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Spiritual needs, well-being and perception of health among community dwelling older adults

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Abstract; Background: *Spirituality is recognized as personally essential thing to older adults and it affects their health. Although the research on spiritual well-being and needs of elders with chronic diseases increases, there is limited research about community dwelling older adults in Egypt.* ***Aim:*** *The aim of this study was to determine the spiritual needs, well-being, and perception of health among community dwelling older adults.* ***Method:*** *Descriptive (cross-sectional) research design was used. This study was carried out at four randomly selected districts affiliated to Dakahlia Governorate, Egypt. A purposive sample of 250 community dwelling older adults were enrolled in the study. Data was collected using socio-demographic and health related data structured interview schedule, Spiritual Well-Being Scale to assess religious and existential well-being, and Spiritual Needs Questionnaire to measure religious needs, existential needs, need for inner peace, and need for active giving/ generativity.* ***Results:*** *The mean scores of needs for peace, giving / generativity need, religious need, and existential were 8.56±2.79, 14.89±5.39, 8.70±4.59, 9.53±3.85; respectively. The total mean score of overall spiritual well-being was 102.50 ± 8.05. Spiritual well-being had a moderately positive significant association with age, living alone, number of co morbidities, perceived health status, and spiritual needs.* ***Conclusion and recommendations:*** *The need for giving / generativity scored high followed by existential (reflection / meaning), while religious need and need for peace scored low. Spiritual well-being is predicted by need of giving / generativity, number of co morbidities, and perceived health status. Strategies to determine and improve spiritual well-being of the institutionalized and non-institutionalized older adults should be formed, tested, and put into nursing practice as well as training and education for nurses to discover and respond to spiritual needs.*

Keywords: *older adults, perceived health status, spiritual needs, spiritual well-being.*

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I. Introduction

Within the arena of nursing profession, individuals' biopsychosocial-spiritual being is increasingly obtaining a vital detection. It is affirmed in the holistic model of care that nurses should consider the spiritual needs of their clients in the providing of total client care. [1, 2] The spiritual aspect is a unifying force that incorporates all other aspects of health, i.e., mental, psychological, physical, and social. As the spiritual is interlaced with all life dimensions, the entirety of human needs can't be met without consideration to spiritual well-being. [3]

Spiritual needs are the expectations and needs that human has to find aim, value, and meaning to his life. These needs may be in specific religious, however even persons who don't belong to any organized religion or have no religious faith hold belief system which provide their life purpose and meaning. [4, 5] There are four interconnected core spiritual needs dimensions, that is, meaning/purpose, peace, connection, and transcendence, which can be assigned to core categories emotional, psychosocial, religious, and existential needs. [4, 6] Actually, there are numerous obstacles in the system of health care which trigger difficulties in meeting that needs. Nurses' unwillingness to deal with spirituality is due to a belief that spiritually care of the person is the responsibility of somebody else, lack of education, effect of diversity and secularism in community, and the present context of health-care. [7]

Spiritual well-being is shown by being satisfied in a relationship with God as well as being satisfied with life, despite the consequences of illnesses and failures. [8] Spiritual well-being is one of the most essential dimensions for older adult's health. Perception of spiritual well-being may be examined from two different points of religious well-being and existential one. The religious well-being includes individual's perception of health in his/her spiritual life related to a superior power. The existential well-being examines the individual's mental and social interests and the person's ways of coping with the self, society and environment. [9]

Confronted with aging challenges as illness and low health status, many older adults rely on spiritual issues to cope. Older adults with poor health status are particularly likely to have unmet spiritual needs. [10, 11] Discontentment and dissatisfaction due to illness can lead elderly to indispose themselves from supportive relationships. In addition, coping with chronic diseases can lead to feelings of anger toward God. This spiritual conflict may result in the negative psychological outcomes. [12, 13]

There is rising concern in health and spirituality and the significance of considering the spiritual aspect in the provision of health care service [10, 11], but there is a limited studies about spiritual needs and well- being and their relation to health and illness among older adults in Egypt. Nursing was one of the first healthcare professions to deal with the spiritual needs of patients and to identify spiritual distress as a diagnosis. [3] Nurses are in a perfect position to aid older adults to achieve spiritual comfort by giving them an opportunity to express their spiritual feelings or by transferring them to a suitable religious representative if they want this. When people face a spiritual crisis and need spiritual care, they can prefer to express their concerns only if they have been shown appreciation and respect. [14] So, possessing an understanding of spirituality and its relation to health aids gerontological nurse to provide appropriate and compassionate spiritual care. [15] So, the aim of this study was to determine the spiritual needs, well-being, and perception of health among community dwelling older adults.

