Orginal article

Relationship between spiritual well-being and quality of life in hemodialysis patients

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Abstract

Background and Purpose: Spiritual health is one of the important aspects of health status that may be influenced by QOL. Researchers have shown the relationship between spiritual well-being & a person's general health, so that religion and spirituality are considered the important resources for coping with stressful life events. This study aims to identify the relationship between spiritual well-being and quality of life in hemodialysis patients.

Method: In this descriptive analytical study, 72 hemodialysis patients were selected using convenience sampling method. Information was collected by Paloutzian spiritual health and quality of life questionnaires (SF36). Data were analyzed by using descriptive and analytical statistics (Pearson correlation coefficient, t-test, ANOVA).

Results: In line with these findings, the quality of life of the patients (47.8) 88.47 and their spiritual health scores (21.13) 88/91, most were moderate.There was no significant relationship between spiritual well-being and QOL. But there was a significant positive correlation between spiritual existential aspect of well-being and the dimensions of fatigue (P=0.02, r=0.26), emotional health (P=0.003, r=0.34), social functioning (P=0.01, r=0.29) and general health (P=0.01, r=0.29) and social performance (P=0.01, r=0.27). Also social performance had a significant positive correlation with spiritual well-being.

Conclusion: According to the results, a significant relationship was observed between some aspects of quality of life and spiritual well-being. In order to understand the factors affecting the quality of life, exploring strategies to improve it and strengthen some aspects of spiritual well-being that affect the quality of life in hemodialysis patients is emphasized.

Keywords: Hemodialysis, Quality of life, Spiritual well-being

Introduction

Chronic Renal Failure (CRF) is among the diseases affecting a person's quality of life and defined as a progressive and irreversible impairment of renal function (1). Today, two to three percent of the world population suffers from CRF (2). Hemodialysis is the most common way to treat this disease in Iran and many other countries. Based on the Information System of the United States, about %90 of patients with CRF undergo hemodialysis and in about %92 of dialysis patients, this treatment process is preferred (3). There are more than 13,000 patients on dialysis in Iran and each month, 150,000 hemodialysis sessions are held (4).

Although hemodialysis increases the longevity of renal patients, the disease influences their lives and, in advanced stages, causes impaired functional status and changes their quality of life (5). These disease future. They often lose their jobs and run

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into financial problems and are always depressed and stressed due to their chronic illness and the fear of death (6).

Spirituality occasionally interpreted as spiritual well-being (7) is viewed as the awareness of the universe or a force beyond the material aspects of life that creates a profound sense of unity or a tie to the cosmos (8). Spiritual well-being has two dimensions. The vertical dimension that involves metaphysical communication and the horizontal dimension that includes communication with the environment and others. Some studies suggest that without spiritual well-being, the other biological, psychological and social dimensions cannot function properly, or do not reach their maximum capacity and therefore, the highest quality of life won't be achieve (9). Research in recent years has widely taken this issue into consideration that how religion and spirituality affect different aspects of mental and physical well-being. Some researchers have noted that spirituality is inextricably linked with the overall well-being of an individual (10). It enhances the patient's ability to cope with a disease and accelerates recovery (11). Debilitating and chronic diseases cause individuals get into challenges on meaning and objective in life (12). Moreover, during the last twenty years, spirituality has been emphasized in relation to quality of life process (13). Many studies identify the relationship between spirituality and physical and mental well-being as well as promoting compatibility with illness (13). The results of a study by Litwinczuk et al. (2007) on AIDS afflicted patients revealed that those patients not finding their meaning of lives based on spirituality had better quality of life compared with the diagnosis time (14). McNulty et al. (2004) also studied patients with Multiple Sclerosis (MS) and found out that faith and spiritual beliefs were beneficial in coping with the disease (15). The quality of life of the people with chronic illness depends on individuals' compatibility skills in different situations of life and what they have already learned about self-control. Thus their responses in coping with various life circumstances are different and physical illness is among the situations which affect these responses (16).

Since promoting the quality of life as a broad concept is recently considered to be of prime importance (17) and considering the role of spiritual well-being of patients, especially those with chronic diseases, it seems that assessing the quality of life among dialysis patients and investigating the influencing dimensions and factors, including the concept of spirituality and spiritual well-being as the dimensions on which less attention has been paid to, can present valuable information to provide care for this group of the patients. Regarding such studies being limited in Iran, the present study aims to determine the relationship between spiritual well-being and quality of life in the patients treated with hemodialysis.

