



Physiological and psychosocial factors in spiritual needs attainment for community-dwelling older adults



Jennifer A. Palmer^{a,b,*}, Elizabeth P. Howard^c, Margaret Bryan^a, Susan L. Mitchell^{a,b}

^a Hebrew SeniorLife, Institute for Aging Research, 1200 Centre Street, Boston, MA, 02131, USA

^b Department of Medicine of Beth Israel Deaconess Medical Center, 330 Brookline Avenue, Boston, MA, 02215, USA

^c School of Nursing, Northeastern University, 360 Huntington Avenue, Boston, MA, 02115, USA

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ABSTRACT

Background: Spiritual well-being enhances older persons' health status. Factors that optimize their spiritual well-being are not well-established.

Objective: To describe spiritual needs attainment and identify factors associated with such attainment among community-dwelling older persons.

Design: Cross-sectional.

Setting: Sixty-five U.S. continuing care retirement communities or independent housing facilities.

Subjects: 4077 persons entering the facilities between January 1, 2007 and November 30, 2016.

Methods: Standardized Community Health Assessment and Wellness Survey instruments were used to determine the proportion of subjects reporting their spiritual needs were met. Multivariate logistic regression identified characteristics independently associated with this outcome.

Results: Among the 4077 subjects (mean age 81.6 ± 7.5 ; male, 28.8%; and White race, 70.7%), 93.4% stated their spiritual needs were met. Factors independently associated with a greater likelihood of spiritual needs attainment were: satisfaction with life (adjusted odds ratio (AOR) 2.81, 95% confidence interval (CI) 2.00, 3.96; $p < 0.001$), feeling valued (AOR 2.51, 95% CI 1.61, 3.92; $p < 0.001$), strong and supportive family relationship (AOR 1.99, 95% CI 1.20, 3.29; $p = 0.008$), sufficient sleep (AOR 1.59, 95% CI 1.15, 2.19; $p = 0.005$), no pain (AOR 1.35, 95% CI 1.01, 1.82; $p = 0.046$), and having someone to talk to about death among those interested in doing so (AOR 0.39, 95% CI 0.29, 0.54; $p < 0.001$).

Conclusions: The majority of community-dwelling older persons reported their spiritual needs were met. Adequate sleep, pain relief, and having a person with whom to discuss death are potentially modifiable factors that may promote spiritual needs attainment in this population, which in turn, may improve their health outcomes.

1. Introduction

By 2030, 20% of all Americans will be over the age of 65, with the medical needs of this population putting increasing demands upon the U.S. health care system. (Ortman, Velkoff, & Hogan, 2014) Prior research has shown that spiritual well-being may promote positive physical and psychological health outcomes among relatively healthy (Lawler-Row & Elliott, 2009) and chronically and terminally ill (Chen, Lin, Chuang, & Chen, 2017; Salsman et al., 2015) older persons. Thus, understanding what may promote the outcome of spiritual well-being of older adults, such as those factors associated with the process of spiritual needs being met, may also illuminate ways to improve their general health status.

Prior research focused on the intersection of aging, spirituality, and health has largely investigated the impact of personal spirituality and/or religion on health outcomes. (Daaleman, Perera, & Studenski, 2004; Lawler-Row & Elliott, 2009; McCullough, Hoyt, Larson, Koenig, & Thoresen, 2000; Mofidi et al., 2006; Sawatsky et al., 2005) Associations in the reverse direction (e.g., how health status affects spiritual needs being met), has less grounding in the literature. Studies that have examined the prevalence of and the factors associated with spiritual needs attainment have done so in chronically and terminally ill older patients (Balboni et al., 2007; Bussing, Janko, Baumann, Hvidt, & Kopf, 2013; Hermann, 2007; Pearce, Coan, Herndon, Koenig, & Abernethy, 2012). Empirical studies have in fact not established the proportion of individuals with spiritual needs met within the community-dwelling older

* Corresponding author at: Hebrew SeniorLife, 1200 Centre Street, Boston, MA 02131, USA.
E-mail address: jennypalmer@hsl.harvard.edu (J.A. Palmer).

population. Potential modifiable factors that could optimize spiritual needs attainment of community-dwelling older persons also remain largely unexplored. As an exception, one quantitative study from Germany, that administered standardized survey instruments to community-dwelling and institutionalized older persons, found that religious trust and “mood states” (especially “tiredness”) were associated with whether or not spiritual needs were met across a variety of domains of spirituality; however, this study had a small sample size ($N = 80$), was not generalizable to other countries, and the analysis did not distinguish associations in the community versus institutionalized living environments. (Erichsen & Bussing, 2013) We sought to address this knowledge gap by examining spiritual need attainment in a large, exclusively community-dwelling sample. Thus, this report is the first to leverage an inter-RAI standardized assessment instrument administered to a large sample of U.S. community-dwelling older persons ($N = 4077$) to achieve two main objectives: 1. To describe the proportion of individuals who reported that their spiritual needs were met, and 2. To identify physical, functional, psychosocial, and health service use factors associated with whether or not spiritual needs were met.