Research questions

1) What are the spiritual needs reported by community dwelling older adults?
2) What is the level of spiritual well-being of community dwelling older adults?
3) Is there any significant correlation between spiritual well-being of community dwelling older adults and their sociodemographic characteristics, perceived health status, presence of co morbidities and spiritual needs?
4) What are the predictors of spiritual well-being among community dwelling older adults?

II. Subjects And Method

Research design:

A cross-sectional descriptive study was used.

Settings:

This study was carried out at four districts namely Mansoura, Mhlt Damna, Meetsalseel, and Sinbilawin. The districts were selected randomly (simple random sampling) from 18 districts affiliated to Dakahlia Governorate, Egypt.

Subjects:

The study included a purposive sample of 250 older adults living in the above-mentioned settings, aged 60 years and above, and able to communicate. Older adults diagnosed with severe medical/neurological disorder or malignant diseases were excluded from the study. The sample size was calculated through using DSS sample size calculator at 5% ∞ error (95.0% confidence level) and 20.0 β error (80.0% power of the study), enter average value equal 38.07 with SD 11.46 and test value equal 40.0. [3, 16] The calculated sample size was 218 and added 10% to become 240 older adults to compensate withdrawal of study subjects. The researchers included 250 older adults for more reliable findings.

Tools:

Socio-demographic and health related data structured interview schedule: this tool was developed by the researchers after reviewing relevant literature [3, 13, 15] and included 2 parts:

- **Socio-demographic data** such as; age, sex, marital status, education level, and living arrangement.
- **Health related data such as;** number of co morbidities and self-rated health. For self-rated health, the study subjects were asked: 'How would you rate your health? The responses were rated on a five-point likert scale.

Spiritual Well-Being Scale (SWBS)

The Spiritual Well-Being Scale (SWBS) was developed by Paloutzian and Ellison (1982)[17] as a general indicator of the subjective state of religious and existential well-being. It was translated and validated into Arabic by Musa and Pevalin (2012).[18] The reliability was assured by the Cronbach's alpha coefficient α=0.83. The SWBS is composed of twenty items and has two subscales: Religious Well-Being (RWB) and Existential Well-Being (EWB). The RWB subscale measures the degree to which individuals experience a satisfying relationship with God. The EWB subscale assesses the degree to which individuals experience satisfying relationships with others and the degree of life satisfaction and purpose. Every one of those two subscales

involve ten items, measured individually on a six-point Likert scale, ranging from "strongly agree" to "strongly disagree". The items are scored from one to six, with six showing a greater well-being. Some items are worded in a reversed direction. The overall SWB score is computed by summing responses to all twenty items. Scores range from 10 to 60 on the subscales and 20 to 120 on the SWBS value. Higher scores reflect a higher perception of spiritual well-being.

Spiritual Needs Questionnaire (SpNQ)

Spiritual needs questionnaire was developed by Büssing, Balzat, and Heusser (2010) [6] for measuring the spiritual needs. The questionnaire includes 27 items. It covers 4 main factors; Religious Needs, Existential Needs (Reflection/Meaning), Need for Inner Peace, and Need for Active Giving/ Generativity. The scoring of the responses of the older adults are rated on a four -point likert scale from disagreement to agreement (0: not at all; 1: somewhat; 2: very; 3: extremely). The higher the scores the stronger the respective needs.

Procedure:

Approval to conduct the study was obtained from the responsible authority. Demographic and health related data structured interview schedule was developed by the researchers after review of the relevant literature. The Arabic version of SWBS was used. SpNQ was translated into Arabic by researchers and tested for content validity by five panels of experts in gerontological nursing, psychiatric and mental health nursing, and biostatistics and the required corrections and modifications were done accordingly. SpNQ was applied on 10 older adults' selected from Meetkhamees village in Mansoura city and the tool was repeated again for these older adults after two weeks. The reliability was assured by means of the Cronbach's coefficient alpha (r = 0.87). A pilot study was carried out on 20 older adults to test feasibility and clarity of the tools and to identify the approximate time needed for the interview. These older adults were not included in the study subjects. The data obtained from the pilot study was analyzed and according to the results, the recommended changes were done. Researchers used to go to selected villages following a prepared schedule which starts from 11 am to 4 pm on Monday and Thursday/ week. A face to face interview was conducted with each older adult who fulfills the inclusion criteria of the study in his home. The interview was managed to include 8-10 older adult daily. The time needed to complete the study tools ranged from 25-30 minutes. The collection of data was done during the period from April 1 to July 30, 2018.