Materials and Methods

The present analytical-descriptive research pursues the goal to investigate the relationship between spiritual well-being and quality of life in hemodialysis patients undergoing dialysis in Imam Hossein Hospital wards in Shahroud.

Sampling in this study was conducted based on census sampling method and inclusion criteria. The inclusion criteria encompassed hemodialysis patients receiving treatment for at least 6 months and with the ability to communicate to answer the questions, and willing to participate in the study. The study population involved 102 patients treated with dialysis at Imam Hossein hospital. 28 patients were excluded due to a very high or low age and a lack of ability to communicate the responses to the questionnaires. Furthermore, 22 patients expressed reluctance and did not participate in the study. Finally 72 patients were examined.

patients are worried about their unpredictable Data collection instruments included a demographic/personal and social information form, a quality of life questionnaire (18) and a

standardized 20-item questionnaire on spiritual well-being (19). The demographic/personal and social form included age, gender, education level, marital status, employment status, the number of family members living together, and the time period since the diagnosis. The36-Item Short Form Quality of Life Questionnaire (SF36) is to assess the quality of life. This questionnaire consists of statements in the following subscales: physical function, physicalrole, physical pain, general health, vitality, social performance, emotional role, and mental health. The maximum score for each section or subscale is 100 and the minimum score is zero. Higher scores indicate better quality of life. Different levels of quality of life (18, 20) have been considered as: desirable (71-100), somewhat desirable (31-70) and undesirable (0-30). In Iran, the validity of the questionnaire has been confirmed using "Comparison of Known Groups" method and "Convergent validity". The reliability of the questionnaire has been examined in Montazeri et al. (2005) using statistical analysis of "Internal consistency" and reported as 0.9 (20). Spiritual well-being was evaluated using Paloutzian and Ellison's 20-Item Spiritual Well-being Scale (SWBS). This test consists of 20 questions of which 10 questions measure religious well-being and the other 10 questions measure existential well-being. These items are scored based on six-point Likert scale. Scores are from 1 to 6 as: strongly disagree-disagree-slightly agree-agree-strongly agree. In addition, 9 items have been scored in reverse. These 20 items generally measure the underlying philosophy of life, having purpose and meaning in life, as well as love and forgiveness. Existential well-being deals with having life satisfaction and purpose and religious well-being deals with being satisfied because of a relationship with a supreme power or God. The overall score of spiritual well-being has been divided into three levels: High (100-120), Moderate (41-99) and Low (20-40) (19). SeyedFatemi, et al. (2006) confirmed the validity of spiritual well-being questionnaire through content validity. They also determined the reliability through alpha-Cronbach' reliability coefficient obtained as 0.82. In order to collect data, researchers first got the permission from university officials and then went to Imam Hossein Hospital in Shahroud. Researchers then selected the subjects and provided them with adequate explanation about the study objectives. Researchers finally asked these participants to complete the questionnaires. Data were collected over a period of two months and analyzed with SPSS 16 using descriptive statistics (mean, standard deviation) and inferential statistics (Pearson correlation coefficient, t-test, ANOVA).

Results

In this study, 72 patients treated with hemodialysis were studied. Demographic characteristics of these patients are presented in Table 1.

The quality of life score for the majority of the patients (86%) with a mean of 47.88 (8.47) was moderate. A statistically significant correlation was observed between the patients' age (mean=47.51), and their quality of life ($P<0.02$), but there was no statistically significant correlation between the other demographic variables (gender, marital status, monthly income, education, the disease duration) in the patients and their quality of life. ANOVA results gave a significant difference between employment status and the quality of life in the patients ($P<0.02$). This resulted from the difference between the two retired and self-employed groups. In addition, there was a significant difference between the patients' education level and the quality of life ($P<0.02$). This difference was observed between the patients with diploma, literate patients, and illiterate ones (Table 1).

The results revealed that spiritual well-being of most patients (68.1%) with a mean of 91.88 (13.21) was moderate. There was no significant correlation between the demographic variables & the mean score of their spiritual well-being (Table 1).

