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The Relationship between Spiritual Well-Being and Quality of Life among Postmenopausal Women

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ABSTRACT

Background & aim: Menopause exerts negative impacts on women's quality of life. It seems that drawing on spiritual resources can be effective in improving the quality of life among this population. Therefore, the present study aimed to determine the relationship between spiritual wellbeing and the quality of life of postmenopausal women.

Methods: This descriptive correlational study was conducted on postmenopausal women referring to Ibn Sina and Amir Hamzeh health centers in Isfahan, Iran in 2018-2019, among whom 340 cases were selected via the non-probability sampling method. The research instruments included the Spiritual Well-Being Scale (SWBS) developed by Paloutzian and Ellison and the SF-36 Quality of Life Questionnaire. Data were analyzed in SPSS software (version 21) using descriptive statistical tests and Pearson correlation coefficient.

Results: The obtained results pointed to the positive and significant correlation of existential and religious dimensions of spiritual wellbeing with the eight dimensions of quality of life ($P<0.05$).

Conclusion: As evidenced by the obtained results, spiritual wellbeing and its components are important variables affecting the quality of life of postmenopausal women. Therefore, it is essential to design interventions aiming at strengthening spiritual/religious values and beliefs to promote the health of postmenopausal women and consequently improvement of their quality of life.

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Introduction

Menopause is a biological and inevitable event comprising one-third of women's life (1). Although it is considered "natural" and is a normal part of aging, menopausal problems, such as hot flashes, mood swings, sleep disorders, and sexual disorders, severely affect their quality of life (2, 3). These problems not only give rise to distress and disability among women but also place heavy pressure on the limited resources of health systems (4).

Moreover, health services provided to women in the community have mainly focused on women of childbearing age and undermined the problems of other women, including postmenopausal women (1). Meanwhile, more than 5 million Iranian women of menopausal age will be living in Iran by 1400 (5). Quality of life in postmenopausal women refers to a set of symptoms affecting physical, emotional, and social

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functioning, and it is a matter of concern for health professionals (6).

Menopausal symptoms are closely related to women's health, exerting physical, psychological, and social impacts on their quality of life (7). According to studies, menopause has a negative effect on the quality of life of most women (8, 9). Meanwhile, drawing on spiritual resources can be effective in improving the quality of life (10). Spiritual wellbeing as one of the dimensions of health consists of existential and religious domains.

Religious well-being refers to the satisfaction derived from a relationship with a higher power, while existential well-being refers to one's attempt trying to find purpose and meaning in life (11). In other words, religious well-being focuses on how people perceive health in their spiritual lives when they are associated with spiritual force. On the other hand, existential health focuses on people's social and psychological concerns and deals with how individuals adapt to themselves, society, or the environment (12, 13).

Spiritual wellbeing is a sense of connection to others, understanding the meaning and purpose of life, and connection with a superior power toward living a better life (14). Biological, psychological, and social dimensions of health cannot function properly without spiritual wellbeing; consequently, it is not possible to achieve the highest level of quality of life (15). Numerous studies demonstrated that there is a significant relationship between quality of life and spirituality in patients with chronic diseases (16).

The World Health Organization defined health in more than three dimensions of physical, mental, and social, adding to it the 'spiritual well-being' (17). Spiritual wellbeing encompasses two dimensions of existential and religious which form the physical, psychological, and social dimensions of human beings (12, 13). Health professionals and psychologists have recently highlighted the importance of spirituality and spiritual growth in human beings. The spiritual needs of human beings have been prioritized over their material needs in the present era even in western and developed countries.

In Iran, the majority of studies in the field of spiritual wellbeing have been conducted on specific groups, such as people with cancer or chronic physical and mental illnesses (22-28). Nevertheless, no study was found on the effect of postmenopausal women's spiritual well-being on their quality of life. Quality of life improvement is regarded as one of the goals of public health in this century. Therefore, the present study aimed to determine the relationship between spiritual wellbeing and quality of life in postmenopausal women.