Ethical considerations of the study:

Ethical approval was taken from Mansoura University Faculty of Nursing Ethics Committee to conduct the study. Informed consent was obtained from the older adults. The objective of the study explained to the older adults and assured about confidentiality and anonymity of the collected data. The privacy of each older adults was maintained and were informed that, their participation is voluntary and they can withdraw from the study at any time.

Data analysis:

Statistical analysis was done by utilizing the Statistical Package for Social Science version sixteen. The data obtained were coded, analyzed and tabulated. Basic descriptive statistical analysis was carried out using; frequencies, minimum-maximum, means, and standard deviations. The analytical statistics was carried using; student t-test, and spearman's correlation coefficient. Variables significantly associated with spiritual wellbeing were entered into a stepwise multiple regression model for analysis. The 0.05 and 0.01 levels were utilized as the cut off value for statistical significance.

III. Results

Table 1 shows that, the mean age of studied subjects was 67.12±6.34. Males constituted 58.4% of older adults. About 67.6% of older adults were married and 30.4% were widows. 49.2 % of older adults were illiterates and 24.4% were read and write. Regarding living condition, 76.4% of the study subjects are living with their families. The findings also indicated that approximately 42.0 % of older adults had one chronic disease and 34.0% had two.

Table 1: Socio-demographic characteristics of older adults (N= 250)

Socio-demographic characteristics	N (%)
Age	
60<65	113 (45.2)
65<75	114 (45.6)
75 < 85	14 (5.6)
85 and more	9 (3.6)
Mean ± SD	**67.12±6.34**
Sex	
Male	146 (58.4)
Female	104 (41.6)
Marital status	
Single	1 (0.4)
Married	169 (67.6)
Widow	76 (30.4)
Divorced	4 (1.6)
Education level	
Illiterate	123 (49.2)
Read and write	61 (24.4)
Secondary	40 (16.0)
University	26 (10.4)
Living arrangement	
Alone	10 (4.0)
With family	191 (76.4)
With one of sons	46 (18.4)
With relatives	3 (1.2)
Comorbidities	
No disease	30 (12.0)
One disease	105 (42.0)
Two diseases	85 (34.0)
Three or more disease	30 (12.0)

Figure 1 shows that, 38.8% of older adults perceived their health status as good, while 33.2% and 16.8 % of them perceived it as very good and fair; respectively. Only 6.4% and 4.8% of older adults perceived their health status as excellent and poor; respectively.

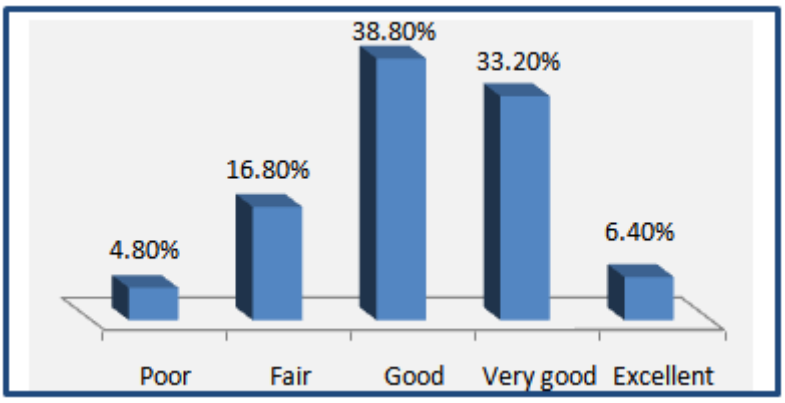

Figure 1: Perceived health status of older adults

Table 2 shows that, the mean scores of needs for peace, giving / generativity need, religious need, and existential were 8.56±2.79, 14.89±5.39, 8.70±4.59, 9.53±3.85; respectively. The need to "feel connected with family" and "re involved by family in their life concerns" were the strongest (2.04±0.88 and 2.03±0.86; respectively), followed by "be assured that your life was meaningful and of value and " receive more support from your family" (2.01±0.87 and 2.01±0.91; respectively). On the other hand, the need of "reading of spiritual/religious books" and " talk about the possibility of a life after death" was relatively low (0.69±1.01 and 0.82±0.74; respectively).

