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Chapter 10

LIFE SATISFACTION IN COGNITIVELY INTACT LONG-TERM NURSING-HOME PATIENTS: SYMPTOM DISTRESS, WELL-BEING AND NURSE-PATIENT INTERACTION

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ABSTRACT

Spirituality and nurse-patient interaction have shown significant impact on quality of life (QoL) in nursing home patients, providing health promoting resources. The present study assessed nursing home patients' symptom burden, and investigated the associations between QoL (physical, emotional, functional, social and spiritual wellbeing), hope, meaning, self-transcendence, anxiety, depression and perceived nurse-patient interaction. In a cross-sectional design, a sample of 202 cognitively intact nursing home patients in 44 different Norwegian nursing homes responded to the Herth Hope Index, the Purpose-in-Life test, the Self-Transcendence Scale, the Hospital Anxiety and Depression Scale, the Nurse-Patient Interaction Scale, and three different QoL questionnaires: the FACT-G, the FACIT-Sp-12 and the QLQ-C15-PAL. Descriptive and correlational analyses were carried out and several hypotheses of relationships were tested by means of structural equation modeling (SEM). This chapter focuses on implications for QoL in long-term nursing home patients showing that: 1. Cognitively intact nursing home patients' symptom burden is high (56% fatigue, 49% pain, 43% obstipation, 41% dyspnea, 38% sleep disturbance, 25% appetite loss, 18% nausea/vomiting, 30% depression, 12% anxiety) and correlated with meaning-in-life. 2. Self-transcendence and meaning-in-life demonstrate significant effects on all dimensions of QoL (physical, emotional, functional, social and spiritual). 3. Nurse-patient interaction shows significant effects on patients' sense of hope, meaning-in-life, self-transcendence, anxiety and depression. The associations found encourage the idea that in particular, meaning-in-life, intra-personal self-transcendence and nurse-patient interaction are powerful health-promoting resources

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that significantly influence nursing home patients' QoL. Therefore, pedagogical approaches for advancing nursing home caregivers' competence in pain and symptom management, as well as presence and confidence in health-promotion interaction should be upgraded and matured. Proper educational programs for developing interacting skills including assessing and supporting patients' meaning-in-life should be utilized and their effectiveness assessed and evaluated. Finally, this chapter points out and reflect on what's important when caring for nursing home patients.

Keywords: cognitively intact nursing home patients, self-transcendence, meaning-in-life, hope, quality of life, nurse-patient interaction, key assets for quality-of-life

INTRODUCTION

This chapter is based on 17 scholarly papers published in international peer-reviewed journals during the years 2012–2014 (Haugan, 2013a, 2013b, 2014a, 2014b, 2014c; Haugan & Drageset, 2014; Haugan, Hanssen, & Moksnes, 2013; Haugan, Hanssen, Rannestad, & Espnes, 2012; Haugan & Innstrand, 2012; Haugan, Innstrand, & Moksnes, 2013; Haugan & Moksnes, 2013; Haugan, Moksnes, & Espnes, 2013; Haugan, Moksnes, & Løhre, 2014; Haugan, Rannestad, Garåsen, Hammervold, & Espnes, 2012; Haugan, Rannestad, Hammervold, Garåsen, & Espnes, 2013, 2014; Haugan, Utvær, & Moksnes, 2013), documenting the statistical analyses investigating one sample. The present study was motivated by a search for new and alternative perspectives on how nurses can improve well-being and thus life satisfaction among nursing home (NH) patients. The actual sample comprised of 202 cognitively intact NH patients, representing 44 different NHs in 20 Norwegian municipalities. Global quality-of-life (QoL) was assessed by physical, emotional, social, functional and spiritual QoL domains. Hypothesized associations of QoL with meaning and inter- and intra-personal self-transcendence were tested. Also, symptom severity and the impact of nurse-patient interaction on NH patients' sense of hope, meaning, self-transcendence, anxiety and depression were examined as well as the psychometric properties of the scales used. This chapter presents some of the principal points learned from this NH sample (Haugan, 2013a, 2013b, 2014a, 2014b, 2014c; Haugan & Drageset, 2014; Haugan, Hanssen, et al., 2013; Haugan, Hanssen, et al., 2012; Haugan & Innstrand, 2012; Haugan, Innstrand, et al., 2013; Haugan & Moksnes, 2013; Haugan, Moksnes, et al., 2013; Haugan, Moksnes, et al., 2014; Haugan, Rannestad, et al., 2012; Haugan, Rannestad, et al., 2013; 2014; Haugan, Utvær, et al., 2013). Based on the findings, an overall picture of the main results is given; the arguments are organized as follows: (1) Self-reported symptom severity is fairly high among NH patients, requiring competent health care personnel. (2) In particular, perceived meaning-in-life and intra-personal self-transcendence appear to be vital health promoting resources, showing significant influence on all the QoL dimensions (physical, emotional, social, functional, spiritual). (3) The nurse-patient interaction demonstrates a significant impact on anxiety and depression, as well as on their spirituality, as assessed by the patient's sense of hope, meaning and self-transcendence. (4) Finally, based on these core findings, this chapter suggests how to promote QoL in long-term NH patients. However, first the reader is introduced to the fact that our world is an aging world with attendant