Materials and Methods

The present cross-sectional study was conducted based on the analytical-correlational design with the ethical code of IR.MUI.RESEARCH.REC.1397.237. Participants were selected via non-probability sampling method from among postmenopausal women referring to Ibn Sina and Amir Hamzeh Health Centers affiliated to Isfahan University of Medical Sciences in 2018-2019. The sample size was calculated at 340 cases according to the study conducted by Ramezankhani (23) using Cochran's formula. Out of this population, eight subjects were excluded due to impartial completion of the questionnaire.

Finally, the study was performed on 332 cases. The inclusion criteria were as follows: 1) provision of informed consent, 2) healthy postmenopausal women in the age range of 65-45 years, 3) literacy, 4) absence of traumatic or unexpected events in the last six months (e.g., surgery, accident, unemployment of a spouse, diagnosis of incurable disease among family members, severe family dispute, conditional suspension or expulsion, dismissal, immigration, divorce, bankruptcy, furniture, death of a spouse or family member, hysterectomy, and similar procedures). On the other hand, the exclusion criteria were self-reported chronic physical or mental illnesses.

Data were collected using three instruments. Demographic characteristics of participants were assessed using the demographic form, including age, weight, menopausal age, marital status, occupation of the spouse, number of children, education level of woman and spouse. Spiritual wellbeing data were collected by Spiritual Well-Being Scale (SWBS) developed by

Paloutzian and Ellison. This questionnaire Spiritual Well-Being Scale (SWBS) consists of 20 items in three dimensions of cognition, emotion, and behavior. Each item is rated on a 5-point Likert scale (strongly agree, agree, no opinion, disagree, and strongly disagree).

Among 20 items, 10 even items measure existential well-being, and 10 odd items measure religious well-being. Negative expressions are reverse-scored. The total score of the SWBS ranges from 20-120. The validity of this questionnaire was confirmed by Paloutzian and Ellison who reported Cronbach's alpha coefficients of religious, existential, and total well-being as 0.91, 0.91, and 0.93, respectively (24). The content validity of this questionnaire in Iran was confirmed after translation into Persian. Moreover, its reliability was reported to be 0.82 using Cronbach's alpha (20). In the present study, the reliability coefficients of religious, existential, and total wellbeing were calculated at 0.93, 0.86, and 0.94, respectively.

Furthermore, the SF-36 Quality of Life Questionnaire is employed to obtain data regarding the quality of life. This questionnaire is the most widely used instrument for measuring the quality of life worldwide. It consists of 36 items to calculate eight subscales: physical functioning, physical functional limitations, physical pain, general health, role limitations due to emotional problems, vitality, mental health, and social functioning. The first four scores can be summed to create the physical composite score, while the last four can be summed to create the mental composite score. Scores for the SF-36 scales range between 0 and 100, with higher scores indicating a better quality of life. The score between 71-100, 31-70, and 0-30 are indicative of the good, moderate, and poor quality of life, respectively (25).

The validity of the original version of this scale was evaluated and reported to be acceptable using two methods of differential validity and construct validity, and its Cronbach's alpha was obtained at 0.82 (26). The validity and reliability of this questionnaire in Iranian population have also been assessed and confirmed (27), reporting a Cronbach's alpha coefficient of 0.6-0.96 (28). In the present study, Cronbach's alpha coefficients of quality of life in physical, psychological, and total dimensions were reported as 0.81, 0.79, and 0.76, respectively.

In order to collect information, the researcher initially obtained the approval of the Ethics Committee of Isfahan University of Medical Sciences and an official letter of introduction from the Vice-Chancellor of Isfahan School of Nursing and Midwifery. Thereafter, he/she referred to selected health centers in the province (Amir Hamzeh and Ibn Sina). After obtaining permission, non-probability sampling was performed. Written consent was obtained from eligible women referring to the center; subsequently, the participants were provided with the aims and process of the research and were ensured of the confidentiality of their information. The questionnaire was then provided to the subjects.

Data analysis was performed in SPSS software (version 21). Firstly, the Kolmogorov-Smirnov test was employed to assess the normal distribution of quantitative variables. Parametric tests were used for normally distributed data; otherwise, non-parametric tests were employed. Mean, standard deviation, and frequency distribution table were used to describe demographic characteristics. Pearson correlation test was utilized to determine the correlation between variables. A p-value less than 0.5 and a 95% confidence interval were considered in the tests.

