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The relation between the spiritual orientation and quality of life in hemodialysis patients

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Abstract

The present study was conducted to examine the relation between the spiritual orientation and quality of life of hemodialysis patients. A total of 66 hemodialysis patients were included in this relational and descriptive study. The data of the study were collected by using the Patient Introduction Form, Spiritual Orientation Scale, and Rolls Royce Quality of Life Scale. The mean age of the patients who were included in the study was 55.74 ± 14.86 years, 53% were male, 93.9% were married, 47% were illiterate, 92.4% did not work, 43.9% had income equal to expenses, 48.5% were treated for hemodialysis for 0-5 years, 34.8% were heart failure-hypertension patients. The Rolls Royce Quality of Life Scale total score of the patients was 138.31 ± 21.30 , and the mean total score in the Spiritual Orientation Scale was 97.07 ± 11.88 . The difference between marital status, learning status, and mean the quality of life total score was found to be statistically significant ($p < 0.05$). It was found that there was an important relationship between the mean physical symptom and activity sub-dimension score of the quality of life scale and the mean spiritual orientation scale score. The mean quality of life score of the patients was found to be moderate and the mean spiritual orientation score was high. A positive relation was detected between the mean scores of the physical symptom and activity sub-dimensions of the quality of life scale and the spiritual orientation scale.

Keywords: Hemodialysis, spiritual orientation, quality of life

Introduction

Chronic Renal Failure (CRF) is an important health problem in the whole world and our country depending on its increased incidence [1]. According to the Turkish Nephrology Association (TNA) 2017 data, the total number of patients was 77.311 in our country. A total of 58.635 these patients underwent hemodialysis, 3.346 patients were treated for peritoneal dialysis, and 15.330 patients underwent kidney transplantation [2]. CRF causes loss of workforce and many complications for individuals in all age groups and is life-threatening. Hemodialysis (HD) is the most used treatment method in chronic kidney disease [3-5].

Quality of life includes factors like being able to meet basic needs, being adequate in terms of social behaviors, providing satisfaction from life, normal physical and emotional status, allocating time to have fun, and maintaining interpersonal relations [1,6]. Although

the symptoms associated with CRF are controlled by HD treatment, patients face lifelong treatment with HD machines [1,7]. Patients experience many important problems during HD treatment like the restriction of social life, emotional and psychosocial problems, deterioration in physical functionality, and anxiety about losing independence [8,9]. These problems faced during hemodialysis treatment cause negativity in families, and the work and social lives of patients. These negativities can affect the performance of patients and reduce the quality of life [10,11]. In studies conducted on HD patients, it was determined that the quality of life of patients was moderate or low [1,5,12-14]. It was also reported that quality of life is associated with dialysis time and program, social support, anxiety, depression, sleep problems, age, and gender [1,4,6,9,13,15-18].

Spirituality is defined as intangible and spiritual phenomena perceived only with senses. It is an important resource and reference point to deal with the negative consequences of the disease and allow patients to question themselves, their importance, purpose, and personal aspects [19]. Spirituality, which has a meaning for life for patients, is perceived as an "escape door" to find hope in cases of chronic disease like CRF. HD patients can turn to spirituality to improve the quality of life and to think positively. It was found in previous studies that patients moved towards spirituality in their

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difficult times and in dealing with diseases [3,20]. Spirituality brings benefits for patients in many ways like making their health better, reducing pain, facilitating the acceptance of the disease, coping with difficulties, improving quality of life, and ensuring that individuals take on social responsibility. For this reason, it is important in nursing practice to address the spiritual needs of patients [1,21,22].

The purpose of the present study was to examine the relations between the spiritual orientation of hemodialysis patients and quality of life.

Material and Methods

The study was conducted in a state hospital dialysis center in a descriptive and cross-sectional design between December 2019 and March 2020. The universe of the study consisted of 80 adult patients who were treated at a state hospital dialysis center. In the sample selection step of the study, all patients were included in the sampling without using any sampling methods. 10 patients who refused to participate in the research and 4 patients who failed to fill in survey forms properly were left out of the research, and so the research was undertaken with the participation of a total of 66 patients (Approximately 83% of the universe).

The inclusion criteria were the absence of a diagnosed psychiatric disease and being able to communicate.