consequences for health care, followed by knowledge about the NH population, QoL and spirituality. The latter includes meaning-in-life, hope and self-transcendence, all of which are found to be significant health and QoL promoting resources among vulnerable populations.

AN AGING WORLD

With advances in medical technology and improvements in the living standard globally, the life expectancy of people is increasing worldwide. In the next 30 years, the number of people in the world over age 65 will almost double to 1.3 billion (Kinsella & He, 2009). The most rapidly growing segment is people over 80. By 2050 the percentage of those 80 and older will be 31 percent, up from 18 percent in 1980 (OECD, 1988). This shift to an older population globally has given rise to the notions of the "third" (65-80 years) and "fourth" (80+) ages in the life-span developmental literature. This differentiation of the last part of the life-span into two separate phases is important because of the characteristic patterns of gains (growth) and losses (decline) seen in the "young old" and the "old old" (Kirkevold, 2010). For many of those in the fourth age, issues such as physical illness and approaching mortality decimate their ability to function and subsequently lead to the need for NH care.

A large proportion of older people will live for a shorter or longer time in a NH at the end of life. This group will increase in accordance with the growing population of people older than 65, and in particular for individuals older than 80 years. The proportion of older people with residence in long-term care institutions is increasing worldwide: currently 1.4 million older adults in the U.S. live in long-term care settings, and this number is expected to almost double by 2050 (Zeller & Lamb, 2011).

By 2011 in Norway, the segment of people 67 years and older was nearly 640.000, and by 2060 this may rise to 1.5 million with life expectancy increasing to 90.2 years for men and 93.4 years for women (Statistics of Norway, 2010). About 44.000 Norwegians were NH patients by 2011, and nearly 73% of these were 80 years and older. Because of the high number of individuals in need of advanced care and treatment, knowledge about QoL in NHs is becoming more important in research and practice.

QUALITY OF LIFE IN NURSING HOMES

QoL and well-being are concerned with what makes up the "good life", covering satisfaction with life based on the individual's cognitive and affective assessment. QoL is a central issue and a universally desired patient outcome in nursing literature and research. Considerable nursing research on QoL of individuals with various health challenges is conducted – more than 1000 articles focusing on QoL are published annually (Emery, Perrier, & Acquardo, 2005). Despite the large amount of research, the construct of QoL lacks clear or definitive demarcation; there is no consensus regarding definitions for QoL (Fayers & Machin, 2007). Neither is a standard approach to QoL measurement given, which complicates the operationalization of the concept. Furthermore, although the established perspective provides valuable information about factors that inhibit QoL, information about how elders, and NH patients in particular, achieve QoL remains elusive.