Table 2: Spiritual needs of older adults (N= 250)

Spiritual Need		Mean ± SD
Need for peace		
1.	Wishing to dwell at quiet and peaceful places	1.75±0.77
2.	Finding inner peace	1.77±0.68
3.	Immersing in the beauty of nature	1.75±0.87
4.	Talking with others about one's fears and worries	1.64±0.86
5.	Being complete and safe	1.64±0.70
Mean ± SD		**8.56±2.79**
Giving / Generativity		
1.	Turn to someone in a loving attitude	1.98±0.95
2.	Give away something from yourself	0.98±0.98
3.	Addresses the active and autonomous intention to give solace someone	1.90±0.84
4.	Feel connected with family	2.04±0.88
5.	To pass own life experiences to others	1.92±0.94
6.	Be assured that your life was meaningful and of value	2.01±0.87
7.	Re involved by family in their life concerns	2.03±0.86
8.	Receive more support from your family	2.01±0.91
Mean ± SD		**14.89±5.39**
Religious needs		
1.	Someone prays for you	0.90±0.94
2.	Pray for yourself	1.90±0.96
3.	Praying with someone	1.56±0.89
4.	Participate at a religious ceremony	1.35±1.032
5.	Reading of spiritual/religious books	0.69±1.01
6.	Turn to a higher presence (i.e. God, angels etc.)	1.22±0.99
7.	Someone of your community (i.e., priest, chaplain) cares for you	1.06±0.96
Mean ± SD		**8.70±4.59**
Existential (Reflection / Meaning)		
1.	Talk about the possibility of a life after death	0.82±0.74
2.	Reflect previous life	0.95±0.74
3.	Find meaning in illness and/or suffering	1.06±0.79
4.	Talk with someone about the question of meaning in life	1.16±0.82
5.	Dissolve open aspects in life	1.46±0.89
6.	Forgive someone from a distinct period of your life	1.89±0.89
7.	Be forgiven	2.16±0.86
Mean ± SD		**9.53±3.85**
Total Mean Score for Spiritual Need Scale		**41.69±12.03 Min-Max (10-74)**

Table 3 reveals that, the mean total score for overall SWB was 102.50 ± 8.05 (high spiritual well-being), and for the two subscales, the means were 56.52±5.79 and 45.97±3.84 for RWB and EWB; respectively.

Table 3: Spiritual well-being of older adults (N= 250)

Spiritual well-being		Mean ± SD
Religious Well-Being Scale (RWS)		
1.	I find much satisfaction in private prayer with God	5.76±0.56
2.	I believe that God loves me and cares about me	5.64±0.63
3.	I believe that God is interested in my daily situations	5.67±0.65
4.	I have a deep relationship with God.	5.62±0.66
5.	I get much personal strength and support from my God	5.67±0.643
6.	I believe that God is concerned about my problems	5.63±0.66
7.	I have a personally satisfying relationship with God	5.61±0.77
8.	My relationship with God helps me not to feel lonely	5.58±0.76
9.	I feel most fulfilled when I'm in close communion with God	5.64±0.65
10.	My relation with God contributes to my sense of well-being.	5.66±0.62
RWS mean score		**56.52±5.79** **Min-Max (37-60)**
Existential Well-Being (EWB)		
11.	I know who I am, where I came from, or where I'm going	5.39±0.67
12.	I feel that life is a positive experience	5.00±0.66
13.	I feel unsettled about my future	3.65±1.32
14.	I feel very fulfilled and satisfied with life.	5.04±0.71
15.	I feel a sense of well-being about the direction my life is headed in	4.97±0.67
16.	I enjoy much about life	4.88±0.83
17.	I feel good about my future	4.53±1.18
18.	I feel that life is full of conflict and unhappiness	2.54±1.11
19.	Life has much meaning	4.92±0.86
20.	I believe there is some real purpose for my life	5.03±0.78
RWS mean score		**45.97±3.84** **Min-Max (35-58)**
Total Mean Score for Spiritual Well-Being Scale		**102.50±8.05** **Min-Max (76-118)**