It was approved by the Scientific Research and Ethical Committee of Siirt University with the number 03.12.2019/E.18360. Informed consent was obtained from all participants included in the study.

The data of the study were collected with the Patient Introduction Form, which was prepared by the researchers, the Spiritual Orientation Scale, and Rolls Royce Quality of Life Scale. The data were collected by the researchers by using the face-to-face interview technique. Each meeting lasted approximately 15-20 minutes.

Patient Introduction Form: This form, which was created by the researchers, included questions about the age, gender, marital status, level of education, working status, income status, duration of hemodialysis treatment, and the presence of any comorbidities.

Spiritual Orientation Scale (SOS): The scale was developed by Kasapoglu in 2015 to evaluate the spiritual orientation of individuals. As a result of validity and reliability studies, it was created as 16 items and one dimension. The scale was in a 7-Point Likert design, and the minimum score that can be received is 16, and a maximum of 112. The total score refers to the level of spiritual orientation. Cronbach's Alpha Reliability Coefficient of the scale was found as 0.95 [23]. In this study, Cronbach's alpha value of the scale was found as 0.96.

Rolls Royce Quality of Life Scale: The validity and reliability of the Rolls-Royce Quality of Life scale was conducted by Ozyilkan et al. (1995). The scale consists of 42 questions [24]. The scale was in a 5-Point Likert design, and the minimum score that can be received is 42, and a maximum of 210. High scores received from the scale show that the health-related quality of life is high in a positive way. There are positive and negative statements on the scale. The

scale consisted of 8 sub-dimensions as general wellbeing; physical symptoms and activity; sleep disorder; appetite; sexual function; perception function; medical interaction; social relations and job performance. The reliability coefficient of the scale is 0.99 [24]. In this study, the Cronbach's alpha value of the scale was found to be 0.96.

Statistical Analysis

The statistical analysis of the data was made with the SPSS 22 Package Program. Standard deviation, percentage, mean values, and minimum and maximum values were used for demographic data. The t-test, Kruskal Wallis, and Mann Whitney U-test were used in the calculations of the scale scores. The significance level was taken as $p < 0.05$.

Results

The mean age of the patients included in the study was 55.74 ± 14.86 years, 53% were male, 93.9% were married, 47% were illiterate, 92.4% were not working, 43.9% had income equal to expenses, 48.5% received hemodialysis treatment for 0-5 years, and 34.8% were heart failure and hypertension patients (Table1).

Table 1. Distribution of Patients by Descriptive Characteristics (n=66)

Descriptive Characteristics	Number	%
Gender		
Female	31	47.0
Male	35	53.0
Marital Status		
Married	62	93.9
Single	4	6.1
Educational Status		
Illiterate	31	47.0
Literate	12	18.2
Primary/High-School	19	28.8
Undergraduate and Postgraduate	4	6.1
Working Status		
Working	5	7.6
Not working	61	92.4
Monthly Income Status		
Income more than expenses	37	40.9
Income equal to expenses	29	43.9
Income less than expenses	10	15.2
Hemodialysis Treatment Duration		
0-5 years	32	48.5
6-10 years	23	34.8
11 years and above	11	16.7
Other Chronic Disease		
Diabetes	18	27.3
Heart Failure-Hypertension	23	34.8
COPD-Asthma	8	12.1
No diseases	17	25.8
Age	55.74±14.86	
COPD: Chronic Obstructive Pulmonary Disease		

The mean total score of the Rolls Royce Quality of Life Scale of the patients was 138.31 ± 21.30 , the mean overall wellbeing sub-dimension score of the Rolls Royce Quality of Life Scale was 23.98 ± 4.20 , and the other mean scores were as follows; 23.40 ± 3.46 in physical symptom and activity, 9.30 ± 2.41 in sleep disorder, 6.63 ± 1.62 in appetite, 13.34 ± 2.85 in sexual function, 21.95 ± 3.54 in perception function, 12.28 ± 1.46 in medical interaction, 27.39 ± 4.38 in social relations and work performance, and 97.07 ± 11.88 in Spiritual Orientation Scale (Table 2).

