European Journal of Science and Theology, September 2012, Vol.8, No.3, 135-141

QUALITY OF LIFE AND SPIRITUALITY

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(Received 27 February 2012, revised 9 April 2012)

Abstract

Quality of life is a concept often used at the level of European health policies, being considered an important factor for general strategy orientation from Public Health System. There are some simultaneous discourses about core values integrated in this latent multidimensional construct and, sometimes, there are interrelated tensions between liberty and equality, between individualism (quality of life of society members) and collectivism (quality of societal life) and between subjective and objective components of quality of life. We bring to discussion a few models which emphasized the interdependence between these oppositions or complementarities and we underlined the importance of spirituality in evaluation of subjective quality of life.

Keywords: quality of life, ecological approach, normative approach, spirituality

1. Introduction

Quality of life is one of the popular concepts we hear with increasing frequency. For example, at individual level is a commonplace in professional discussions about disability and serious illness, and at collective level is given serious attention in social policy debates, and is a tock-in-trade for EU policy-makers [1]. Unfortunately, though, it is used so often, and in so many different contexts for so many different purposes, that it is difficult to pin down an agreed meaning [2].

The fact that quality of life might be at population level as heterogeneous as it is at individual level is shown in the diversity of indicators from the literature. There is a broad agreement that quality of life is a multidimensional construct, and that quality of life can be related to relative universal expectations about the qualities which people's lives may reasonably be anticipated to activate. Precisely which dimensions of the individuals or communities lives are selected as indicators of life quality varies according to different authorities, depending on certain theoretical and practical criteria. Another existing issue regards the role of objective and subjective indicators in quality of life assessment at both population and individual level.

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Subjectivists focus on hedonistic pleasure as the basic building block of human happiness or life quality, while objectivists have a radically different perspective: for them the important questions to ask are whether people are healthy, well fed, economically secure and well educated rather than whether they feel happy; their central concern is to do with meeting *needs.* So, again, there are two completely different criteria for the quality of life: subjectivists promote happiness whereas objectivists want to meet needs [2].

Cummins underlined that the separate measurement of objective and subjective components of life quality is essential [3].

Noll suggested that the possible combinations of circumstances and personal appraisals of them ca be conceptualised as a 2 x 2 matrix. He termed bad living conditions with a negative evaluation of them - *deprivation* (very low subjective well being) and *well-being* - good living conditions and positive evaluation (very high). *Dissonance* refers to the inconsistent combination of good living conditions and dissatisfaction, possible in the case of a person who has a lot of consumer goods but who is looking for deeper spiritual values. *Adaptation* refers to whatever many researchers see as the problematic combination of bad living conditions and high levels of satisfaction. Such a person would have a very restrictive access to hedonistic pleasures but a high level of satisfaction based on the respect of humanistic values [4].

2. Definitions of life quality

Rapley emphasised the key characteristics of what he refers to as several widely accepted definitions of life quality: „All specify that quality of life is an *individual psychological* perception of the material reality of aspects of the world" (italics in original). So this perspective is firmly embedded in individuals' psychological perceptions rather than in the independent objective reality of their existence [5]. The perspective he starts from is the definition given by the influential World Health Organization Quality of Life (WHOQOL) Group: „[Quality of life] is an individual's perception of their position in life in the context of the culture and value systems in which they live and in relation to their goals, expectations, values and concerns ... Quality of life refers to a subjective evaluation which is embedded in a cultural, social and environmental context." [6]

This definition of life quality benefit from comprehensiveness and efforts to relate the idea to cultural, social and environmental contexts and to local value systems embedded in our personal judgements [5, p. 53]. That means people are not independent in their assessments, and, unfortunately they are not sufficient aware of social messages (digital and analogical communication) when they make decisions.

Based on this definition, Ponce emphasized that the subjective evaluation of the person integrates the objective side of the culture and value system, being a broad-ranging concept. It incorporates in a complex way the person's physical health, psychological state, degree of independence, social relationships,

personal beliefs and relationship to salient features of the environment. Taking into consideration its definition of the life quality, the World Health Organization divides the quality of life into four domain: physical domain, environmental domain, relational domain and psychological domain. The four domains represent the four major concern in human life that need to be attended to before a human life can be considered in terms of good quality [7].