Table 4 shows that, SWB had a high positive significant correlation with age (P=0.007), living alone (P=0.018), number of comorbidities (P=0.019), perceived health status (P=0.000), spiritual needs (P= 0.000), RWB (P=0.000), and EWB (P=0.000). RWB also had a high positive significant relationship with age (P=0.017), sex (P=0.024), living alone (P=0.040), and spiritual needs (P=0.001). While, EWB had a high positive significant correlation with age (P=0.012), number of comorbidities (P=0.006), perceived health status (P=0.000), spiritual needs (P=0.002) and RWB (P= 0.000). There were no correlations between spiritual needs and age, sex, living alone, and number of comorbidities but perceived health status was associated significantly with spiritual needs (P=0.028).

Table 4: Correlations among study variables

Items	Perceived health status	Spiritual Needs	Religious well-being	Existential well-being	Spiritual well-being
Age	- 0.009 (0.888)	0.037 (0.562)	0.151 (0.017) *	0.159 (0.012) *	0.170 (0.007) **
Sex	- 0.015 (0.818)	- 0.080 (0.205)	0.143 (0.024) *	0.025 (0.688)	0.081 (0.202)
Living alone	0.106 (0.094)	- 0.040 (0.526)	0.130 (0.040) *	0.105 (0.096)	0.149 (0.018) *
Number of co morbidities	- 0.202 (0.001) **	- 0.021 (0.738)	0.040 (0.528)	0.173 (0.006) **	0.149 (0.019) *
Perceived health status	----------	0.139 (0.028) *	0.105 (0.097)	0.296 (0.000) **	0.257 (0.000) **
Spiritual Needs	----------	----------	0.203 (0.001) **	0.197 (0.002) **	0.219 (0.000) **
Religious well-being	----------	----------	----------	0.323 (0.000)**	0.762 (0.000)**
Existential well-being	----------	----------	----------	----------	0.821 (0.000)**

Note: Living alone = 1 versus living with family= 2; Sex male=1 versus female= 2.
* P < 0.05
**P < 0.01

Table 5 reveals that, SWB was taken as dependent variable and demographic variables (age, sex, marital status, education, income, living arrangement), number of comorbidities, perceives health status, and spiritual needs were added as predictor variables. SWB is best predicted (R=0.015) by the need of giving / generativity, number of comorbidities, and perceived health status.

Table 5: Stepwise multiple regression analysis predicting spiritual wellbeing

Variable	Un standardized Coefficients		Standardized Coefficients	t	Sig.	R Square Change
	B	Std. Error	β			
Need of Giving /Generativity	0.500	0.088	0.335	5.665	0.000	0.015*
Perceived health status	1.342	0.510	0.159	2.632	0.009	
Number of comorbidities	1.470	0.560	0.156	2.627	0.009	

*P < 0.01

IV. Discussion

Older adults have specific spiritual needs which are different from these of others, mainly in periods of illness and poor health status. Achievement of these spiritual needs has a positive impact on life satisfaction. [19] The results of the current study indicate that the need for giving / generativity scored high followed by existential (reflection / meaning). This result was supported by psychosocial development stage of Erikson named “generativity”, that points to the capability of caring for others, direct the following generation, and assuring that the own life was essential to others. [20] But, though the elderly can possess this intention or wish, it sounds that they have create the experience which there is restricted interest regarding their offering. Among the giving / generativity need, the need to "feel connected with family”, “re involved by family in their concerns of life ", "be assured that your life had meaning and value”, and " receiving more support from your family” were of strong relevance. Noticeably the elderly has something for offering; they would like to be connected to these who shall remind them. Regarding religious need, the need to "pray for yourself" and “praying with someone" were of high relevance. On the other hand, the need of "reading of spiritual/religious books" was relatively low. Praying might be a ritual much more an index of a special longing for higher support for them. The need to "talk about the possibility of a life after death”, "talk with someone about the question of meaning in life”, and " find