Table 2. Distribution of Mean Scores of the Patients Received from Spiritual Orientation Scale and Rolls Royce Quality of Life Scale (n=66)

Scale and Sub-dimensions	Item count	Min. Max. Values	X \pm SD
Rolls Royce Quality of Life			
General Wellbeing	7	11-31	23.98 \pm 4.20
Physical symptom and activity	8	14-30	23.40 \pm 3.46
Sleep disorder	3	4-13	9.30 \pm 2.41
Appetite	2	3-9	6.63 \pm 1.62
Sexual function	4	6-16	13.34 \pm 2.85
Perception function	6	15-28	21.95 \pm 3.54
Medical interaction	4	10-16	12.28 \pm 1.46
Social relations and job performance	8	14-36	27.39 \pm 4.38
Total	42	85-176	138.31 \pm 21.30
Spiritual Orientation Total Score	16	64-112	97.07 \pm 11.88

It was found in the study that the difference between the total and sub-dimensions of the Rolls Royce Quality of Life Scale according to patients' marital status was statistically significant ($p < 0.05$). It was also found that there were statistically significant differences between the averages of total scores in Rolls Royce Quality of Life Scale, sleep disorder, according to the educational status, perception function, social relations, and sub-dimensions of work performance of the patients ($p < 0.05$). According to the income status of the patients, there were statistically significant differences between the averages of total scores in the Rolls Royce Quality of Life Scale appetite and social relations and work performance sub-dimensions ($p < 0.05$). It was also found that there were statistically significant differences between the averages of total scores of the patients in Rolls Royce Quality of Life Scale and appetite sub-dimension ($p < 0.05$). It was found that there were no statistically significant differences in the Spiritual Orientation Scale scores according to their demographical characteristics ($p > 0.05$) (Table 3).

Table 4. The Relation between Patients' Mean Scores in Rolls Royce Quality of Life Scale Score, Its Sub-Dimensions and Spiritual Orientation Scale (n=66)

Rolls Royce Quality of Life Scale and Sub-dimensions	Spiritual Orientation Scale
General wellbeing	r:0.10 p:039
Physical symptoms and activity	r:0.24 p:0.04
Sleep disorder	r:0.08 p:0.52
Appetite	r:0.14 p:0.25
Sexual function	r:0.16 p:0.19
Perception function	r:0.18 p:0.12
Medical interaction	r:0.19 p:0.11
Social relations and work performance	r:0.21 p:0.08
Scale Total	r:0.19 p:0.12

Discussion

Chronic Renal Failure is a chronic disease, which may affect the quality of life at significant levels. Health-related quality of life is the experience, beliefs, expectations, and perceptions of a person in physical, psychological, and social health areas [4,12]. Dialysis treatment is a repetitive and exhausting routine for CRF patients, and changes in lifestyle and occupational inactivity cause mood changes and emotional stress affecting the mental and physical health of patients [4]. Other factors like addiction and limitations brought by the treatment and changes in bodily appearance, can result in a negative effect in this scenario. These negative factors may affect the spiritual orientation of patients [3,16].

In the present study, the mean SOS total score of the patients was 97.07 ± 11.88 . It was determined that the spiritual orientation of the patients who participated in the study was high. In their study, Ottaviani et al. examined the level of spirituality in HD patients and found that patients were directed to spiritual beliefs in difficult times as a method of dealing with their disease [20]. Duran et al. conducted a study and found that HD patients were more inclined to spirituality in the face of difficulties and in dealing with diseases [3]. In their study conducted on hemodialysis patients, Hicdurmaz and Oz found that the coping method used frequently by patients was "turning to religion" [19]. Spiritual needs can come to the forefront in the face of life-threatening diseases, fear of death, stress when hope begins to decrease, and it may be considered that these factors also have effects on similar conditions in high spiritual orientation in HD patients. In this study, the high levels of spiritual orientation in HD patients can be caused by believing in divine power and feeling the need for seeking refuge in a divine power in difficult times.