Results

At the commencement of the study, a total of 340 postmenopausal women were included in the study; thereafter, eight cases were excluded from the study due to impartial completion of the questionnaire. On a final note, the study was performed on 332 postmenopausal women. The mean age of participants was reported as 55.16±5.62 years. In terms of educational level, the majority of cases had a diploma. The mean scores of total spiritual wellbeing and its subscales, including religious and existential dimensions, are demonstrated in Table 2.

The mean scores of quality of life in the physical and mental dimensions regarding the domains of each variable are listed in Table 3. The demographic characteristics of participants are presented in Table 1.

The subjects obtained the highest and lowest scores in the dimensions of social functioning (60.01±20.62) and vitality (46.38±18.80), respectively. In addition, the mean score of the religious dimension (42.42±10.76) was higher, compared to that of the existential dimension (38.14±10.64) (Table 2).

Table 1. Demographic characteristics of postmenopausal women participating in the study

Variable	N (%)	Mean± Standard deviation
Age (year)	-	55.16±5.62
Menopausal age (year)	-	49.67±5.74
Education		
High school	41.6±6.138	-
Diploma	36.1 (20)	-
Bachelor's degree and higher	22.3 (74)	-
Marital status		
Married	88 (292)	-
divorced	2.4 (8)	-
Widow	9.6 (32)	-

Table 2. Mean spiritual health scores and its dimensions in postmenopausal women participating in the study

Variable	Mean	Standard deviation
Religious dimension of spiritual well-being	42.42	10.76
Existential dimension of spiritual well-being	38.14	10.64
Spiritual well-being (total)	80.56	20.63

Table 3. Mean scores of quality of life in physical and psychological dimensions in postmenopausal women participating in the study

Variable	Mean	Standard deviation
Quality of life in the physical dimension		
Physical function	50.30	29.58
Physical functional limitations	46.98	38.94
Physical pain	55.00	19.61
general health	49.45	24.22
Quality of life in the psychological dimension		
Role limitations due to emotional problems	50.60	42.37
Energy and vitality	46.38	18.80
Mental health	54.79	19.75
social functioning	60.01	20.62

Table 4. Results of Pearson correlation test between the quality of life domains and components of total spiritual health in postmenopausal women

Variable	Religious well-being		Existential well-being		Total spiritual well-being	
	r	p	r	p	r	p
Quality of life in the physical dimension						
Physical function	0.289	0.001	0.309	0.001	0.311	0.001
Physical functional limitations	0.130	0.018	0.169	0.002	0.155	0.005
Physical pain	0.389	0.001	0.495	0.001	0.458	0.001
General health	0.681	0.001	0.717	0.001	0.726	0.001
Quality of life in the psychological dimension						
Role limitations due to emotional problems	0.285	0.001	0.301	0.001	0.304	0.001
Energy and vitality	0.626	0.001	0.707	0.001	0.692	0.001
Psychological Well-being	0.701	0.001	0.766	0.001	0.761	0.001
Social functioning	0.511	0.001	0.591	0.001	0.571	0.001

The scores of all dimensions of spiritual wellbeing and quality of life had a normal distribution.

Therefore, the Pearson correlation test was used to assess the correlation of physical and mental dimensions of quality of life with total spiritual wellbeing and its dimensions. The results of this test are reported in Table 4.

The test results pointed to the significant and positive correlation of different domains of quality of physical and mental life with total spiritual wellbeing and its dimensions. In this regard, postmenopausal women with a higher score in spiritual and as its subscales had a better quality of life in physical dimension (physical function, physical functional limitations, physical pain, and general health) and mental dimension (role limitations due to emotional problems, vitality, mental health, and social functioning) ($P<0.05$).