explanation of suffering and/or illness " were relatively lower compared to " speaking with others about one's fears and worries". This may be because of fright from burdening others with one own concerns. It sounds that elders refuse to speak about death, valediction, and suffering; alternatively, they choose to speak about "worries and fears", yet there is a need for close relations that could ease this. In this regard, a study conducted in Germany by Erichsen and Büssing (2013) [16] reported that needs of inner peace scored slightly higher and giving/generativity needs were the highest spiritual needs, while religious needs and existential needs scored low among elderly living in retirement/nursing homes. They added that throwing into nature beauty" was expressed highest, as well the need to "feel linked to family," to "turn to somebody in an amicable attitude" and to "reflect prior life" had strong relevance. The same results reported by Büssing et al. (2013)[21] in China who revealed that needs of inner peace and giving/generativity were the highest relevance for the elderly. They rationalized that the need for inner peace act as facilitators of mind peaceful states to allow going of pain and suffering for a while. While religious needs were of minor relevance because of three-quarters of the elderly in their study had no religious affiliation. [21]

The spiritual aspect of human beings plays a main role in detecting an elderly overall well-being. Some studies indicate that without SWB, other life aspects as psychosocial can't act correctly or may not give their extreme capability and the higher level of quality of life. [5, 12, 15] The present study pointed out that the mean of SWB was high and no one of the elderly possess lower domain of SWB. This may be because of religiosity of elderly Egyptians that spirituality and religion play a significant role in overall life stages particularly aging. Studies conducted in Iran by Heydari- Fard et al. (2012) [15] and Jadidi et al. (2011) [22] reported the same results. Various studies had as well confirmed the spirituality role during this time of life. [23-25]

The results of current study revealed that, there was significant correlation between socio-demographic characteristic and SWB of community dwelling older adults. Concerning age, the study revealed a significant positive association between age and SWB. This is supported by Gerotranscendental theory which was originally expressed by Tornstam (1994). Based on this theory, Gerotranscendental term points out to change in view of elderly and a shifting in metaperspective, from a rational and materialistic view to a more transcendent and cosmic one. Gerotranscendental term suggests exceed developmental dynamic point of view in older adults. [26] In contrast with materialist theory, this theory believes that people have low attention to life material aspects by raising age and become much more interested in meaningful life, spirituality, and more interested in communication with others. Based on this theory, all people are prone to be mature and wise and life crisis speed the gerotranscendental evolution. [26] Furthermore, sex differences in RWB was noted in the present study where greater RWB was found to be positively associated with female sex. This is in accordance with You et al. (2009) [3] in Korea who demonstrated that women attended church, perceived faith as important, had a high level of daily spiritual experiences, and had a high level of SWB than men. Hafeez and Rafique (2013) [27] in Pakistan reported that SWB is greater among Muslim elderly females residing in the residential facilities. In contrast, studies had done in Iran by Heydari- Fard et al. (2012) [15] and Jadidi et al. (2011) [22] showed that no significant relationship was found between socio-demographic variables and SWB. Unless, the average of SWB in elderly groups was higher, however the variation wasn't significant and they justified this because of the small sample size. [15, 22] Inconsistency in results disseminated by various researchers is largely due to diversity in sample and its varied characteristics.

Social network has an independent effect on well-being of elderly who dwell in community. [28] Unlike Western elderly who prefer to be independent from their children and live alone, Egyptian elderly have a perception that staying with the family not only gives emotional and financial support from their families but also reprove their meaningfulness. Living alone usually associated with an isolation sense, a self-esteem loss, slipping into depression, that negatively influences SWB. [29] In this regards, the current study findings reveal that elderly who live alone have lower SWB than those who live with their family. This is in agreement with Korean study by You et al. (2009). [3]

Spirituality is a major contributor to health status for older adults with chronic diseases and it promotes psychosocial adjustment to illness by decreasing anxiety and depression, a total rising in psychological well-being and quality of life, and higher role satisfaction. [30-32] In this accordance, the result of the current study revealed that there is a significant positive relation between SWB, number of co morbidities, and perceived health status. This is due to many Egyptians believe that they became sick because God might have decided to test their faith, or illness was the will of God and they have nothing to do about it. Acceptance of illness with its related consequences may be due to Islamic religious values that, with patience and acceptance one will be relieved later by God. Additionally, the results of current study revealed that EWB had a positive significant relationship with number of comorbidities and perceived health status of community dwelling elderly. This can be explained that existential beliefs can improve well-being through giving a clarification for the illness experience, assisting people in adjusting to their illness and worth their lives and themselves, even as they approach death. [33, 34] In the same direction, Reda (1994) [35] in Egypt stated that predominance of praying as a coping behavior is not surprising in the Egyptian culture. Religion may be a source of strength to individual that

