หนังสือรับรองการใช้ประโยชน์ของผลงานวิจัย

ชื่อหน่วยงานที่รับรอง .....ชมรมผู้สูงอายุ บ้านแม่กึ๋ง .....

ที่อยู่หน่วยงานที่รับรอง .....ชมรมผู้สูงอายุ บ้านแม่กึ๋ง ต. บ้านเป้า อ. เมือง จ. ลำปาง .....

วัน เดือน ปีที่ให้การรับรอง .....29 ตุลาคม 2555.....

เรื่อง การรับรองการใช้ประโยชน์ของผลงานวิจัย

เรียน ผู้อำนวยการวิทยาลัยพยาบาลบรมราชชนนี นครลำปาง

ข้าพเจ้า.....นายวาท ต๊ะคำวรรณ..... ตำแหน่ง.....ประธานชมรมผู้สูงอายุ บ้านแม่กึ๋ง..... ขอรับรองว่าได้มีการนำผลงานวิจัยเรื่อง.....จิตวิญญาณและคุณภาพชีวิตของผู้สูงอายุ..... นำไปใช้ประโยชน์ ดังนี้ (กรุณาเลือกโดยการทำเครื่องหมาย ☐ หน้าข้อความที่ตรงกับความเป็นจริง และกรุณาให้รายละเอียดการใช้ประโยชน์เพิ่มเติมท้ายข้อความที่เลือก)

- ☐ การนำไปใช้ประโยชน์เชิงสาธารณะ (การใช้งานวิจัยให้เกิดประโยชน์แก่สาธารณชนในเรื่องต่างๆ ที่ทำให้สุขภาพ คุณภาพชีวิตและเศรษฐกิจของประชาชน/ชุมชนดีขึ้น) .....
- ☐ การใช้ประโยชน์เชิงนโยบาย (เช่น การนำผลจากการวิจัยไปประกอบเป็นข้อมูลการประกาศใช้กฎหมาย
- √ ☐ การใช้ประโยชน์ตามวัตถุประสงค์/เป้าหมายของงานวิจัย/งานสร้างสรรค์ คือ ....นำผลการวิจัยไปช่วยออกแบบกิจกรรมของชมรมโดยเพิ่มความสำคัญของจิตวิญญาณมากขึ้น เช่นการปฏิบัติธรรม การทำสิ่งที่ตนเองชอบ เป็นต้น.....

ช่วงเวลาในการใช้ประโยชน์

☐ ตั้งแต่..... 27 ธันวาคม 2555.....จนถึงปัจจุบัน

☐ ตั้งแต่.....จนถึง.....

โดยการใช้ประโยชน์นั้น ก่อให้เกิดผลดีหรือประโยชน์ ดังนี้

1. มีกิจกรรมด้านจิตวิญญาณหลากหลายขึ้น

ลงชื่อ.....วาท ต๊ะคำวรรณ์.....

(ชื่อ-สกุล.....นายวาท ต๊ะคำวรรณ์.....)

ตำแหน่ง.....ประธานชมรมผู้สูงอายุบ้านแม่กึ๋ง

หมายเหตุ: ท่านสามารถประทับตราของหน่วยงานในเอกสารนี้ได้ (ถ้ามี)

Spirituality and quality of life in older people with chronic illness in Thailand

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Aim: Spirituality has been identified as an important strategy for coping with chronic illness and as a resource to promote quality of life (QOL). This pilot study aimed to determine existing correlations between spirituality and participant-based domains of the QOL of the chronically ill elderly.
Methods: Participants ($n = 100$) aged 60+ who had at least one chronic illness were recruited from members of an Elderly Club in Thailand. Data were collected using a demographic questionnaire, the JAREL Spiritual Well-Being instrument, and the QOL Index-Generic Version. Demographic and JAREL questionnaires were analysed using descriptive statistics. Ferrans and Powers' scoring syntax was utilized in the analysis of QOL questionnaires. The correlation between spirituality and the QOL domains was tested using the Pearson correlation coefficient.
Results: All participants reported a high level of spirituality ($M = 4.47$, SD = 0.45), especially in the domain of life satisfaction/self-actualization ($M = 5.14$, SD = 0.61). The 70+ group rated their life satisfaction significantly higher than did those aged <70 years ($P < 0.05$). Participants reported a relatively high QOL and were satisfied with areas of life important to them ($M = 22.80$, SD = 3.76), especially in the family domain ($M = 24.60$, SD = 5.11).
Discussion: This outcome suggests that spirituality is associated with QOL, which is consistent with similar work undertaken in other countries.
Conclusion: Providing spiritual care for older people with chronic illnesses is important and exploring the spiritual needs of older people should continue for further study.

