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Quality of Life and Spiritual Well-Being in Geriatric Patients With Chronic Depression

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Background: Most people do not appreciate the aging period because of lack of knowledge or unknown backgrounds; therefore, they get affected by chronic mental disorders. Depression is one of the most predominant chronic mental disorders.

Objectives: In this study, we aimed to examine the relationship between quality of life (QOL) and spiritual well-being among geriatric retired employees of the oil industry in Khuzestan, Iran, who had chronic depression.

Patients and Methods: This was a cross-sectional study on 200 retired employees of the oil industry in Khuzestan, Iran, selected using simple random sampling technique. The variables were measured by three different standard questionnaires, including the QOL questionnaire (SF12), spiritual well-being scale (SWB), and depression scale (GDS).

Results: The mean age of the study group was 65 ± 4 years. Most of the patients had elementary or middle school level of education (44%). Hypertension was the predominant chronic disease associated with depression (37%). The mean QOL, spiritual well-being, and depression scores were 27.9 ± 6.4, 105 ± 13.8, and 4.2 ± 4.35, respectively. Spiritual well-being had a significant negative correlation with depression (P = 0.0001), indicating that the prevalence of chronic diseases such as depression decreased as spiritual well-being increased. There was also a significant negative correlation between the QOL and depression (P = 0.0001).

Conclusions: The results of our study showed that chronic depression disorder was significantly correlated with QOL and spiritual well-being of the elderly. To have healthy, independent, and happy geriatrics, it is important to consider such problems.

Keywords: Quality of Life; Depression; Geriatrics

1. Background

Aging is a critical period in human life; thus, focusing on its needs is a social necessity (1). The United Nations (UN) has announced that in 2008, there were approximately 688 million old people in the world, which will become 1.9 billion in 2050 (2). In the USA, 13% of the total populations were over 65 years old in 2000, predicted to increase by 21% in 2050 (2). According to the census from the Statistical Center of Iran (SCI) in 2006, the old population was reported 5.1 million (7.2% of the total population), predicted to rise to more than 25 million by 2050 (3). Aging is the period of facing the life challenges. Most of the old people have chronic diseases, which make their lives unmanageable, put their independence at risk, and decrease their health-related quality of life (QOL). Disability in old people is defined as a condition which limits their daily activities, necessitating others' helps and supports in at least one daily activity. Functional independence refers to active participation of the elderly in daily activities. Therefore, measuring the QOL and daily activities are effective methods in evaluating their functional independence. Many researchers have described aging as the greatest neglected natural phenomenon. Changes in physical appearance and functions of elderly people often lead the society to forget that older generations are not isolated from the community (4). QOL is recognizing one's position in life, in terms of culture, value systems, goals, expectations, standards, and priorities; thus, it is an individual matter, which is based on various aspects in life (5). In recent studies, QOL has been measured in two ways: first the objective indicators, which are measurable social and economic indicators, reflecting the human needs. These indicators are observed by reviewing the reports and statistics and indicate the status of visual and tangible life. The second method includes subjective indicators, used to observe the satisfaction levels of individuals and groups, called subjective well-being. These indicators are based on reports of personal perceptions on various aspects of life, as complements to social, economic, and environmental variables. These indicators display the perceptions and evaluations of individuals from the objective status of their lives (6).

One of the issues affecting QOL, especially among the elderly, is health or well-being. As defined by the World Health Organization (WHO), health and well-being have

various aspects, including physical, psychological, social and spiritual. Spiritual well-being is the mental aspect of health with two dimensions: vertical and horizontal. The vertical dimension reflects the relationship with God, which can be referred to as existential or religious well-being and horizontal dimension involves communication with others as well as the environment. There are many different scales to measure spiritual well-being; Palutzian and Ellison scale is one of these tools (7). In this scale, both horizontal and vertical scales are considered. Achieving higher scores indicates more spiritual well-being. Some studies indicated that without spiritual well-being, other biological, psychological and social aspects do not function properly or do not reach their maximum capacity; thus, the highest QOL will not be available (8).