The field of QoL has witnessed the formation of two relatively distinct, yet overlapping, perspectives and paradigms for empirical inquiry into well-being, revolving around two distinct philosophies. The first of these is broadly labeled hedonism (Ryan & Deci, 2001; Ryff, Singer, & Love, 2004) and reflects the view that well-being consists of pleasure or happiness. The second view is that well-being consists of more than just happiness; it lies instead in the actualization of human potentials, which has been called eudemonism (28, 29). These two different traditions, eudemonism and hedonism, are founded on distinct views of human nature and of what constitutes a good society; both are rooted in the old Greek philosophical traditions (28, 29). Implicitly or explicitly, they suggest different but closely related approaches to the enterprise of living and the sense of QoL. Correspondingly, definitions of QoL as well as the translations into the empirical level by developing operational measures have included both perspectives. Spiritual aspects, such as finding hope (Lohne, 2008) and meaning in one's existence (Frankl, 1963), self-transcendence (P. G. Reed, 2008), self-actualization (Maslow, 1987), becoming a fully functioning person (Rogers, 1961) and psychosocial development (Erikson, 1998) drew on the eudemonic view of QoL. Likewise, the hedonic view has been expressed in many forms varying from a narrowly focus on bodily pleasure given the notion "Health-related-QoL" (HRQoL) including symptom burden, to a kind of satisfaction with life which often has been entitled "Global QoL". This study's approach integrates both perspectives; the hedonic view is covered by assessing NH patients' symptom burdens and global QoL, whereas the eudemonic view is covered by assessing NH patients' perceived hope, meaning and self-transcendence, as well as perceived nurse-patient interaction. This chapter uses the notions of well-being and life satisfaction as synonymous with QoL.

Global QoL covers several domains, such as physical, emotional, social, functional and spiritual well-being, all of which reciprocally influence each other. QoL constitutes wholeness in each human being. Thus, the experience of spiritual, emotional and social well-being contributes to positive health in terms of the effective functioning of multiple biological systems, which are supposed to help keep the individual from succumbing to disease, or, when illness or adversity occurs, may help promote rapid recovery (Kirby, Coleman, & Daley, 2004; Ryff et al., 2004). Hence, this study hypothesized, among others, that meaning and self-transcendence affect all the QoL domains, including the physical (Haugan, 2014b; Haugan, Rannestad, et al., 2013).

Cognitively Intact Long-Term Nursing Home Patients

In the present study NHs were defined as long-term primary health care facilities that offer skilled and basic 24-hour nursing care for chronically ill and disabled humans in frail health. To qualify to enter a NH, individuals must demonstrate substantial dependence due to physical or mental impairment (Nygaard, 2002). Consequently, the NH population is generally marked by high age, physical impairment, and high mortality. In Norway, yearly mortality is about 35%, and 5-years survival is about 10% (Høie, 2005). The mean age in UK, U.S and Norway is 85-87 years, while the mean duration of residence in NHs is about 2 years (Forder & Fernandez, 2011; Høie, 2005; NCAL, 2013). Generally, high incidence of chronic illness and functional impairments characterize long-term care patients, representing complex medical states typified by many different, simultaneous diagnoses; they require different

types of medical treatment, not to cure their illness, but for palliation (Linton & Lach, 2007). The top ten conditions in NHs reported in 2010 in the U.S. were high blood pressure (57%), dementias (42%), heart disease (34%), depression (28%), arthritis (27%), osteoporosis (21%), diabetes (17%), COPD and allied conditions (15%), cancer (11%) and stroke (11%) (NCAL, 2013). The most common diagnoses in Norwegian NHs have been reported to be dementia (40-48%), stroke (15-19%), chronic heart disease (5-6%), hip fracture (3-4%), and arthritis (3%) (Nygaard, 2002). Systematical registrations throughout an eight years period in a typical Norwegian NH providing 150 beds displayed a stable list of patients' physical impairments: approximately nine out of ten needed help washing and dressing and were not capable of walking up a stairway, three of four could not feed themselves, and all needed help getting to the lavatory, while two of three patients never read a paper (Høie, 2005). Accordingly, the main function of NHs is to help with the activities of daily living (ADL) such as dressing, feeding, and personal hygiene.