It was determined that the quality of life of the patients who participated in the present study was at a moderate level (138.31 ± 21.30). In our study, the lowest quality of life was detected in the sub-dimension of appetite (6.63 ± 1.62), and the highest score was found in the quality of life sub-dimension of social relations and work performance (27.39 ± 4.38). Bayoumi et al. found that the quality of life in HD patients was at a moderate level [12]. Some

Table 3. Comparison of the Total Scores of Patients in Rolls Royce Quality of Life Scale, its Sub-dimensions and Spiritual Orientation Scale according to Descriptive Characteristics (n=66)

Descriptive Characteristics	General wellbeing X±SD	Physical symptoms and activity X±SD	Sleep disorder X±SD	Appetite X±SD	Sexual function X±SD	Perception function X±SD	Medical interaction X±SD	Social relations and performance X±SD	Total X±SD	Spiritual orientation Total X±SD
Gender										
Female	24.22±3.85	23.22±3.80	9.09±2.39	6.70±1.65	13.54±2.95	21.77±3.53	12.00±1.31	27.19±4.74	137.77±21.31	94.77±13.83
Male	23.77±4.54	23.57±3.18	9.48±2.44	6.57±1.61	13.17±2.79	22.11±3.59	12.54±1.55	27.57±4.09	138.80±21.59	99.11±9.60
Test	t=0.43	t=0.40	t=0.65	t=0.34	t=0.53	t=0.38	t=1.51	t=0.34	t=0.19	t=1.49
Significance	p=0.66	p=0.68	p=0.51	p=0.73	p=0.59	p=0.70	p=0.13	p=0.72	p=0.84	p=0.14
Marital status										
Married	23.69±4.16	23.14±3.38	9.11±2.36	6.53±1.61	13.17±2.86	21.69±3.49	12.17±1.42	27.00±4.19	136.53±20.67	97.22±11.99
Single	28.50±1.29	27.50±0.50	12.25±0.50	8.25±0.50	16.00±0.00	26.00±0.81	14.00±1.15	33.50±2.38	166±7.11	94.75±11.23
Test	MWU=24.00	MWU=29.50	MWU=26.50	MWU=43.50	MWU=44.00	MWU=30.50	MWU=37.00	MWU=16.00	MWU=16.50	MWU=104.50
Significance	p=0.00	p=0.01	p=0.00	p=0.02	p=0.02	p=0.01	p=0.01	p=0.00	p=0.00	p=0.59
Educational status										
Illiterate	23.09±3.98	22.45±3.44	8.41±2.26	6.25±2.90	12.90±2.90	20.48±2.93	11.90±1.16	25.58±3.97	131.09±18.76	95.45±14.38
Literate	23.41±6.15	23.33±4.11	9.41±2.90	6.41±1.83	13.00±3.76	22.75±4.15	12.50±1.62	27.91±4.54	138.75±28.07	95.50±9.05
Primary school - High-school	25.63±2.87	25.15±2.69	10.47±2.03	7.31±1.20	14.15±2.24	23.47±3.47	12.84±1.77	29.68±4.17	148.73±18.30	100.73±8.12
Undergraduate/post-graduate	24.75±2.98	22.75±2.62	10.25±0.95	7.00±0.81	14.00±1.63	23.75±2.62	12.00±0.81	29.00±2.44	143.50±12.17	97.00±13.14
Test	KW=5.64	KW=6.96	KW=10.09	KW=4.58	KW=2.08	KW=11.62	KW=3.66	KW=12.08	KW=11.59	KW=1.41
Significance	p=0.13	p=0.07	p=0.01	p=0.20	p=0.55	p=0.00	p=0.30	p=0.00	p=0.00	p=0.70
Working status										
Working	24.40±3.36	23.80±4.14	9.60±2.88	6.80±2.16	13.00±3.31	22.20±3.56	13.00±2.82	28.40±6.26	141.20±27.39	102.20±6.01
Not working	23.95±4.29	23.37±3.44	9.27±2.39	6.62±4.59	13.37±2.84	21.93±3.57	12.22±1.32	27.31±4.25	138.08±20.99	96.65±12.17
Test	MWU=151.00	MWU=137.00	MWU=141.50	MWU=136.00	MWU=147.00	MWU=145.00	MWU=126.00	MWU=135.00	MWU=134.00	MWU=108.50
Significance	p=0.97	p=0.70	p=0.78	p=0.67	p=0.89	p=0.86	p=0.51	p=0.97	p=0.65	p=0.28
Income status										
Income more than expenses	22.88±5.08	22.88±3.63	8.74±2.72	6.11±1.85	12.81±3.24	21.48±3.81	12.18±1.54	26.81±4.96	133.92±24.59	97.74±10.72
Income equal to expenses	24.10±3.46	23.24±3.35	9.51±2.02	6.79±1.44	13.31±7.20	21.96±3.38	12.03±1.26	26.89±3.95	137.86±18.70	95.58±13.43
Income less than expenses	26.60±2.11	25.30±2.98	10.20±2.39	7.60±0.96	14.90±1.44	23.20±3.25	13.30±1.49	30.40±2.63	151.50±13.79	99.60±10.52
Test	KW=5.30	KW=4.33	KW=2.39	KW=5.89	KW=53.17	KW=5.48	KW=5.48	KW=6.92	KW=5.39	KW=0.22
Significance	p=0.07	p=0.11	p=0.30	p=0.05	p=0.20	p=0.06	p=0.06	p=0.03	p=0.06	p=0.89
Hemodialysis Treatment duration										
0-5 years	24.50±3.61	24.00±3.37	9.34±2.08	6.71±1.48	13.71±2.63	22.62±3.28	12.21±1.53	27.81±4.86	140.93±20.25	97.21±11.98
6-10 years	23.30±4.42	22.78±3.38	9.43±2.51	6.30±1.69	12.82±2.82	21.52±3.62	12.30±1.39	26.95±3.63	135.43±21.24	96.30±14.14
11 and above	23.90±5.44	23.00±3.92	8.90±3.17	7.09±1.86	13.36±3.58	20.90±4.01	12.45±1.50	27.09±4.59	136.72±25.29	98.27±5.49
Test	KW=1.10	KW=1.52	KW=0.23	KW=2.41	KW=2.31	KW=2.35	KW=0.49	KW=0.96	KW=1.19	KW=0.23
Significance	p=0.57	p=0.46	p=0.88	p=0.30	p=0.31	p=0.30	p=0.78	p=0.61	p=0.54	p=0.89
Diagnosis of other chronic diseases (if any)										
Diabetes	22.33±5.42	22.33±4.01	8.50±3.05	5.61±1.88	12.38±3.66	21.22±4.34	11.88±1.49	25.72±5.30	130.00±27.17	98.55±12.82
Heart Failure-Hypertension	24.43±3.25	23.56±2.98	9.34±2.26	7.13±1.17	13.82±1.94	21.78±3.48	12.47±1.23	27.82±2.99	140.39±15.56	98.65±8.36
COPD-Asthma	23.87±4.25	23.62±3.29	9.62±2.19	6.75±1.48	13.00±3.25	21.62±2.19	12.25±1.66	27.87±4.70	138.62±21.39	97.62±11.30
I do not have any disease	25.17±3.64	24.23±3.56	9.94±1.81	7.00±1.54	13.88±2.68	23.11±3.15	12.47±1.66	28.35±4.64	144.17±20.11	93.11±14.97
Test	KW=4.04	KW=2.93	KW=2.35	KW=8.30	KW=1.61	KW=2.69	KW=2.11	KW=3.20	KW=2.85	KW=1.25
Significance	p=0.25	p=0.40	p=0.50	p=0.04	p=0.65	p=0.44	p=0.54	p=0.36	p=0.41	p=0.74