For instance, the physical domain of World Health Organization refers to the physical health condition and cover areas such as: activities of daily living, mobility, energy level and work capacity (enthusiasm and endurance). The psychological domain refers to bodily image and appearance, anxiety, depression, positive feelings, self-esteem, spirituality/religion and or personal beliefs and thinking, learning, memory and concentration. Emotional capability designates that a person is able to have attachments to people outside himself/herself, to love, to grieve, to experience longing, gratitude, and justified anger.

The capability for affiliation means, on the one hand, that a person is able to live with and toward other, to recognize and to show concern for other human being (empathy), to engage in various forms of social interaction; to be able to imagine the situation of another (mentalisation) and to have compassion for that situation: to have the capability for both justice and friendship, and on the other hand, it means that a person enjoys having social basis for self-respect and non-humiliation: being able to be treated as a dignified being whose worth is equal to that of others [7, p. 126] .

3. Models of life quality

Based on World Health Organisation's quality of life definition, Ponce presented her theoretical model of quality of life, defined as the human capability of conducting valuable acts, execute valuable functions and reaching valuable states of being. She adopted a normative approach to the quality of life acknowledging that it has its ontological basis in the view of the human person whose being is acting and his acting is being. She distinguished between two dimensions of the life quality, namely, the „moral conditions in the quality of life" and the „moral values and norms in the quality of life" [7, p. 167]. The first dimension refers to the basic conditions (basic needs approach) that are to be met before human life can be considered in terms of the life quality (all domains of life quality defined by World Health Organisation: physical health, environmental needs such as financial resources, security, accessibility, psychological needs such as positive feelings, and social needs of interpersonal relationships, social support, network systems, mobility, work capacity, etc.). This dimension is concentrating material goods and services rather than on the quality of human life [8]. The second dimension refers to the moral values (self-esteem – desiring a good life for oneself, solicitude – desiring the good life with and for others, and justice - desiring the good life for the anonymous other) and moral norms (autonomy, respect and human rights) in the quality of life

proceeding from the ontological reflection on the life of the human being and what means to live a life of human quality. Moral norms refer to the categorial imperatives which can be seen as minimal universalizable criteria according to which moral values should be interpreted and defined [9]. This distinction is built on the assumption that the two dimensions are closely linked to each other.

Ponce tried to integrate two different philosophical perspectives. From an egalitarian perspective, quality of life is important at both individual and collective level because humans are essentially *social,* at the centre of interlocking right, duties, obligations and collective identities, whereas for a libertarian it is situated firmly at the individual level because human beings are essentially *individualists,* seeking their own quality of life as discrete, independent, free-thinking beings [5, p. 63].

Veenhoven has developed the concept of life quality by introducing an important distinction: quality of social life, which evaluates communities systems as holistic entities and life quality of society members (quality *in* societies), meaning at individual level. It is obvious that those two levels are interdependent, a fundamental aspect for efficiency of local or national intervention programmes [10].

Veenhoven proposed four fundamental criteria of societal quality of life: stability (comprising order, predictability and continuity), productivity covers cultural and financial resources and refers to a holistic notion of societal development, ideal expression (tolerance and pluralism in relation to both universal goals such as human rights and to a range of moral systems found within a pluralistic society, including honour, religious devotion, filial piety and humanism), and liveability (ethics).

Bulboze et al. emphasised an ecological perspective of life quality, in the form of a concentric model. The main thrust of this approach concerns *vertical* links between different systems [11].

The innermost of these circles concerns individuals; their objective well-being, including their health and material circumstances and their subjective well-being which comprises three elements: pleasant affect, unpleasant affect and satisfaction, generated via computation of multiple internal comparisons [12]. It is worth noting here that there is a strong interaction, a real permeability, between the first two circles, between the individual and their family, kinship and associational networks (along with associated norms and obligations). This is particularly true in relation to material circumstance and the important facet of our subjective well-being that is influenced by family and other close relationships. These two circles, taken together, represent the *microsystem* within which people negotiate their day-to-day quality of life. The third circle, including the neighbourhood and community, taken with the first two, comprises the *mesosystem.* For most people there are these three areas which are the most central for their quality of life and it is within the ambit of the micro and mesosystems that the more individualistic, health promotion-oriented approach to public health is focused.