Some experts believe that it is necessary to pay more attention to this aspect. Unfortunately, often misunderstood in today's society, physical and psychological needs of the elderly are of low priority and not much attention is given to their psychological and spiritual needs. One of the psychological issues at this stage of life is chronic diseases such as depression, a common, increasing cause of disability in the elderly (7). Due to an aging population in Iran, depression has dramatically decreased the QOL and caused complications such as isolation and avoidance of social activities in the community. Depression affects health of the elder people as well as their families; therefore, it is a social challenge (9).

2. Objectives

In this study, we aimed to examine the relationship between QOL and spiritual well-being in geriatric patients with chronic depression among retired employees of the oil industry in Khuzestan, Iran. We found that no other study had evaluated the three factors together. This study was conducted to address this deficiency.

3. Patients and Methods

3.1. Study Design and Population

This was a cross-sectional study on 200 retired employees from the oil industry in Khuzestan, Iran, selected using simple random sampling technique. The study was approved by the Ethics Committee of the Islamic Azad University, Education and Research, Khuzestan Branch and all the participants signed the informed consents before the study. Inclusion criteria were patients over 60 years old, having no risk of cognitive disorders or schizophrenia, and willing to cooperate. Exclusion criteria were patients with schizophrenia or dementia, and stroke dysarthria.

3.2. Measuring Tools

The variables were measured by three different standard questionnaires, including the QOL questionnaire (SF12), spiritual well-being scale (SWB), and depression scale (GDS).

3.2.1. The QOL Questionnaire

This is a 12-item questionnaire on the overall perception of health (item 1), physical function (items 2 and 3), physical health (items 4 and 5), emotional problems (items 6 and 7), physical pain (item 8), social functioning (item 9), vitality and life energy (item 11), and mental health (items 10 and 12). Validities of the instruments used in this study were determined by content validity and test-retest method was used to determine the reliability (r = 0.90) (5). The participants were divided into three groups of poor, medium, and good QOL, based on the scores obtained in the questionnaires. The scores of 37-48 indicated good, 25-36 moderate, and 12-24 poor QOL (6).

3.2.2. Spiritual Well-Being Scale

Spiritual well-being scale (SWB) is comprised of 20 questions, first introduced by Palutzian and Ellison in 1982, in which 10 questions are about religious beliefs and other 10 items measure the individual's well-being. Spiritual well-being is the sum of these two groups of questionnaires and ranges from 20 to 120. Answers to these questions are classified from completely disagree to strongly agree. The spiritual well-being is classified into three levels, including low (20-40), medium (41-99), and high (100-120). Terms with odd numbers, even numbers, health, and religious expressions, were measured. The reliability of this questionnaire had been previously validated in Iran (10).

3.2.3. Depression Scale

Geriatric depression scale (GDS) was first introduced by Yesavage. A short-form 15-item GDS questionnaire was constructed in 1986 with 90% sensitivity and 80% specificity for diagnosis of depression in hospitalized patients (11). The subjects belong to three groups, including moderate depression (5-10), severe depression (10-15), and healthy volunteers (12).

3.3. Methods

Necessary permits were obtained from the authorities. The participants were comprehensively justified to reduce their sensitivity to the selection criteria and the propose of the research and how to complete the questionnaires was described for them. The participants were asked to complete the questionnaires and the researcher expressed clarification if they faced ambiguity. The subjects were acknowledged at the end of the study.

3.4. Statistical Analysis

Descriptive statistics tests such as frequency, percentage, mean, standard deviation, Pearson correlation, multiple regression, analysis of variance (ANOVA), Scheffe's

test and LSD, and the bisection method to compute Cronbach's alpha reliability coefficient were performed. Data were analyzed using SPSS 18.0. P Values less than 0.05 were considered significant. The study was approved by the Committee on Petroleum Research Hospital.

4. Results

The age group of 61-65 was the most frequent, comprising 46.5% of the participants, and the least common groups were 71-75 and 76-80 with of 5% frequency. The mean ± SD of age was 64.72 ± 4.92 years. Most of the patients had elementary or middle school level of education (44%). The lowest frequency belonged to master degree which accounted for about 1.5% of the participants. Healthy geriatrics had the highest frequency of about 37% and hypertension was the predominant chronic disease associated with depression. The correlation between QOL and depression was negative and significant (P = 0.0001, r = -0.51) (Table 1). The relationship between spiritual well-being and depression was also significant and negative (P = 0.0001, r = -0.51) (Table 1).