provide a reason for accepting suffering and make coping easier. Fathalla (1991) [36] and Ashour (1992) [37] in Egypt added that the main interest of the elderly in their later years is directed toward the spiritual aspects of life, where they usually find relief from the stress that might confront them. You et al. (2009) [3] stated that SWB had a positive relationship with general health among Korean older adults in the community. The same results reported in Brazil by Vitorino, et al. (2016) [38] and in Canada by Davison and Jhangri (2013). [39] On the contrary, other studies have systematically showed negative correlations between SWB and chronic illness among community dwelling older adults. [40, 41]

Regarding to the relation between SWB and spiritual needs, the present study findings proved that there is a significant relation between SWB and spiritual needs of community dwelling older adults, however it is one of the 1st studies to overpass questions of SWB with spiritual needs from Egyptians elderly in the community. This may be due to the majority of elderly in the current study had chronic diseases, and during chronic diseases, elderly patients seek to achieve spiritual satisfaction and well-being as they consider the presence of chronic diseases is an affliction from God and a test for them, and thus increases the spiritual needs to achieve this wellbeing. Additionally, spiritual beliefs and practices act as a barrier when elderly are faced with negative events of life. Researchers have recommended that most Americans believe that spirituality is an essential aspect of their overall health and may enhance coping and recovery from illness. These researchers have proposed that patients with cardiovascular disease, cancer, HIV, and other chronic disease often turn to spiritual practices to aid them cope. [42] Furthermore, there is a significant association between spiritual needs and perceived health status of community dwelling elderly while age, sex, living status, and number of comorbidities had no significant influence on spiritual needs. Büssing et al. (2013) [21] in China reported that living status had no significant influence on spiritual needs while age and sex significantly influenced religious needs. As well, it was reported by Erichsen and Büssing (2013) [16] in Germany that age significantly influenced religious needs as religious needs were lowest in elderly males. Büssing et al. (2018) [43] reported that there were significant differences between healthy and persons with chronic diseases, especially on the inner peace needs and existential needs subscales as spiritual needs are higher among chronic ill persons than non-ill. Additionally, they found that the mean scores of spiritual needs differed significantly between males and females as females expressed greater needs than males, particularly on the religious needs' subscale. Concerning independent predictors of SWB among older adults in the community, this study showed that need of giving / generativity, number of comorbidities, and perceived health status were significant predictors of spiritual well-being. This finding is consistent with the results of You et al. (2009) [3]. Based on these results, it is very substantial for gerontological nurses to realize the spiritual dimensions importance of elderly and enhance these dimensions in their care. Elderly should be motivated to participate in spiritual practices and reflect on how these practices assist them to best understanding of themselves, their lives, and illnesses and health. Doing so can improve patients' psycho-emotional stability, degrees of meaning and hope, and thus peaceable states of mind in spite of their chronic illness.

Limitation

The cross-sectional design was the limitation of this study, that doesn't permit causal interpretations.

V. Conclusion

In this study, the majority of community dwelling older adults had a high score of spiritual wellbeing, spiritual needs and minority of them perceived their health status as excellent. The need for giving / generativity scored high followed by existential (reflection / meaning). Moreover, spiritual well-being had a positive significant correlation with age, living alone, number of comorbidities, perceived health status, and spiritual needs and it is predicted by need of giving / generativity, number of comorbidities, and perceived health status.

VI. Implications For Nursing Practice

1. Spiritual assessment should be a part of the comprehensive assessment for older adults and should include spiritual history, spiritual needs, believes, and practices and these should be integrated into the treatment plan.
2. Strategies to improve spiritual well-being of older adults as praying, recall positive memories, and meditation must be created, tested, and put into nursing practice as well as training and education for nurses to discover and respond to spiritual needs.
3. Further studies to compare spiritual needs and spiritual well-being of institutionalized older adults and community dwelling older adults.
4. Qualitative studies to clarifying the spiritual needs and well-being in the context of health and co morbidities are important towards the application of holistic care.

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