Moving to a NH results from numerous losses, illnesses, disabilities, loss of functions and social relations, and approaching mortality, all of which increase an individual's vulnerability and distress; in particular, loneliness and depression are identified as risks to the emotional well-being of older people (Routasalo, Savikko, Tilvis, Strandberg, & Pitkälä, 2006; Savikko, 2008) showing significant associations with mortality (Drageset, Eide, Kirkevold, & Ranhoff, 2012). The NH life is institutionalized, representing loss of social relationships, privacy, self-determination, and connectedness. Depression in NH patients has been reported to be three to four times higher than in community-dwelling older adults (Jongenelis et al., 2004). Social and emotional support are seen to be vital resources for reducing depression among NH patients (Drageset, Eide, Nygaard, et al., 2009; Grav, Hellzèn, Romild, & Stordal, 2012).

Loneliness, social exclusion, low self-esteem and self-worthiness, for example, are possible consequences of frailty and disability for which NH care can offer help (Forder & Caiels, 2011). NH care increasingly targets those elderly with the greatest needs in terms of personal daily activities, while services supporting their psychosocial and spiritual needs tend to be ignored (Vaarama & Tiit, 2007). However, NH care is supposed to address people's mental, social, and emotional well-being, as well as their basic physical needs. Nurses are increasingly aware that good nursing care consists of more than the competent performance of a number of caring activities. However, for many NH caregivers it is much less clear what this "more" means and what importance it has in NH care. In general, NH patients suffer chronic illnesses and several impairments; therefore, they largely experience dependency on the NH staff. Actually, NH patients report feelings of fear and desperation over the actions of staff and express a lack of negotiation about how best to meet an elderly person's needs and desires. This is insulting and threatening to their dignity and sense of self (Franklin, Ternestedt, & Nordenfelt, 2006; Haugan Hovdenes, 2002).

Recent research has highlighted positive aspects and gains associated with becoming old. Several studies state that as people mature into old age, they continue to grow, both intellectually and with regard to skills. Nevertheless, becoming old in Western societies has traditionally been associated with losses and declines of body and mind. Accordingly, limitations more than possibilities, have come to be the main concern in the care for older individuals. Several studies have thus focused the personal power and driving forces of older individuals, searching for insight into how and why some older people demonstrate more strength and are more efficiently coping with and compensating the various losses and disabilities. Diverse concepts aimed at elucidating this type of inner strength has been

described (Nygren et al., 2005); i.e., resilience, sense of coherence, hope, purpose in life, and self-transcendence.

In Norway, nearly 48% of NH patients are diagnosed as having a dementia disorder. However, patients suffering various extents of cognitive impairments represent a larger group comprising about 70-80% of NH patients (Nygaard, Naik, & Ruths, 2000). Thus, mentally intact NH patients constitute a minority, and unfortunately their needs have largely been given less attention and lower priority (Randers, Olson, & Mattiasson, 2002). Although many NH patients suffer from chronic illnesses and physical impairments, their mind and spirit might still be a resource for well-being. The holistic wellness model views individuals holistically as bio-psycho-social-spiritual units in whom the body, mind, and spirit are interconnected and affect one another (Narayanasamy et al., 2004; Quinn, 2005). Hence, within a holistic framework of body-mind-spirit as a whole, NH patients' mental and spiritual needs cannot be separated from their body or their physical needs. Individuals' spiritual and emotional dimensions including facets such as self-acceptance, meaning and purpose in life, personal growth, inner strength and hope, positive relations with others, environmental mastery and autonomy (Holtslander & Duggleby, 2009; Lundman et al., 2010; Ryff et al., 2004), have been found to embrace vital resources in maintaining physical and functional well-being (Kirby et al., 2004; Ryff et al., 2004). In spite of many simultaneous diagnoses followed by physical impairments, in cognitively intact NH patients their mind and spirit might be a resource to well-being. Thus, it is surprising that the study of aging as a spiritual process has been given only a limited attention, whereas aging as a biological process has been extensively studied.