Keywords: Chronic illness, Older people, Quality of life, Spirituality, Thailand

Introduction

Ageing is a rising global phenomenon. Changes in Thailand's social structure are likely to lead to an ageing society within the next 20 years.[1] Three-quarters of elderly Thai people have chronic illnesses such as hypertension, diabetes, arthritis, heart disease, and cerebral vascular disease.[2] Social and emotional adjustments are also associated with such illness,[3] whereas functional limitations and health problems also impact on the quality of life in the elderly.[4,5]

In Thailand, nurses are the major group of health care providers[1] playing an important role in the holistic care of patients including spiritual care.[6,7] Spirituality has also been identified as an important strategy for coping with chronic illness,[8–10] being acknowledged as a resource that promotes quality of life.[5]

Spirituality in Thailand is based on both religious (predominantly Buddhist) and supernatural beliefs.[11] Buddhism offers a sense of connectedness in life, which includes adherence to a religious practice, belief in a supernatural power and relationship with other persons, and has a positive influence on the spiritual health of the Thai people.[12] One of the essential elements of spirituality identified among rural Thai elders was the belief in the Law of Karma and life after death.[13] Although the Law of Karma is of Buddhist origin, there are some supernatural beliefs and related practices that are of cultural origin rather than Buddhist.

Hungelmann *et al.*,[14,15] developers of the JAREL Spiritual Well-Being Scale (JSWBS) used in this study, defined spiritual well-being as 'a sense of harmonious interconnectedness between self, others/nature, and Ultimate Other which exists throughout and beyond time and space' (p. 263). The JSWBS incorporates three dimensions of spiritual well-being: faith/belief (spiritual belief, purpose in life, relationship between spiritual belief and life style, prayer, belief in a supreme power, and life after death); life/self-responsibility (lack of belief in supreme power,

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lack of forgiveness of others, and an inability to accept change in life or make decisions regarding one's life); and life satisfaction/self-actualization (life satisfaction, goal-setting, acceptance of life situations, loving relationship with others, and self-esteem).

This study used the concept of quality of life agreed by Ferrans and Powers,[16] based on satisfaction and defined as 'a person's sense of well-being that stems from satisfaction or dissatisfaction with the areas of life that are important to him/her' (p. 15). This 'quality of life framework' incorporates four dimensions: health and functioning, psychological and spiritual, social and economic, and family[17] (p. 295).

The relationship between spirituality and quality of life, including that among the chronically ill, has been explored by many researchers.[18–23] However, in examining the relationship between spirituality and quality of life among elderly Thais who have chronic illness fill a gap in current knowledge.

Methods

Sample

Convenience sampling[24] was used to recruit participants ($n = 100$) from an Elderly Club that had a membership of between 200 and 230 at the time of data collection. The inclusion criteria for participants were: older adults, more than 60 years of age, and who had been diagnosed with at least one chronic illness. Neuman[25] proposed that for small populations (under 1000) a sampling ratio of up to 30% is required for a high degree of accuracy. It should be noted that membership of an Elderly Club and participation in its activities will improve quality of life but is unlikely to impact on levels of spirituality.

Questionnaires

Three questionnaires were utilized:

1. Demographic data including gender, age, marital status, educational level, income, type of chronic illness, and duration of illness.
2. The JSWBS,[14,15] developed for use in older people and including 21 items, 14 positive items and 7 negative items. The items incorporate three dimensions: the faith/belief, self-responsibility life satisfaction/self-actualization, and were rated on an ordinal, six-point Likert scale ranging from strongly agree to strongly disagree;
3. Quality of Life Index-Generic III Version, appropriate for chronically ill patients,[26,27] was used. This has two parts: satisfaction and the importance of various aspects of life, each part having 33 items arranged in four domains: health and functioning; psychological/spiritual; social and economic; and family. Items were rated on an ordinal, six-point Likert scale.