Discussion

The present study aimed to determine the relationship between spiritual wellbeing and quality of life in postmenopausal women. The results of the present study were based on a statistically significant correlation between spiritual wellbeing and participants' quality of life. The results of the present study indicated that people with higher levels of spiritual wellbeing have a better quality of life. It is noteworthy that no study was found in this field. As a result, the findings of the present study were compared with those reported in other studies that examined spiritual wellbeing and quality of life in different populations of patients.

In this regard, the results of the current study were in line with those reported by Marzban (29), Shahbazi (30) and Jafari (31), Salsman (32) and Krupski (33). Nevertheless, they were inconsistent with those obtained by Ebrahimi (34). This discrepancy can be ascribed to the fact that in the study by Ebrahimi, the occurrence of chronic renal failure and treatments, including hemodialysis, led to changes in lifestyle and health status of people. Moreover, they endanger other dimensions of health, including spiritual wellbeing, apart from physical health; consequently, the patient's quality of life is affected.

In fact, people with higher levels of spiritual well-being have a better quality of life since spirituality is a step toward the elimination of anxiety and stress. Furthermore, it can be of great help in the prevention and treatment of diseases in society increasing people's quality of life. Based on the results of the study and the mean scores in each domain, the mean participants' quality of life in eight dimensions was moderate. This finding is in agreement with the studies performed by Sharifnia (35), Abedzadeh (36), Marzban (29), and Dehbashi (37).

Nonetheless, in other studies conducted outside Iran, most postmenopausal women had a high quality of life (38, 39). This lower quality of life among Iranian women can be attributed to lower economic levels and their unawareness of appropriate adaptive strategies to cope with changes during menopause. The subjects obtained the highest and lowest scores in the dimensions of social functioning (60.01±20.62) and vitality (46.38±18.80), respectively. In a study performed by Asarroodi, the lowest score was related to the vitality domain (40). Moreover, this finding was different from those stated by Sharifiniya (35). This discrepancy can be ascribed to the use of different questionnaires in these studies. The SF-36 was employed in the present study, while Sharifiniya utilized the Menopause-Specific Quality of Life Questionnaire.

Moreover, the mean score of the religious dimension (42.10±42.76) was higher than the existential dimension (38.14±10.64). This finding seems somewhat reasonable considering the Iranian culture since Iranians are religious and believe in God and a higher power. This finding is in line with those stated by Asarroodi (40), Arbabi (41), and Rezaei (42) and contradicts the results reported by Allah Bakhshian (20). This discrepancy can be attributed to the fact that the study by Allah Bakhshian was conducted on patients with multiple sclerosis, while the healthy population were assessed in the present study and that conducted by Asarroodi.

The results of the present study indicated the statistically significant and positive correlation of different domains of quality of physical and mental life with total spiritual wellbeing and its

dimensions, including religious and existential well-being. In this regard, postmenopausal women with a higher score in spiritual and its subscales had a better quality of life in physical dimension (physical function, physical functional limitations, physical pain, and general health) and mental dimension (role limitations due to emotional problems, vitality, mental health, and social functioning) ($P<0.05$).

This finding was in line with the study by Allah Bakhshian (20). However, in the study performed by Morgan on women with breast cancer, spiritual wellbeing was significantly correlated only with the physical, mental, and functional dimensions of quality of life (43). Moreover, in the study by Milan, it was only correlated with dimensions of social functioning and physical pain (44).

Regarding the notable limitations of the current study, one can refer to individual differences and participants' conditions while answering the questionnaires which may have affected the accuracy of responses. To solve this problem, the researchers completed the questionnaire upon participants' full readiness to respond. On the other hand, the absence of a study on the relationship between spiritual wellbeing and the quality of life of healthy postmenopausal women, as well as the relatively large sample size were the strengths of the present study.

Conclusion

As evidenced by the obtained results, spiritual wellbeing and quality of life have a positive and significant correlation. The positive correlation between spiritual wellbeing and quality of life in postmenopausal women highlights the need for interventions aiming at strengthening spiritual and religious values and beliefs in an attempt to promote the health of postmenopausal women and improve their quality of life. Therefore, it is suggested that such interventions be designed and their impacts on the quality of life of postmenopausal women be assessed.

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Conflicts of interest

Authors declared no conflicts of interest.

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