study results were also parallel to our findings [5,25]. Unlike our study results, Moattari et al. found that the quality of life was low in hemodialysis patients [13]. In other studies, conducted by using different quality of life scales, it was determined that the quality of life scores of hemodialysis patients were low [7,14]. The difference in the results of this study may be that the scales with which quality of life was evaluated were different, or that the individual characteristics of patients might have affected the quality of life scores.

In our study, it was found that the spiritual orientations of the male patients were higher than female patients; however, these scores were not statistically significant. Unlike our study, a study that examined the spiritual conditions of patients with renal failure before and after hemodialysis reported that the female HD patients had higher spiritual status [8]. It can be argued that this difference stems from a large number of male patients in our study.

In our study, no statistically significant differences were detected between SOS total scores in terms of the marital status of patients, and the spiritual orientation of married patients was higher. Studies conducted with HD patients reported that marital status did not have significant effects on spirituality [26,27]. The results of the literature and our study results show similarities. Considering life more positively with the support of spouses and feeling psychologically well can positively affect spiritual wellbeing.

In our study, no statistically significant differences were detected between the educational status of patients and the SOS total scores, and the spiritual orientation of the patients who had primary school/high-school education was higher than other groups. Similar to our study results, it was observed in a similar study that the educational status did not affect the level of spirituality in previous studies [28].