HUMAN SPIRITUALITY – A VITAL RESOURCE FOR QOL

Nonetheless, spiritual care has been and continues to be recognized as an integral part of nursing older people (Bano & Benbow, 2010; Daaleman, Williams, Hamilton, & Zimmerman, 2008). Spirituality is of particular importance to well-being in the lives of many older adults (Joyce Knestrick & Brenda Lohri-Posey, 2005) in NHs (Burack, Weiner, Reinhardt, & Annunziato, 2012) and at the end of life (Daaleman et al., 2008). Spiritual well-being has been described as a predictor of overall NH life satisfaction (Burack et al., 2012), demonstrating a positive impact on illness and impairments (Kirby et al., 2004).

Peterman and colleagues' (Peterman, Fitchett, Brady, Hernandez, & Cella, 2002) contribution of the Functional Assessment of Chronic Illness Therapy-Spiritual Well-Being (FACIT-Sp-12) measure (presented in this chapter's method section) has allowed for much progress in this research area. They state a broad concept of spirituality described as *a personal search for faith, meaning, and inner peace through connections with others, nature, and a transcendent dimension of existence, and the experiences and feelings associated with that search.* Humans' spirituality is expressed and experienced in the context of *caring connections with oneself, others, nature, and a life force or God* (Buck, 2006; Miner-Williams, 2006; Pesut, 2008). Accordingly, spiritual well-being seems closely related to connectedness.

Conversely, several different definitions of spirituality have been presented in nursing and other social sciences through the years (Unruh, Versnel, & Kerr, 2002). In the nursing

literature the different definitions include an individual's essence as a person, connectedness with oneself, others, and a Higher Being (such as God), as well as the search for self-transcendence, life satisfaction, hope, and meaning (Atchley, 2008; Buck, 2006; Ellis & Narayanasamy, 2009). Accordingly, hope (Fitzgerald Miller, 2007) and meaning (Starck, 2008) are highlighted as central spiritual aspects, along with self-transcendence involving both spiritual and non-spiritual facets (P.G. Reed, 2008). Furthermore, hope, meaning and self-transcendence have performed as mediating variables in psychological health (Halama & Dedova, 2007; Holahan, Holahan, & Suzuki, 2008; Kleftaras & Psarra, 2012) and physical health (Haugan, 2014b; Haugan, Rannestad, et al., 2013; Wright et al., 2011). Meaning is related to mortality (Boyle, Barnes, Buchman, & Bennett, 2009; Krause, 2009), fatigue and common symptoms (Haugan, 2013a; Thompson, 2007), and psychosomatic illnesses (Mausch, 2008). Hope, meaning and self-transcendence appear to be significant spiritual aspects, supporting QoL in old age.

Consequently, although the specific role of spirituality may differ among NH patients, spirituality provides hope, self-transcendence, purpose and meaning toward the end of life as well as a framework for coping with illness, losses, loneliness, despair, and death (Joyce Knestrick & Brenda Lohri-Posey, 2005; Thomas, Burton, Quinn Griffin, & Fitzpatrick, 2010). These spiritual resources are derived through *relationships and connectedness*; by communication with others, self-reflection on responsibilities, inner dialogue, and completing unfinished business (Buck, Overcash, & McMillan, 2009; Haugan Hovdenes, 2002; Mok, Wong, & Wong, 2010). Individuals are capable of transcending and/or accepting experiences such as losses, disabilities, and facing death (O'Brien, 2003). This ability to accept and in some cases even embrace illness and suffering is primarily a function of the patient's personal spiritual resources such as inner strength (Lundman et al., 2012; Lundman et al., 2010). Faith represents the religious component of spiritual well-being and increases QoL by providing social support via clergy, support groups, and integration in a social network (Koenig, George, & Titus, 2004; Ladd & McIntosh, 2008). However, these resources are scarce in NHs and hardly available to NH patients. Nurses' identification of patients' spiritual resources is vital for supporting and strengthening QoL, as well as research testing the relationships between spiritual well-being and other coping resources (O'Brien, 2003). Hope, meaning and self-transcendence are described as powerful coping mechanisms involving adaption to physical, emotional, and spiritual distress (Duggleby et al., 2012; Folkman, 2010; Teixera, 2008), and thus they enhance QoL.