2. Methods

The conduct of this study was approved by the Hebrew SeniorLife Institutional Review Board.

2.1. Setting

Data for this study were derived from older adults living in facilities that were part of the COLLAGE, a national consortium of aging services organizations in the U.S. (COLLAGE Consortium, 2008). These facilities were located in 24 states in Northeast and Midwest regions of the U.S. and include continuing care retirement communities (CCRCs) and independent senior housing facilities ($N = 65$ facilities).

2.2. Data sources

Data were derived from the Community Health Assessment (CHA) and Wellness Survey, two tools that are part of the interRAI suite of instruments that have been used for research purposes. This suite of assessment instruments are related and share common standardized items which are adapted for use in various health settings. For example, the Minimum Data Set (MDS), a well-known instrument mandated for use in all U.S. nursing homes, was originally created by researchers who later founded interRAI and led to a current day version of interRAI's long-term care facilities assessment tools. (interRAI, 2017) Specifically, the CHA was designed to assess the health and well-being of older persons living in the community setting and includes items related to their physical and mental health and cognitive, functional, and psychosocial status. The Wellness Survey is designed for the same population but focuses on quality of life variables, including those related to physical, psychosocial, spiritual, and environmental factors; the tool is used to facilitate development of healthy aging plans based upon individual preferences.

The CHA and Wellness Survey are administered as a pair to older persons living in COLLAGE facilities who opt in to participate. This administration happens during wellness coaching sessions that routinely occur upon facility admission and annually thereafter. CHA data are collected through a semi-structured conversation between a trained staff member (i.e., a nurse or social worker) and the respondents (or their proxies). The Wellness Survey is completed directly by the respondents (or their proxies).

2.3. Population

For this report, we utilized admission CHAs and Wellness Surveys from the aforementioned COLLAGE facilities between January 1, 2007

and November 30, 2016. Eligible subjects had to have a Cognitive Performance Scale (CPS) score no more than 3 to maximize the likelihood data were ascertained directly from the subjects rather than their proxies. The validated CPS score uses five CHA variables to group residents into seven cognitive performance categories: 0 = intact, 1 = borderline intact, 2 = mild impairment, 3 = moderate impairment, 4 = moderately severe impairment, 5 = severe impairment, and 6 = very severe impairment with eating problems. (Hartmaier et al., 1995; Morris et al., 1994; Morris et al., 2016)

2.4. Variables

2.4.1. Outcome variable

The outcome variable derived from the Wellness Survey was a dichotomous response to the question: “Do you feel your spiritual needs are being met?”

2.4.2. Independent variables

Independent variables were selected from CHAs and Wellness Surveys that were felt to be potentially associated with spiritual needs being met based on our clinical experience and the literature. (Chen et al., 2017; Erichsen & Bussing, 2013) Only variables with < 10% missing data values were considered.

2.4.3. Demographics

Demographic data from the CHA included age and gender, as well as race (White vs. other) given documented racial differences in the association between spirituality and life satisfaction amongst the elderly. (Cummings & Galambos, 2016) Race was self-reported or reported by a proxy according to a closed-ended question with fixed response options, though respondents were able to report race in an open-ended manner within an “other” category as well.

2.4.4. Medical conditions

Other CHA variables included the presence or absence of common age-related physical conditions (Alzheimer's disease, cancer, cardiac disease, chronic obstructive pulmonary disease (COPD), diabetes, stroke) and mental health symptoms (anxiety and depression) over the last three days.

2.4.5. Cognitive and functional status

Cognitive function was dichotomized into having a CPS score of 0 or 1 (cognitively intact or borderline intact, respectively) versus 2 or 3 (mild or moderate cognitive impairment, respectively). Subjects were categorized either as fully independent in all Activities of Daily Living (ADLs) (personal hygiene, locomotion, toilet use, and eating) or requiring assistance for at least one ADL. Similarly, subjects were categorized as being either fully independent in all Instrumental Activities of Daily Living (IADLs) (meal preparation, housework, finances, medication management, and shopping) or having difficulty with at least one IADL.

2.4.6. Other health-related factors

Self-rated health was categorized into excellent or good versus fair or poor. The CHA measures pain as follows: 0 = no pain; 1 = pain less than daily; 2 = pain daily with moderate-severe intensity; and 3 = pain daily with more than severe intensity. We dichotomized pain into having a score of 0 versus ≥ 1 . Whether or not the subject had a hospital transfer in the last 90 days (emergency room visit or overnight stay) was also ascertained.

2.4.7. Psychosocial factors

Psychosocial factors included the presence of a “strong and supportive relationship with family” (yes/no), an item from the CHA. A question from the Wellness Survey about satisfaction with life was dichotomized as follows: 0 = not satisfied with life (unhappy, mostly

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