Results suggested that significant correlation existed between the overall score of spiritual well-being

and quality of life of the patients (P<0.41). A significant positive correlation was seen between the mean score of the patients' social performance of and their spiritual well-being (P<0.01) so that with an improvement in social performance score, the spiritual well-being was boosted, too (Table 2). Studying the relationship between the quality of life dimensions and spiritual well-being, the results indicated a significant positive correlation between the existential well-being dimension and exhaustion, emotional health, social performance and general health dimensions, so that increasing the score of the patients' existential well-being led to the mean score of the aforementioned dimensions increase, too. But no significant correlation was observed between religious well-being dimension and quality of life dimensions (Table 2).

Table 1. Demographic characteristics and its Correlation with quality of Life and spiritual well-being among hemodialysis patients in Imam Hossein Hospital of Shahroud.

	Demographic Characteristics	Frequency (percent)	QOL MEAN (SD)	Spiritual Wellbeing MEAN (SD)
Gender	Female	34 (47.2)	47.51 (10.41)	92.80 (13.16)
	Male	38(52.8)	48.22 (6.39)	91.06 (13.38)
Age (year)	< 20	3 (4.2)	* 51.20 (3.20)	92.07(64.31)
	20-40	20 (27.8)	51.68 (9.30)	93.84 (10.45)
	40-60	22 (30.6)	46.80 (7.89)	89.64 (10.58)
	>60	27 (37.5)	45.58 (7.95)	92.23(14.90)
Education Level	Illiterate	19 (26.4)	*45/07 (6/20)	89/88 (14/28)
	literate	25 (34.7)	49/78 (9/24)	91/66 (14/42)
	High school	13 (18.1)	47/82 (10/06)	94/45 (3\/06)
	diploma	13 (18.1)	48/69 (8.06)	92.82 (10/87)
	Higher education	2 (2.8)	46/13 (10/41)	90/85 (9/69)
Marital Status	Single	8 (11.1)	51/58 (4/85)	91/36 (17/28)
	Married	54 (75)	47/38 (8.21)	90/63 (12/58)
	Divorced/Dead	10 (13.9)	47/63 (11/75)	99/03 (12/12)
Monthly income	Sufficient	7 (10.1)	46/05 (3/78)	97/28 (13/37)
	Somewhat adequate	17 (24.6)	47/29 (12/17)	93/63 (12/21)
	Inadequate	45 (65.2)	48/58 (7/55)	90/49 (13/71)
Duration of illness (year)	< 1	10 (14.9)	49.55 (8.17)	95.07 (13.42)
	1-5	30 (44/8)	45.43 (10.25)	94.77 (11.95)
	6-10	13 (19/4)	47.80 (5.87)	91.70 (12.09)
	>10	14 (20.9)	5.60 (5.59)	85.26 (15.85)
Employment Status	Self-employed	7 (9.7)	*48.66 (7.75)	90.61 (11.15)
	Unemployed	13 (18.1)	47.71 (8.51)	90.68 (9.81)
	Housekeeper	28 (38.9)	46.87 (10.70)	94.51 (11.78)
	Student	3 (4.2)	51.20 (3.20)	92.07 (31.64)
	Retired	16 (22.2)	*47.88 (5.75)	90.48 (15.89)
	Employee	5 (9.6)	50.95(6.11)	86.46 (11.77)

Table 2. Examining the correlation between the dimensions & overall score of quality of life and spiritual well-being of Hemodialysis patients in Imam Hossein Hospital of Shahroud.

Spiritual Well – being Dimensions / Quality of life Dimensions	Correlation Test Results	Correlation Test Results	Correlation Test Results
	Religious well-being	Existential well-being	Total score of spiritual well-being
	P valuer	P valuer	P valuer
Physical function	0.60 - 0.06	0.88 - 0.01	0.72 - 0.04
Physical role	0.90 0.01	0.09 0.19	0.31 0.12
Emotional role	0.45 - 0.08	0.72 - 0.04	0.56 - 0.06
Fatigue	0.45 - 0.09	* 0.02 0.26	0.42 0.09
Mental health	0.54 - 0.07	*0.003 0.34	0.19 0.15
Social performance	0.15 - 0.16	*0.01 0.29	*0.01 0.27
Pain	0.74 - 0.04	0.76 - 0.03	0.88 0.01
General health	0.62 0.05	*0.01 0.29	0.07 0.21