Accordingly, spiritual care embraces an integrative approach that includes facilitating hope, meaning and self-transcendence by means of providing caring relationships and connectedness. Therefore, further relevant research concerning the concepts of hope, meaning, self-transcendence and the nurse-patient interaction is described.

Hope

The hope dimension has long been a central nursing concept and has been largely described in nursing theories (Fitzgerald Miller, 2007; Tutton, Seers, & Langstaff, 2009). An oft-quoted definition of hope by nurses sees hope as a multidimensional dynamic life force characterized by a confident, yet uncertain expectation of achieving something good, which is realistically possible and personally significant (Dufault & Martocchio, 1985). Tutton and

colleagues (2009) examined the nature of hope in nursing literature, identifying several nursing frameworks linking hope with suffering, enduring and uncertainty (Morse & Penrod, 1999; Travelbee, 1979).

Travelbee's model of nursing care emphasized that helping patients to experience hope and to avoid hopelessness is a fundamental part of nursing practice. In accordance with Travelbee, hope is facilitated through connectedness in relationships with self, family and friends, as well as the nursing staff (Travelbee 1979). Thus, an understanding of hope and its meaning in the lives of institutionalized elders may aid in developing interventions to enhance hope and well-being in this setting.

Hope is necessary for all persons throughout the life cycle and through illness and loss, including the end of life (Miller, 2007). The experience of hope has been described in different patient groups, although studies exploring hope in the long-term NH population are scarce; most existing work has been done with chronic illness, stroke, cancer and palliative patients (Akechi et al., 2012; Alidina & Tettero, 2010; Bright, Kayes, McCann, & McPherson, 2011; Duggleby et al., 2012; Ellefsen, 2012).

However, as populations are getting older and thus live with several chronic illnesses affecting their everyday lives, it is relevant to broaden the definition of palliative care to include other patient groups than cancer patients (Franklin et al., 2006). NH patients are not getting healthier; they suffer from several chronic illnesses and losses and are facing death. Therefore, the literature describing hope in palliative patients might illuminate the hope facets among NH patients.

The focus of hope in palliative patients is different from that in other patient populations; chronically ill patients (Duggleby et al., 2010), trauma patients (Tutton, Seers, & Langstaff, 2012), stroke patients (Satink et al., 2013) and patients with chronic pain (Wright et al., 2011) focus their hope on getting better and living longer. However, this might not be the main hope for long-term NH patients. Studies among palliative patients demonstrate hope to be an inner resource (Alidina & Tettero, 2010; Bright et al., 2011; Buckley & Herth, 2004) and a coping mechanism essential for QoL (Farone, Fitzpatrick, & Bushfield, 2008; Smedema, Catalano, & Ebener, 2010). Older palliative patients described their main concern as wanting "to live with hope" and achieved this through acknowledging "life the way it is" and searching for meaning and positive reappraisal (Duggleby et al., 2007; Olsson, Östlund, Grassman, Friedrichsen, & Strang, 2010). Positive self-worth and humor are seen to be positively associated with hope and well-being (Ivan Woo Mun Hong, SocSci, & Rosaleen, 2008; Smedema et al., 2010).

Hope is the act by which the temptation of despair is actively overcome. Hope is perceived to be an inner strength and central to a dignified end-of-life-time and death among NH patients (Bright et al., 2011; Franklin et al., 2006). Furthermore, inner strength among older individuals has been associated with connectedness, firmness, flexibility, creativity, a sense of confidence in oneself yet having faith in others, accepting both the light and the dark side of life, and being the same yet growing into a new garment (Holtslander & Duggleby, 2009; Lundman et al., 2010; Nygren, Norberg, & Lundman, 2007). Hope is highly correlated with perceived meaning-in-life (Cotton Bronk, Hill, Lapsley, Talib, & Finch, 2009).