Data collection and procedures

University and Health Service ethics approval was granted, including approval of the Thai translation of the explanatory statement and questionnaires.

The first author attended the club and explained the project to the nurse educator who then described the research project orally to club members. The researcher introduced herself, related the objectives of the study, and invited members to complete the questionnaire. Their right to anonymity and to withdraw at any time were also explained. The researcher was not present during data collection. Completed questionnaires were placed in a box provided, completion being taken as consent to participate. The Statistical Package for the Social Services version 11.5 for windows (SPSS) was utilized in data analysis.

Results

Demographic data

All participants ($n = 100$) identified as Buddhists. Demographic data, stratified by age, material status, education level, monthly income, chronic illness, and duration of illness are tabulated (Table 1). Respondents classified as young–old (age < 75) made up 77% of the cohort, old–old (age > 75) 23%, 64%

Table 1 Demographics ($n = 100$)

Variables	*n*
Age (years)	
60–64	30
65–69	20
70–74	27
75–79	15
80 and older	8
Marital status	
Single	4
Married	64
Widowed	28
Divorced/separate	4
Educational level	
Primary school	38
Secondary school	23
High school	14
Associate/junior college	6
Bachelor's degree	19
Monthly income (baht)	
less than 5000	42
5000–10 000	27
10 001–15 000	16
15 001–20 000	10
More than 20 000	5
Chronic illness	
Hypertension	56
Heart disease	10
Diabetes	8
Chronic renal failure	1
Arthritis	24
Others	1
Duration of illness (years)	
1–10	70
11–20	17
21–30	1
More than 30	12

were married, 61% had an education level less than high school, 61% had coronary heart disease, and 42% had an income of less than 5000 baht per month. In 2002, the official poverty line in Thailand was 1,163 baht/person/month. The current exchange rate is 1.00USD = 30.4770 THB.

Spirituality

The details of mean and standard deviation in overall spirituality and its subscales are presented in Table 2. The mean score (SD) on spirituality was 4.47 (0.45) indicating a high level of spirituality with life satisfaction scoring higher than the other domains ($M = 5.14$, SD.61). Spirituality is compared with demographic variables in Table 3. Females scored higher than males in all domains, the life satisfaction domain scoring highest for both (females, $M = 5.16$, SD = 0.62; males, $M = 5.06$, SD = 0.59) and self-responsibility scoring lowest for both (females, $M = 3.26$, SD = 0.85; males, $M = 3.00$, SD = 0.54). Overall, the following were associated with higher levels of spirituality: being over 70, no spouse, higher education levels, higher income, and having coronary heart disease.

The test for significance of spirituality and its subscales in the demographic data are summarized in Table 4. At $P > 0.05$, there was no statistically significant mean difference in spirituality in relation to the variables gender, age group, marital status, education level, income, chronic disease, and duration of illness. However, a statistically significant mean difference was identified in the domain of life satisfaction correlated with the age group variable ($F = 6.93$, $P < 0.05$).

Quality of Life

Table 5 tabulates the means and standard deviations of quality of life when contrasted with health and functioning, social and economic, psychological and spiritual, and family subscales. The overall mean (SD) score on quality of life was 22.80 (3.76), indicating participants had a relatively high quality of life the highest scoring subscale being family ($M = 24.60$, SD = 5.11) with health and functioning the lowest ($M = 21.54$, SD = 4.66).

Table 2 Mean and standard deviation of spirituality

Spirituality	Potential range	Actual range	Mean	SD
Faith/belief dimension	1–6	4.43–5.00	4.89	0.45
Self-responsibility	1–6	2.71–3.07	3.21	0.80
Life satisfaction/ self-actualization	1–6	4.75–5.21	5.14	0.61
Overall spirituality	1–6	3.19–5.43	4.47	0.45

A comparison of mean and standard deviation of quality of life with demographic variables is recorded in Table 6. Overall, a higher score was associated with the following variables: being female, old–old age group, no spouse, higher education levels, higher income levels, and suffering coronary heart disease for a period of less than 10 years.