Discussion

This study results displayed a moderate level of quality of life in most patients. In a study conducted by SeyedFatemi, et al. (2006) on quality of life in hemodialysis patients in the hospitals of Mashhad University of Medical Sciences (21) as well as the study by Zeraati et al. (2011) on the patients undergoing hemodialysis in Imam Reza hospital in Mashhad, the majority of the patients had a relatively good quality of life (22). Theofilou (2011) and Feroze et al. (2011) reported a low quality of life among dialysis patients in their studies (23, 24). Their results also indicated a significant correlation between age and quality of life. In general, as age goes up, the risk of late life diseases and the incidence of disability increase, too (25). Besides, chronic renal failure and therapeutic procedures such as Hemodialysis result in a change in the lifestyle and the health status of the individuals. This issue not only endangers the physical health but also other health dimensions. All these factors affect the patient's quality of life (18). There was also a significant difference between the patients'

employment status and education level with their quality of life so that a higher quality of life existed in self-employed patients compared to the retired ones. It seems that the differences in income level and better economic situation of a self-employed individual as well as his/her employment and his/her presence in society and creating positive interactions can all affect the individual's life. Employment which provides social capital will have a positive impact on quality of life (26). Mokhtari et al. (2003) in their study also observed a correlation between employment and quality of life (27). Bayoumi et al. (2013) reported education level and employment status as the influencing variables affecting the dialysis patients' quality of life so that lower levels of education and unemployment triggered lower quality of life (28). Results from various studies indicate that the patients with similar clinical conditions typically report different quality of life. Schoffer believes that stressful events do not equally affect individuals and these various effects depend on the individuals' personality traits and their assessment of these events and factors. In relation to the factors influencing cognitive response, Laske proposes factors such as life stages, age, and prior mental performance of patient during their social adjustment with problems, cultural and religious attitudes, social support of their personality and self-confidence. Individuals who have more facilitating factors such as flexibility, social and family support become compatible with their disease faster and their quality of life is less affected by the disease (29).

Data represented a moderate level of spiritual well-being in the patients. Sharifinia et al. (2011) report on the patients treated with hemodialysis (30), Allahbakhshian et al. (2009) report on MS patients, and Bredle et al. (2011) report on the patients with chronic diseases all suggested moderate levels of spiritual well-being (19, 31). The results of Habibi's study (2011) showed that most patients with cancer had a moderate level of spiritual well-being (32). Further research studying spiritual well-being and quality of life in hemodialysis patients was not found in other societies. Probably the patients with chronic diseases experience stressful mental and social changes such as existential conflicts associated with the meaning and purpose of life (33). The disease suffering and pain mostly challenges the meaning and purpose of life (34).

The results of this study demonstrated that there was no significant correlation between the overall score of spiritual well-being and quality of life whereas Hemmti et al. (2004) reported a moderate correlation between quality of life and spiritual well-being in the patients with cancer (35). Moreover, Jadidi et al. (2011) found a significant correlation between spiritual well-being of the aged and their quality of life (36). In addition, Finkelestine (2007) observed a direct and significant relationship between spiritual well-being and quality of life in the patients with renal failure (37). This relationship could be explained in such a manner that the researchers have consensus on three characteristics of quality of life. These features are: 1. being multidimensional including physical, mental-emotional, social, spiritual, and disease symptom dimensions 2. subjectivity and 3. being dynamic. Lack of correlation, thus, may reflect the influence of the other factors on the study patients quality of life .Studies also revealed that seeking religious compatibility and support is not equally applied in different societies and cultural and personal values are involved (38). Furthermore, the small sample size could be 'influencing' in the present study.

Investigating the quality of life dimensions and spiritual well-being, a significant positive correlation was observed between the following dimensions: 1. spiritual well-being and social performance domain; 2. existential well-being and fatigue, emotional health, social performance and general health, and 3. social performance and spiritual well-being.

The study of Allah-bakhshian et al. (2010) on the relationship between spiritual well-being and

quality of life in MS patients disclosed a significant correlation between spiritual well-being in the religious dimensions and quality of life in mental dimension. A meaningful correlation was also observed between the existential dimension and quality of life in both physical and mental dimensions. The important factors resulting in poor quality of life in these patients include: stressful environment in hemodialysis process, problems and difficulties in providing and presenting good health-care services, transportation costs and time-consuming process of commuting between house and hospital and wasting time in dialysis unit, repeated visits per week for dialysis, and being still during dialysis (19). Engaging the patient in therapeutic process, which takes several hours and incapacitates the patient to do other things, disrupts the patient's emotional health and social performance. In this study, two standard questionnaires were used to assess the quality of life and spiritual well-being variables regarded as the remarkable advantage of this study. Among the limitations of this study were non-random sampling, sample loss due to the fact that some participants lacked inclusion criteria for the study (high or low age and inability to communicate the response to the questionnaire), and also some patients being unwilling to participate in the study, which all may reduce the generalizability of the results.