Meaning-in-Life

Experiencing meaning-in-life is fundamental to humans (King, Hicks, Krull, & Del Gaiso, 2006; Schulenberg, Hutzell, Nassif, & Rogina, 2008), and of particular significance in health and well-being in later years (Moore, Metcalf, & Schow, 2006; Wang, 2011; Wang, Lin, & Hsieh, 2011). Meaning-in-life is commonly addressed in nursing literature (Angel, 2009; Starck, 2008) underpinning the importance of nurses in helping patients and their families not only to cope with illness and suffering but also finding meaning in these experiences (Dossey & Keegan, 2009; Starck, 2008; Travelbee, 1979). Several nurse researchers have remarked on meaning-in-life as a significant element in health and spiritual well-being (Atchley, 2008; Hodge, Horvath, Larkin, & Curl, 2012; Hodges, 2009).

Meaning as a concept originates from Frankl's writings on meaning as a motivational and vitalizing force in humans' lives (Frankl, 1963, 1978) and has been used as a basis for research and practice in nursing (Starck, 2008). Purpose and meaning-in-life are broad constructs understood as mindsets and perspectives that make the world comprehensible, encouraging individuals to attain goals to strive for as well as seeking for connectedness with other people, nature, or a higher power. Meaning is conceptually and empirically related to many central nursing phenomena such as hope, self-transcendence (Haugan & Moksnes, 2013), faith, subjective well-being, happiness, depression, anxiety, psychological distress, boredom proneness, and drug/alcohol use (Melton & Schulenberg, 2007, 2008; Schulenberg & Melton, 2010). To find meaning is to understand the nature of one's life, and to feel that life is significant, important, worthwhile, or purposeful (Morgan & Farsides, 2009). Purpose generally refers to intention in terms of achieving personal aims, whereas meaning refers to establishing a sound coherence in one's existence (Hedberg, Brulin, Aléx, & Gustafson, 2011). In accordance with Frankl (1963, 1978), this chapter uses meaning and purpose synonymously.

Meaning provides a framework for coping with illness, losses, loneliness, perceived burdens, despair, and anxiety about death (Thomas et al., 2010; Van Orden, Bamonti, King, & Duberstein, 2012). Along these lines, meaning has been identified as an indicator of successful aging (Flood & Scharer, 2006) and found to predict overall NH satisfaction (Burack et al., 2012). Studies have demonstrated that meaning-in-life is associated with mortality (Boyle et al., 2009; Krause, 2009), fatigue, and overall symptoms/plagues (Thompson, 2007), as well as psychosomatic disorders (Mausch, 2008).

Considerable correlations between physical health, emotional adjustment, and meaning-in-life in older adults have been demonstrated; such correlations include lower rates of mortality from all causes-less cardiovascular disease, less hypertension, less sensation of abuse, less depression, better immune function and better coping with and recovery from illness (Chibnall, Videen, Duckro, & Miller, 2002; Koenig et al., 2004; Koenig, Weiner, Peterson, Meador, & Keefe, 1997; Starkweather, Wiek-Janusek, & Mathews, 2005). Likewise, meaning-in-life is described as being a mediator for physical (Canada, Murphy, Fitchett, Peterman, & Schover, 2008; Meraviglia, 2001; Vance, Struzick, & Raper, 2008) and psychological health (Ho, Cheung, & Cheung, 2010; Kleftaras & Psarra, 2012; Westerhof, Bohlmeijer, van Beljouw, & Pot, 2010), and of particular importance for many older adults (Hedberg et al., 2011; Joyce Knestrick & Brenda Lohri-Posey, 2005) in NHs (Burack et al., 2012; Touhy, Brown, & Smith, 2005) and at the end of life (Daaleman et al., 2008; Hermann, 2007). Meaning relates negatively to depression (Danhauer, Carlson, & Andrykowski, 2005;

Krause, 2007) predicting higher psycho-spiritual functioning and offering a potential buffer for an individual's reactions to stressful life experiences (Krause, 2007). Depression is observed to be three to four times higher in NH patients than in community-dwelling older individuals (Jongenelis et al., 2004).