The fourth circle is of central importance to ecological perspectives on public health. It denotes the macrosystem, including national identity, culture, wealth, politic, citizenship and, crucially, central government health policy. Its content can be further expanded to include what Bulbolz *et al.* call the *exosystem*, including international aspects of sustainability, global governance, global environmental conditions among others [11]. This area is a major feature of the large-scale quality of life constructs such as the notion of quality of societies developed by Veenhoven [10]. The principle is robust and can be used as a systemic framework for presenting and exploring the theoretical dimensions of life quality. The strength of this approach is that shows the potential impact of both the meso and macroenvironments upon individual' quality of life.

4. The relation between quality of life and spirituality

Diener and Suh have analysed some national cases where is a high rate of suicide in countries with both material standards of life and reported levels of happiness [13].

Idler and Benyamini have demonstrated, in clinical context, that the patient's self-report regarding the health status is a significantly better predictor for mortality and morbidity (macroindicators of life quality) than many (objective) physiological variables of health, so the applicative potential of life quality for social system is extremely important at both levels [14]. Generally speaking, for human beings are more effective their own subjective perceptions because they organise their behaviours around this mental image of reality and if we know what they feel and think we can anticipate their behavioural decisions. There are a lot of psychological factors which influence human perception and we choose to discus about the spiritual side of the human nature.

Spirituality and religiousness (like quality of life or health) can be described as *latent constructs* (conceptual underlying entities that are not observed directly but can be inferred from observations of some of their component dimensions), which are complex and multidimensional, with no single measure or dimension being likely to capture their essential meaning. Although no scientific consensus yet exists on operational definitions, substantial progress has been made within the past few years, and increasing attention is being given specially to the relationship between spirituality and health related quality of life [15].

Spirituality/religious resources figure prominently among the methods that people call on when coping with life stress and illness [16]. A majority of patients receiving health care say that they would like their caregivers to discuss spiritual aspects of their illness, with particularly high percentages among patients who regularly attend religious services [17].

There are scientific articles supporting, in varying degrees, a generally positive relationship between religiousness and wellness, although the reasons or causes for this common correlation remain more or less unclear.

Harrison *et al.* in trying to explain the spiritual-health relationship refer to increased social support, positive health practices, connectedness, and psychological enrichment as explanatory factors of spirituality. These factors serve to enhance the positive wellbeing of the individual, and propagate increased ability to overcome adverse events [18].

The majority of theoreticians separate religiousness from spirituality. Religiousness is defined as "a system of beliefs shared and institutionalized, moral values, faith in God or a mighty power and involvement in religious community" [19].

Shafranske and Malony define religiousness as representing the "adherence to faith and practices of an established church or religious institutions" while spirituality is regarded as having a personal and experiential connotation. Therefore, spirituality can or cannot include religion. It may find is manifestation in a religious context or it may stay outside it [20]. To Pargament, religion represents one of the "ways to reach sacredness while spirituality is the search of sacredness within yourself" [16, p. 43].

From a methodological point if view, in Psychology religiousness and spirituality are discussed jointly in most contexts because the field lacks a body of well-designed studies of spirituality, as distinct from religion, and of its relationship to health [21].

In the spirit of two-tailed tests, clearly research on religion should examine both its positive and its negative potential effects on health related quality of life. Positive religious coping can be expressed through: religious forgiveness, spiritual connection, religious support, religious purification, favourable religious framing [16, p. 124]. The negative pattern of the religious coping refers to spiritual disconnection, re-evaluation from the perspective of punishment done by God, inter-personal religious discontent, demonic re-evaluation and the religious passive coping through which God was expected to control the situation.

5. Conclusions

Spirituality in the context of life quality is a topic that already enjoys high public interest. Most people want to live with better health, less disease, greater inner peace, and a fuller sense of meaning, direction, and satisfaction in their lives. Increasing levels of affluence and materialism have failed to bring such changes [22]. Scientific investigation of this neglected aspect of human nature may lead to important new clues for helping people live together with better health, richer positive experiences, and greater meaning and satisfaction in life. Scientific researchers must influence policy makers and administrators to release funds for development of spirituality research centres, infrastructures and environmental conditions to support clinicians' inclusion of spiritual care. Healthcare providers and clinicians can actuate change by incorporating spirituality and quality of life assessments in care delivery, and help individuals organize their lives and improve the quality of life [23].

Acknowledgement

This research was supported by POSDRU/89/1.5/S/61879, 'Postdoctoral studies in the field of ethics of policy in public healthcare', University of Medicine and Pharmacy 'Gr. T. Popa', Iasi, Romania.

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