In our study, no statistically significant differences were detected between the working status of the patients and the SOS total score, and the average score of the working individuals was higher. Based on the findings, it can be argued that patients are directed to spirituality with the support and strength they receive from their friends in their work lives.

In our study, no statistically significant differences were detected between the income status and SOS total score of patients, and the average score of those who had income less than expenses had higher scores. It may be speculated that HD patients are unable to work or have to resign from their work, and depending on this, economic difficulties are experienced, and patients with low economic levels are more likely to be in spirituality.

In our study, it was determined that there were no statistically significant relations between the treatment durations and SOS total scores, and the mean score of patients with 11 years or more was higher. It may be considered that as the duration of HD treatment increases, the patient has increased symptoms related to his/her disease; and for this reason, move towards spiritual coping methods.

In our study, there were no statistically significant relations between other chronic diseases and SOS total scores; and the heart failure-hypertension patients had higher mean scores. It may be considered that patients with renal failure develop spiritual coping strategies if they have comorbidities.

In our study, no significant differences were detected in terms of the quality of life total scores and gender sub-dimension. Similar to our study, Nazlican et al. examined the quality of life and factors affecting it in hemodialysis patients and found that there was no difference between gender and quality of life [7]. Some study findings are in line with our study results [4,6,17], while some contrast with our results [12,29]. It may be considered that the difference in the results of the present study may be due to the characteristics of the sampling group.

In our study, it was found that patients had a significant difference in total scores and sub-dimension in marital status and quality of life and that the mean scores of single individuals were higher. In some previous studies, no significant differences were reported between married and single individuals in terms of quality of life scores [12,17,30]. It was reported in some studies that there is a significant difference in this respect [4,6]. It can be argued that this difference can affect the quality of life because married people manage the family, which increases financial stress and addiction.

In our study, significant differences were detected in overall scores and sub-dimension of educational status, and the average score of primary school-high-school graduates was higher. It was found that there were also some studies reporting contrasting results to our study [6,14,17]. This difference was considered to be stemming from the sociodemographic characteristics of the patients.

In our study, it was found that there were no significant differences in the overall scores and sub-dimension scores of the patients in terms of working status. There are also some studies reporting contrasting results to our study [6,12,17]. It was considered that this difference stemmed from the sociodemographic characteristics of the patients.

It was found in our study that there were no significant differences in the monthly income levels and quality of life total scores and sub-dimension of the patients. Studies are reporting similar results with our study [6]. Unlike our study, there are also several studies reporting contrasting results [17]. The number of people who do not work due to the disease and the lack of benefits from any other jobs may be among the reasons that were influential in this difference.

In our study, no significant relations were detected between the year of treatment, the quality of life sub-dimensions score, and the total quality of life score. Parallel to our study findings, no significant relations were detected between hemodialysis duration and quality of life scores in the study conducted by Nazlican et al. [7]. In some previous studies, the results were found to be similar to those obtained in our study [17,30]. It can be argued that the quality of life will decrease because of dialysis complications and psychological factors that may occur in patients with more dialysis treatment years.

In our study, a positive and significant relationship was detected between the physical symptom and activity sub-dimension of the quality of life and the Spiritual Orientation Scale score averages of the patients. It can be argued that patients have spiritual orientation because physical activity in dialysis patients improves physical and mental functionality, psychological condition, and quality of life.

Conclusion

It was found that the quality of life of the patients was at a moderate

level and their spiritual orientation was high. It was found that there was a positive and significant relation between the physical symptom and activity sub-dimension of the quality of life scale and spiritual orientation. In the present study, it was found that there was a statistically significant relationship between marital status, learning and income status, and quality of life of the patients. It was found that the relation between descriptive characteristics of the patients and the orientation of spirituality was not statistically significant. In the light of these findings, it is recommended to organize pieces of training for hemodialysis patients to evaluate the quality of life at regular intervals, maintain and improve the quality of life, and evaluate the sense of spirituality to cope with possible health level changes, as well as to conduct studies to increase the awareness of healthcare professionals who provide care to HD patients.

Limitations

The fact that the present study was conducted in one single center was the limitation of the study.

Conflict of interests

The authors declare that they have no competing interests.

Financial Disclosure

The financial support no have.

Ethical approval

Ethics Committee approval was received for this study from the Ethics Committee of Siirt University (no. 03.12.2019/E.18360).

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