The test for significance for quality of life and the demographic data for its subscales are displayed in Table 7. Education was the only variable resulting in a statistical difference in quality of life ($F = 5.29$, $P < 0.05$). There were significant differences in the domains of health and functioning among the education group ($F = 4.52$, $P < 0.05$) and the chronic disease group ($F = 7.87$, $P < 0.01$). The social and economic domain also showed a statistically significant mean difference between males and females ($F = 4.14$, $P < 0.05$) and among the education group ($F = 7.55$, $P < 0.01$).

The correlation between spirituality and quality of life

As shown in Table 8 the relationship between spirituality and quality of life in older people with chronic illness was statistically significant ($r = 0.205$, $P < 0.05$). This correlation was positive, indicating the higher the spirituality, the higher the quality of life. Spirituality was also found to have a statistically significant positive correlation with the health and functioning subscale ($r = 0.295$, $P < 0.05$).

Discussion

Demographic issues

The dominance of females among the participants (80%) was consistent with the gender distribution among club members, the higher number of females in the older Thai population[27] and also with the findings of two other Thai studies.[28,29] Similar gender imbalance has been demonstrated in studies of the elderly in Western countries, for example, Finland,[30] Austria,[31] Spain,[32] and UK.[33] Such findings are consistent with longer life expectancy of females which in Thailand has been estimated as 75 years for women compared to 67.9 years for men.[34] As 95% of Thais are Buddhist[20,35] it is not surprising that all the participants of this study were Buddhist.

It was expected that the majority of participants would have been educated at primary school level only, that being the level of government provided education in the twentieth century in Thailand.[36] However, more than one-third of participants had been educated at high-school level and higher (39%), possibly because many had been government officials for which a secondary education is a minimum requirement. Their income is congruent with their education level, with more than half (58%) having an

Table 3 Spirituality compared with demographic variables

Variables	Faith/belief *M* (SD)	Self-responsibility *M* (SD)	Life satisfaction *M* (SD)	Spirituality *M* (SD)
Gender				
Male ($n = 20$)	4.86 (0.69)	3.00 (0.54)	5.06 (0.59)	4.41 (0.43)
Female ($n = 80$)	4.89 (0.80)	3.26 (0.85)	5.16 (0.62)	4.49 (0.46)
Age group				
Young–old (60–69 years, $n = 50$)	4.79 (0.94)	3.35 (0.87)	4.98 (0.61)	4.44 (0.47)
Old–old (70 and older, $n = 50$)	4.99 (0.57)	3.08 (0.71)	5.29 (0.58)	4.50 (0.43)
Marital status				
Having spouse ($n = 64$)	4.85 (0.74)	3.14 (0.78)	5.15 (0.58)	4.44 (0.42)
No spouse ($n = 36$)	4.95 (0.85)	3.35 (0.83)	5.12 (0.67)	4.52 (0.50)
Education				
Less than high school ($n = 61$)	4.84 (0.83)	3.19 (0.83)	5.07 (0.67)	4.42 (0.51)
High school or more ($n = 39$)	4.96 (0.70)	3.26 (0.77)	5.25 (0.50)	4.45 (0.33)
Income				
Less than 10 000 ($n = 69$)	4.81 (0.87)	3.21 (0.86)	5.11 (0.66)	4.44 (0.49)
10 000 and over ($n = 31$)	5.06 (0.49)	3.22 (0.67)	5.21 (0.51)	4.55 (0.34)
Chronic disease				
Coronary artery disease ($n = 66$)	4.88 (0.68)	3.27 (0.75)	5.19 (0.63)	4.50 (0.45)
Others ($n = 34$)	4.91 (0.95)	3.10 (0.90)	5.05 (0.58)	4.41 (0.45)
Duration of illness				
1–10 years ($n = 70$)	4.83 (0.83)	3.27 (0.76)	5.11 (0.67)	4.46 (0.47)
More than 10 years ($n = 30$)	5.02 (0.64)	3.08 (0.89)	5.20 (0.47)	4.50 (0.39)

Table 4 Spirituality and subscales and demographic variables

	Faith/belief		Self-responsibility		Life satisfaction		Spirituality	
Variables	*F*	*P*	*F*	*P*	*F*	*P*	*F*	*P*
Gender	0.02	*0.88*	1.68	*0.19*	0.38	*0.54*	0.40	0.53
Age group	1.76	*0.18*	2.73	*0.10*	6.93	*0.01**	0.58	*0.45*
Marital status	0.38	*0.54*	1.6	*0.21*	0.04	*0.84*	0.68	*0.41*
Education	0.48	*0.49*	0.17	*0.68*	2.18	*0.14*	1.64	*0.20*
Income	2.20	*0.14*	0.00	*0.95*	0.61	*0.43*	1.26	*0.26*
Chronic Disease	0.04	*0.83*	1.03	*0.31*	1.20	*0.28*	1.04	*0.31*
Duration of illness	1.21	*0.28*	1.19	*0.28*	0.47	*0.49*	0.21	*0.65*

*$P < 0.05$.