Conclusion

There was a significant positive correlation in some dimensions of quality of life with spiritual well-being. So nursing interventions to increase the patients' spiritual well-being can improve their quality of life. Since this study applied convenience sampling and the population included only the patients undergoing dialysis in dialysis ward of Imam Hussein Hospital in Shahroud, conducting similar studies using random sampling in other dialysis wards (different hospitals) and other chronic disease centers is recommended. Now people are demanding improvements in quality of life and hence governments around the world are paying attention to this issue. Governments admit that an increase in people's standard of living is not sufficient for their satisfaction and happiness, then their quality of life should also be enhanced. Therefore, focusing attention to chronic diseases is of special importance.

Conflict of interest

No conflict of interest has been expressed by the authors.

Author's contributions

H. Ebrahimi and Z. Ashrafi designed the study, carried out data analysis and wrote the paper, and Gh. Eslampanah and F. Noruzpur were in charge of gathering data.

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References

1. Smeltzer S, Bare B, Hinkle J, Cheever K, editors. Brunner & Suddarth Textbook of Medical Surgical Nursing. Philadelphia: Lippincott Williams& Wilkins; 2008.
2. Narimani M, RafighIrani S. The relationship between methods of coping and mental health in patients treated with hemodialysis. Princ Ment Health. 2008; 2(38): 117-22 (Persian).
3. Jablonski A. The multidimensional characteristics of symptoms reported by patient on hemodialysis. Nephrol Nurs. 2007; 34(1): 29-38.
4. Rambod M, Rafii F, Hosseini F. Quality of life in patients with end stage renal disease. Hayat. 2008; 14(2): 51-61 (Persian).
5. Rambod M, Rafiee F, Hosseini F. Evaluated the quality of life in patients with chronic renal failure. Life Magazine. 2009; 14(2): 51-61.

