quality of life Research, 14*(7), 1651-1668.
Heydari, J., Khani, S., & Shahhosseini, Z. (2012). Health-related quality of life of elderly living in nursing home and homes in a district of Iran: Implications for policy makers. *Indian Journal of Science and Technology, 5*(5), 2782-2787.
Jadidi, A., Farahaninia, M., Janmohammadi, S., & Haghani, H. (2011). The Relationship between Spiritual Well-Being and Quality of Life among Elderly People Residing in Kahrizak Senior House. *Iran Journal of Nursing, 24*(72), 48-56.
Jafarzade, F. M., Behnam Vashani, H., & Vahedian Shahroudi, M. (2010). The quality of life of the elderly in Sabzevar, Iran. *Journal of Sabzevar University of medical sciences, 17*((3 (57)), 213-217.
Johnson, M. E., Piderman, K. M., Sloan, J. A., Huschka, M., Atherton, P. J., Hanson, J. M., et al. (2007). Measuring spiritual quality of life in patients with cancer. *J Support Oncol, 5*(9), 437-442.
Loeb, S. J. (2006). African American older adults coping with chronic health conditions. *Journal of transcultural nursing 17*(2), 139.
Mauk, K. L. (2006). *Gerontological nursing: competencies for care*: Jones & Bartlett Publishers.
McCann Mortimer, P., Ward, L., & Winefield, H. (2008). Successful ageing by whose definition? Views of older, spiritually affiliated women. *Australasian journal on ageing, 27*(4), 200-204.
Montazeri, A., Goshtasebi, A., Vahdaninia, M., & Gandek, B. (2005). The Short Form Health Survey (SF-36): translation and validation study of the Iranian version. *Quality of life Research, 14*(3), 875-882.
Nagalingam, J. (2007). Understanding successful aging: a study of older Indian adults in Singapore. *Care management journals 8*(1), 18-25.
Omidvari, S. (2008). Spiritual health, concepts and challenges. *Specialty Quran Interdisciplinary Res, 1*, 6-17.
Ordu Gokkaya, N. K., Gokce-Kutsal, Y., Borman, P., Ceceli, E., Dogan, A., Eyigor, S., et al. (2011). Pain and quality of life (QoL) in elderly: The Turkish experience. *Archives of Gerontology and Geriatrics*.
Orfila, F., Ferrer, M., Lamarca, R., Tebe, C., Domingo-Salvany, A., & Alonso, J. (2006). Gender differences in health-related quality of life among the elderly: the role of objective functional capacity and chronic conditions. *Social science & medicine, 63*(9), 2367-2380.
Proctor, E. K., Hasche, L., Morrow-Howell, N., Shumway, M., & Snell, G. (2008). Perceptions about competing psychosocial problems and treatment priorities among older adults with depression. *Psychiatric services 59*(6), 670-675.
Ravanipour, M., Salehi, S., Taleghani, F., Abedi, H. A., & Schuurmans, M. J. (2008). Power in Iranian Elders: Barriers and Facilitators. *Psychogeriatria polska, 5*(3), 114-121.
Ravanipour, M., Salehi, S., Taleghani, F., Abedi, H. A., Schuurmans, M. J., & de Jong, A. (2008). Sense of Power Among Older People in Iran. *Educational Gerontology, 34*(10), 923-938.
Reichstadt, J., Depp, C. A., Palinkas, L. A., Folsom, D. P., & Jeste, D. V. (2007). Building blocks of successful aging: a focus group study of older adults' perceived contributors to successful aging. *The American journal of geriatric psychiatry 15*(3), 194-201.
Roelofs, L. H. (1999). The meaning of leisure. *Journal of gerontological nursing, 25*(10), 32-39.
Shin, K. R., Kim, M. Y., & Kim, Y. H. (2003). Study on the lived experience of aging. *Nursing & health sciences, 5*(4), 245-252.
Strydom, H. (2005). Perceptions and attitudes towards aging in two culturally diverse groups of aged males: a South African experience. *Aging Male, 8*(2), 81-89.
Tornstam, L., & T¨ornqvist, M. (2000). Nursing Staff's Interpretations of "Gerotranscendental Behavior" in the Elderly. *Journal of Aging and Identity, 5*(1), 15-29.
Traynor, V. (2005). Understanding the lives of older women. *Nursing standard, 19*(44), 41-48.
Vaillant, G. E., & Mukamal, K. (2001). Successful Aging. *Am J Psychiatry, 158*(6), 839-847.
Wadensten, B., & Carlsson, M. (2001). A qualitative study of nursing staff members' interpretations of signs of gerotranscendence. *Journal of advanced nursing 36*(5), 635-642.

Wadensten, B., & Carlsson, M. (2003). Nursing theory views on how to support the process of ageing. *Journal of advanced nursing 42*(2), 118-124.
Williams, G. L., Keigher, S., & Williams, A. V. (2012). Spiritual Well-Being Among Older African Americans in a Midwestern City. *Journal of Religion and Health, 51*(2), 355-370.

Table 1: Mean±SD of all domains of quality of life

QOL Domains	PF	RP	RE	EF	MH	SF	BP	GH
Mean	51.62	48.50	57.70	47.27	52.18	66.75	56.10	48.07
SD	29.73	41.45	43.74	14.99	14.47	23.25	26.25	18.54

PF (Physical Function); RP (Physical Role); RE (Vitality); EF (Emotional Role); MH (Mental Health); SF (Social Functioning); BP (Bodily pain); GH (General Health)

Table 2: Mean±SD of spiritual well- being based on age groups

age groups	**SWB**	
	Mean	SD
60-64	91.73	13.67
65-70	96.28	14.88
71-75	93.08	13.49
>75	94.55	13.76
Total	94.40	14.03

Table 3: Mean±SD of spiritual well- being based on different domains of quality of life

QOL Domains	SWB	N	Mean	SD	t-test	P-value
PF	2.0*	123	49.91	29.16	1.02	.30
	3.00**	77	54.35	30.63		
RP	2.00	123	42.88	40.68	2.45	.01
	3.00	77	57.46	41.37		
RE	2.00	123	54.26	42.69	1.41	.16
	3.00	77	63.20	45.10		
EF	2.00	123	46.17	14.43	-1.30	.19
	3.00	77	49.02	15.79		
MH	2.00	123	50.76	13.08	1.75	.08
	3.00	77	54.44	16.28		
SF	2.00	123	62.19	24.03	3.60	.000
	3.00	77	74.02	20.04		.
PAIN	2.00	123	55.16	27.13	.63	.52
	3.00	77	57.59	24.87		
GH	2.00	123	47.03	18.26	1.0	.31
	3.00	77	49.74	18.98		

Table 4: The relationship between elderly spiritual well- being and different domains of quality of life

SWB	QOL Domains	PF	RP	RE	EF	MH	SF	BP	GH
r		.03	.16	.14	.15	.19	.29	.14	.13
P-Value Sig. (2-tailed)		.59	.02	.03	.02	.006	.000	.04	.06

PF (Physical Function); RP (physical Role); RE (Vitality); EF (emotional Role); MH (Mental health); SF (Social Functioning); BP (Bodily pain); GH (General Health)