Table 5 Mean, standard deviation of quality of life (QOL)

Quality of life	Potential range	Actual range	Mean	SD
Health and functioning	0–30	5.50–28.27	21.54	4.66
Social and economic	0–30	6.79–30	22.46	3.95
Psychological/ spiritual	0–30	3.43–30	24.15	4.39
Family	0–30	4–30	24.60	5.11
Total QOL	0–30	8.14–28.00	22.80	3.76

income of more than 5000 baht each month, possibly from a government retirement fund. The remaining 42%, however, were probably mainly dependent on family, as the pension policy in Thailand only pays for older people who have no supporting relatives.

It is not surprising that the major chronic illness identified was coronary artery disease (66%), which occurred in 447.7 per 1000 of Thai people in 2002, and had the highest morbidity rate.[34] This is also consistent with other findings elsewhere.[21,30]

Spirituality

In this study, the standardized score for spirituality is high ($M = 4.47$, SD = 0.45, possible range from 1 to 6) which is consistent with reports of spiritual well-being among older Thais.[37,38] The strong belief among Buddhists that personal sickness or life's problems can be alleviated or even overcome through strong religious beliefs that may contribute to these high scores. Other work[11,13] also confirmed that spirituality gave hope, peace of mind, and harmony to many older Thais. The higher score for spirituality for the old–old group is in line with many studies in Western countries which have found that the score from the spirituality instrument implemented was higher in older people.[9,21,39,40] A possible explanation is that spirituality is tied into all aspects of life, and in this particular instance, beliefs about health and illness.[8]

The life satisfaction/self-actualization subscale recorded the highest score ($M = 5.14$, SD = 0.61). The family domain in the quality-of-life questionnaire had the highest score that was consistent with the

Table 6 QOL compared with demographic variables

Variables	Health and functioning, *M* (SD)	Social and economic, *M* (SD)	Psychological, *M* (SD)	Family, *M* (SD)	Overall QOL, *M* (SD)
Gender					
Male ($n = 20$)	21.57 (3.38)	20.88 (3.10)	23.57 (3.05)	24.48 (5.12)	22.32 (2.45)
Female ($n = 80$)	21.53 (4.94)	22.86 (4.05)	24.30 (4.87)	24.63 (5.14)	22.92 (4.02)
Age group					
Young–old (60–69 years, $n = 50$)	21.09 (5.10)	21.80 (4.22)	24.15 (3.78)	24.46 (5.28)	22.45 (4.01)
Old–old (70 and older, $n = 50$)	21.99 (4.17)	23.12 (3.59)	24.16 (4.97)	24.74 (4.98)	23.15 (3.49)
Marital status					
Having spouse ($n = 64$)	21.46 (4.56)	22.16 (3.48)	23.97 (3.81)	24.25 (5.45)	22.60 (3.62)
No spouse ($n = 36$)	21.67 (4.89)	22.99 (4.67)	24.46 (5.31)	25.22 (4.46)	23.15 (4.02)
Education					
Less than high school ($n = 61$)	20.76 (5.52)	21.62 (4.23)	23.67 (5.14)	24.14 (5.76)	22.12 (4.36)
High school and above ($n = 39$)	22.76 (2.44)	23.78 (3.08)	24.90 (2.75)	25.32 (3.85)	23.86 (2.24)
Income					
Less than 10 000 ($n = 69$)	20.97 (5.27)	22.25 (4.41)	23.89 (5.04)	24.26 (5.38)	22.42 (4.33)
10 000 and over ($n = 31$)	22.80 (2.52)	22.93 (2.66)	24.74 (2.32)	25.35 (4.45)	23.63 (1.78)
Chronic disease					
Coronary artery disease ($n = 66$)	22.45 (3.60)	22.44 (3.92)	24.54 (4.03)	24.88 (5.06)	23.28 (3.38)
Others ($n = 34$)	19.78 (5.89)	22.51 (4.06)	23.39 (4.99)	24.06 (5.23)	21.87 (4.31)
Duration of illness					
1–10 years ($n = 70$)	21.62 (4.77)	22.60 (3.75)	24.18 (4.23)	24.74 (4.96)	22.89 (3.61)
More than 10 years ($n = 30$)	21.35 (4.48)	22.15 (4.43)	24.08 (4.82)	24.27 (5.53)	22.58 (4.14)