6. Browner S. Surgical nursing kidney disease. Tehran: Salemi Publication; 2008.
7. Balboni T, Vanderwerker L, Block S, Paulk M, Lathan C, Peteet J, et al. Religiousness and spiritual support among advanced cancer patients and associations with end-of-life treatment preferences and quality of life. J Clin Oncol. 2007; 25(5): 555-60.
8. Mueller P, Plevak D, Rummans T. Religious involvement, spirituality, and medicine: implications for clinical practice. Mayo Clin Proc. 2001; 76(12): 1225-35.
9. Omidvari S. Spiritual health; concepts and challenges. QuranicInterdiscip Stud J Iranian Student's Quranic Organiz. 2009; 1(1): 5-17.
10. Cheraghi M, Molavi H. The relationship between different aspects of religious and public health at University of Isfahan. JNEA. 2006; 2(2): 1-22.
11. Potter P, Perry A, editors. Basic Nursing. St Louis: Mosby Company; 2003.
12. Mauk K, Scnemidt N. Spirituality care in nursing practice. Philadelphia: Lippincott Company; 2004.
13. Johonson C. Assessment tools: Are they anaffective approach to implementing spiritual health care within the NHS? Accid Emerg Nurs. 2001; 9(3): 177-86.
14. Litwinczuk KM, Groh CJ. The relationship between spirituality, purpose in life, and well-being in HIV-positive persons. J Assoc Nurses AIDS Care . 2007; 18(3): 13-22.
15. McNulty K, Livneh H, Wilson LM. Perceived Uncertainty, Spiritual Well-Being, and Psychosocial Adaptation in Individuals with Multiple Sclerosis. Rehabil Psychol. 2004; 49(2): 91-9.
16. Ogutmen B, Yildirim A, Sever MS, Bozfakioglu S, Ataman R, Erek E, et al. Health-related quality of life after kidney transplantation in comparison intermittent hemodialysis, peritoneal dialysis, and normal controls Transplant Proc. 2006; 38(2): 419-21.
17. Jabalameli S, Neshat doost H, Moulavi H. Efficacy of cognitive-behavioral stress management intervention on quality of life and blood pressure in female patients with hypertension. Sci J Kurdistan Univ Med Sci. 2010; 15(2): 88-97.
18. Harirchi A, Rasooli A, Montazeri A. Comparison quality of life in hemodialysis patients and kidney transplanting patients. Payesh J. 2004; 3(2):117-21.
19. Allahbakhshian M, Jaffarpour M, Parvizy S, Haghani H. A Survey on relationship between spiritual wellbeing and quality of life in multiple sclerosis patients. Zahedan J Res Med Sci. 2010; 12(3): 29-33.
20. Montazeri A, Goshtasebi A, Vahdaninia M, Gandek B. The Short Form Health Survey (SF-36): translation and validation study of the Iranian version. Qual Life Res. 2005; 14(3): 875-82.
21. Seyedfatemi N, Rezai M, Givari A, Agha Hosseini F. Prayer and its relation to the spiritual health of patients with cancer. Payesh. 2006; 5(4): 295-304.
22. Zeraati AA, Naghibi M, Ojahedi MJ, Ahmad Zadeh S, HasanZamani B. Comparison of Quality of Life between Hemodialysis and Peritoneal Dialysis Patients in Imam Reza and Ghaem Hospital Dialysis Centers in Mashhad. Med J Mashad Univ Med Sci. 2010; 53(3): 169- 75.
23. Theofilou P. Quality of life in patients undergoing hemodialysis or peritoneal dialysis treatment. J Clin Med Res. 2011; 3(3): 132-8.
24. Feroze U, Noori N, Kovesdy CP, Molnar MZ, Martin DJ, Reina-Patton A, et al. Quality-of-life and mortality in hemodialysis patients: roles of race and nutritional status. Clin J Am Soc Nephrol. 2011; 6(5): 1100-11.
25. Alipoor F, Sajjadi M, Amina F, Biglaryan A, Jalilian A. District 2 of Tehran elderly quality of life. Salmand. 2009; 3(9, 10): 75-83 (Persian).
26. Javaheri f, Serajzadeh SH, Rahmani r. Analysis of the effects of women's employment on quality of life. JWDP. 2010; 8(2): 143-62 (Persian).
27. Mokhtari N, Nasiri M, Mashoof T, Kazemnejad E. A comparative study of hemodialysis patients' QOL from patients' and nurses' perception. J Guilan Univ Med Sci. 2003; 47(12): 16-22.
28. Bayoumi M, Al Harbi A, Al Suwaida A, Al Ghonaim M, Al Wakeel J, Mishkiry A. Predictors of quality of life in hemodialysis patients. Saudi J Kidney Dis Transpl . 2013; 24(2): 254-9.
29. Rafii F, Rambod M, Agha Hosseini F. Quality of life in end stage renal disease and its related factors. Iran J Nurs. 2010; 23(63): 35-42.
30. Sharif Nia SH, Hojjati H, Nazari R, Qorbani M, Akhoondzade G. The effect of prayer on mental health of hemodialysis patients. Iran J Crit Care Nurs. 2012; 5(1): 29-34.
31. Bredle JM, Salsman JM, Debb SM, Arnold BJ, Cella D. Spiritual well-being as a component of health-related quality of life: the functional assessment of

chronic illness therapy-spiritual well-being scale (FACIT-Sp). Religions. 2011; 2(1): 77-94.
32. Habibi A, savadpour MT. Spiritual well-being in cancer patients who undergo chemotherapy. hc.journal. 2011; 13(3): 16-20.
33. Worth H. Transcultural and spiritual issues. In: Worth H. Psychiatric nursing care plan 4ed. London: Mosby; 2004: 358-329.
34. Burkhardt A, Nathaniel M, Alvita K. Ethic in chronic pain. In: Bur-khardt A NM, Alvita K, editor.Ethic and issue in contemporary nursing. 1 ed. London: Mosby; 1998.
35. Hemmett L, Holmes J, Barones M, Russell N. What drives quality of life in multiple sclerosis? Q J M. 2004; 97(10): 671-6.
36. Jadidi A, Farahaninia M, Janm ohammadi S, Haghani H. The relationship between spiritual well-being and quality of life among elderly people residing in Kahrizak Senior House. Iran J Nurs. 2011; 24(72): 48-56.
37. Finkelstein FO, West W, Gobin J, Finkelstein SH, Wuerth D. Spirituality, quality of life and the dialysis patient. Nephrol Dial Transplant. 2007; 22(9): 2432-4.
38. Baljani E, Khashabi J, Amanpour E, Azimi N. Relationship between Spiritual Well-being, Religion, and Hope among Patients with Cancer. Hayat. 2011; 17(3): 27-37.