Table 1. The Correlation of Quality of Life and Spiritual Well-Being With Depression (n = 200) [a]

Variables	Depression	
	CC (r)	P Value
QOL	-0.51	0.0001
Physical aspect of QOL	-0.43	0.0001
Mental aspect of QOL	-0.49	0.0001
Spiritual well-being	-0.51	0.0001

[a] Abbreviations: CC, correlation coefficient; QOL, quality of life.

5. Discussion

The present study examined the relationship between spiritual well-being, QOL and depression, and showed that chronic depression was significantly correlated with QOL and spiritual well-being of the elderly. The study also showed that if the geriatrics' QOL improves in physical and mental dimensions, their prevalence or severity of depression reduces and vice versa; hence, neglecting and failure to improving the QOL of the elderly could result in an increased depression rate. Aslankhani et al. showed that an increase in physical activity and exercising enhanced the QOL, promoted positive personal characteristics and social acceptance, and decreased depression in this age (group 13) (13). Another study also showed that among the factors affecting the QOL in the elderly, higher community participation and improved mood (depression) had high influence on the QOL and the depressed geriatrics had lower QOL scores (14). King et al. reported that physical activity and exercise improved physical health, prevented mental disorders including psychosis, depression, and anxiety, and enhanced the QOL in the elderly (10). Moreover, Eyigor et al. indicated the presence of mild depression in the elderly with physical activity and exercise (16). The results of their study also confirmed the cumulative effect of spiritual well-being on decreasing the elderly's depression. Motamedi et al. claimed that spirituality and religion were useful as social tools and sources of effective functioning, especially in the elderly. They stated that spirituality was effective in coping with depression and mental disorders (14).

Manzouri et al. reported that due to the high prevalence of depression in the elderly and the role of seclusion as an inducer, interventions such as training and early detection of depression can increase the QOL; thus, cultural or spiritual awareness are necessary (15). McFarland reported that religious involvement had higher impact on men's mental health than on women. Women with higher levels of organizational religious involvements showed similar levels of mental health as those with moderate and lower levels, and men with much higher levels of organizational religious involvements tended to have much higher levels of mental health than the others (17). Fry reported that there were significant relationships between spiritual well-being and higher protection against physical and mental conditions, as well as between spirituality, religious involvements, and mental health of elderly people (18). The results of these studies were in agreement with our findings.

There are multiple relationships between components of spiritual well-being (religious and existential) with geriatric depression. Spiritual well-being in terms of an existential variable can be negative and have significant prediction of depression in older adults. Jadidi et al. examined the relationship of spiritual well-being with QOL and showed a significant correlation between them (6). Hosseini et al. reported a significant correlation between QOL and depression in geriatrics. According to the results of these two studies, there are significant correlations among the three factors of QOL, spiritual well-being, and depression in the elderly (9). Fehring et al. examined the relationships between spiritual well-being, religiosity, hope, depression, and mood in the elderly and concluded that built-on religion had a positive relationship with spiritual well-being, mental and emotional states and intrinsic religion had a negative correlation with depression and negative mood (19). McKee et al. studied the relationship between social support, QOL and depression, and found that social support and QOL were negatively correlated with depression and positively associated with mental health (20). The results of these studies were consistent with our findings.

We found that spiritual well-being was significantly related to the QOL. However, it was also revealed that QOL (physical and mental aspects) could be a significant negative predictor of depression. Therefore, providing appropriate strategies to enhance spiritual well-being is suggested. Physical health and spiritual well-being variables can be negative and significant predictors of the geriat-

rics depression. Therefore, education about depression and recovery is required, especially at this stage.

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Authors' Contributions

Izadmehr Azadeh: Study conception and design, acquisition of data; Naderi Farah: Analysis and interpretation of data; Enayati Mirsalahadin: Drafting the manuscript.

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