Table 7 QOL and subscales and demographic variables

	Health and functioning		Social and economic		Psychological		Family		QOL	
Variables	*F*	*P*	*F*	*P*	*F*	*P*	*F*	*P*	*F*	*P*
Gender	0.00	*0.97*	4.14	*0.04**	0.44	*0.51*	0.01	*0.91*	0.40	*0.53*
Age group	0.93	*0.34*	2.8	*0.09*	0.00	*0.99*	0.08	*0.78*	*0.86*	0.35
Marital status	0.04	*0.83*	1.00	*0.32*	0.29	*0.59*	0.84	*0.36*	0.49	*0.48*
Education	4.52	*0.03**	7.55	*0.007***	1.88	*0.17*	1.26	*0.26*	5.29	*0.02**
Income	3.38	*0.07*	0.62	*0.43*	0.79	*0.37*	0.97	*0.33*	2.23	*0.14*
Chronic disease	7.87	*0.006***	0.01	*0.93*	1.54	*0.22*	0.57	*0.45*	3.23	*0.08*
Duration of illness	0.07	*0.79*	0.27	*0.60*	0.01	*0.91*	0.18	*0.67*	0.15	*0.70*

*$P < 0.05$.
**$P < 0.01$.

expectations of Hungelmann *et al.*[15] Although Thai society has changed from the traditional extended family to a nuclear family structure in more recent times, the older generation, particularly in rural areas where the study was undertaken, still has an extended family, the modern trend towards the nuclear family being more evident in the cities. Other qualitative studies that have explored spirituality in the elderly also found that family relationships are important.[11–13,36] This may be because caring within family is one of the Buddhist principles which teaches respect and gratitude towards parents making for strong relationships within Thai families. It was also found in a Western culture study that family support was one positive theme in the experiences of older people with a chronic illness.[41]

Our finding that the domain of life/self-responsibility (representing inability to forgive and to accept

Table 8 Matrix of correlation coefficients among variables

Variables	QOL	Health and functioning	Social and economic	Psychological	Family
Spirituality	0.205*	0.295*	0.148	0.196	−0.106
QOL		0.903**	0.804**	0.845**	0.703**
Health and functioning			0.604**	0.664**	0.473**
Social and economic				0.632**	0.506**
Psychological					0.530**
Family					—

*$P < 0.05$.
**$P < 0.01$.

changes in life) scored the lowest: ($M = 3.21$, SD = 0.80), mirrors previous research using the same questionnaire.[42,43] Considering that the participants of this study were all Buddhist and that one of the tenets of Buddhism, Dharma or the law of nature, teaches that life is temporary,[11] all being in the process of birth, decay and old age, disease, and death[44] this outcome is expected. An examination of the gero-transcendence and preparation for death in older Thai people[45] found that the elderly prepared themselves for death in physical, psychological, spiritual, and social senses.

Only the life satisfaction subscale demonstrated a statistically significant mean difference among age groups ($P < 0.05$), the old–old group, having a higher score than those up to a decade younger. As few studies have examined the correlation between socio-demographic factors and spirituality in older people, it is difficult to interpret these findings in the context of previous studies. However, it has been found[20] that spirituality did not show statistically significant differences for gender and age groups in older people across 18 countries around the world. Other studies that included larger age ranges found no correlation with between gender or age group with spiritual well-being.[46–48]

It is reasonable to conclude that the high level of adherence to Buddhist religious beliefs and practices as well as the strong traditional family relationships which most participants experienced may explain the high scores identified in this study in the spiritual subscales for life satisfaction/self-actualization and the low scores for problems in the areas of adaption to life changes.

Quality of life

The high measures for quality of life are consistent with those previously observed.[29] As over one-third of the participants were educated beyond high school, it is likely that they are more able to understand and apply the education programmes provided by the club. Evidence suggests that such programmes may improve quality of life[49] but higher incomes may also assist in improved higher quality life.[33] This is supported by the finding of only a moderate quality of life among elderly in lower socioeconomic regions of Thailand.[28] Variable results have been observed in a number of studies measuring quality of life in the chronically ill elderly in a range of different countries, some reporting high levels of quality of life[19,33,40,50] while others found that quality of life of the participants of their studies was moderate to low.[39,51] The reasons for this outcome were thought to be lack of support and autonomy and/or the severity of the symptoms of their illness. The high score observed for the subscale of the family domain is not unexpected in the light of the traditional Thai cultural norm of responsibility to care for their elderly.[52]

The fact that the lowest scores of quality of life were observed in the health/functioning or physical domain is consistent with other findings, in several different countries, where the same quality-of-life scale was utilized.[51,53,54] A low score in this domain is expected considering all participants had chronic illness which has been shown to be correlated with a relative decrease in health efficacy.[55] However, a study of older people in 22 countries, of which 92% had one or more co-morbid conditions, showed that most rated themselves as healthy.[56] Other studies have also rated different domains of quality of life, such as financial concerns[57] and the social domain[40] as impacting more negatively on participants.

The relationship between quality of life and demographic characteristics

The findings suggest that quality of life is related to level of education are consistent with those of a cross-cultural study undertaken in 18 countries which found there to be statistically significant differences between educated groups; the highest educational level giving the best quality of life.[20] A number of other studies have reported findings consistent with this study in demonstrating no significant correlation between quality of life and other demographic characteristics such as gender, age, marital status, monthly income, chronic illness, and duration of illness.[31,50,51,53] However, others have reported significant relationship between quality of life and age, particularly a decline of quality for the old–old group.[28,33,56,57] One study has also reported lower quality of life for females.[32]

Correlation between spirituality and quality of life in older people with chronic illness

To our knowledge, this is the first study to specifically examine the relationship between spirituality and the quality of life for older Thai people. The study's hypothesis, 'there is a correlation between the spirituality and quality of life in older people with chronic illness', is supported, the results demonstrating that spirituality has a statistically significant positive correlation with quality of life ($r = 0.20$, $P < 0.05$). This correlation has also been demonstrated in studies conducted elsewhere.[19,40]

It is possible that the severity of illness symptoms may be a factor in determining the degree of correlation between spirituality and quality of life. However available data are variable, some having reported either weak or no positive correlation between spirituality and quality of life for participants with advanced illness.[48,59–61] On the other hand, some have reported a stronger correlation between these two

domains among those with chronic diseases exhibiting milder symptoms.[18,62] Clearly, the relationship between spirituality and quality of life in the elderly with chronic illness is very complex and may need further investigation.

Limitations of this research

The limitations in this pilot study were due mainly to the setting of the study and the recruitment of participants. The setting for this research was not randomly selected and was limited to only one Elderly Club where the participants have higher education and income than the average for the country. The recruitment of the sample employed a non-probability convenience sampling technique and so was biased against older people who cannot join the Elderly Club but stay at home. Therefore, the findings cannot be generalized beyond those who are resident in this particular Elderly Club. Nevertheless, elements of interest from this research may well be used as the basis for further individual institution research, or a country-wide investigation.

Conclusion and recommendations

This study has revealed the importance of spirituality for older people in Thailand. However, the exploration of spirituality using qualitative methods will give more insight into the real meaning of spirituality in the Thai culture and belief system. More broadly based research is also needed to come to general conclusions about the importance of spirituality in the quality of life of older Thai people. Other studies, particularly comparisons among elements of socio-demographic data, are needed to determine their different effects on spirituality and quality of life.

This further study would provide information very helpful to nurses in their provision of appropriate spiritual care. In the mean time these results reaffirm the importance of spiritual care for elderly Thai people and the need for nurses to stress the importance of caring family relationships and the ongoing integration of spiritual practices such as providing opportunity for spiritual practice in patient health facilities involved in the care of the elderly.

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