NH patients have identified connectedness as a core factor that contributes to meaning-in-life (Haugan Hovdenes, 2002). As follows, meaning is seen to be derived through connectedness-inward and outward- and relationships; by communication with others, self-reflection on responsibilities, inner dialogue, and completing unfinished business (Buck et al., 2009; Mok et al., 2010). Similar to hope and meaning, self-transcendence also covers the aspect of connectedness; in fact, connectedness is the core of self-transcendence (P. G. Reed, 2008). Consequently, these constructs of meaning, hope and self-transcendence embrace *connectedness*, inward and outward, as their major center.

Self-Transcendence (ST)

Pamela Reed (1992) presented a paradigm with which to explore spirituality in nursing by defining spirituality as "an expression of the developmental capacity of self-transcendence" (p.350). The theory of self-transcendence addresses an enhanced understanding of well-being in late adulthood, stating self-transcendence as a "well-being maker" in vulnerable populations—and thereby a correlate and resource for well-being (P. G. Reed, 2008). The core of self-transcendence is the expansion of self-boundaries through intrapersonal (within), interpersonal (between), and transpersonal connectedness (beyond), besides temporality-all of which are found to positively affect healing and well-being (Coward & Reed, 1996; P. G. Reed, 2008). Self-transcendence is considered a general human developmental process of maturity (P. G. Reed, 2008) that has been related to spiritual as well as non-spiritual factors. The idea is inspired by human developmental theory emphasizing maturity as the developmental task in later life (Erikson, 1950). This developmental process of self-transcendence in NH patients is stimulated by the challenges of aging and coming to terms with death (Dalby, 2006). Self-transcendence is a process of change, characterized by striving for new and deeper understandings of life, meaning, and acceptance of the self, others, and the life situation.

The core of self-transcendence is the expansion of self-boundaries through connectedness with the self, and between the individual, the environment and a transcendent being (P. G. Reed, 2008). Accordingly, self-transcendence refers to a multidimensional expansion of the self-boundaries intrapersonally (through self-acceptance and finding meaning in life), interpersonally (reaching out to others or connecting with nature), transpersonally (by reaching out to a higher entity), and by temporality (integrating one's past and future into the present; a dynamic process involving adaption to physical, emotional, and/or spiritual distress). Thus, self-transcendence comprises an interpersonal, intrapersonal, and a transpersonal aspect together with temporality: all have great impact on well-being in vulnerable individuals and at the end of life (Coward, 1991; Ellermann & Reed, 2001; P. G. Reed, 2008, 2009a).

The self-transcendence theory comprises three major propositions based on three key concepts of vulnerability, self-transcendence, and well-being (P. G. Reed, 2008). The first proposition states that persons facing end-of-own-life issues are more vulnerable than persons

not facing such issues, and that self-transcendence is greater in vulnerable persons; the more vulnerable the person, the greater their self-transcendence. End-of-own-life issues are interpreted broadly, as they arise with life events, illness, aging, and other experiences that increase one's awareness of personal mortality and vulnerability (Coward, 2010). The second proposition contends that expansions of self-boundaries (the core of self-transcendence) are related to well-being (P. G. Reed, 1991a, 1991b). Depending on their nature, fluctuations in self-boundaries influence well-being positively or negatively across the life-span. For example, an increase in self-transcendence views and behaviors is expected to be positively related to mental health as an indicator of well-being in persons confronting end-of-life issues (P. G. Reed, 1991a). The third preposition states that personal and environmental factors function as correlates, moderators, or mediators of the relationships between the three basic concepts of vulnerability, self-transcendence, and well-being.

The theoretical concept of self-transcendence addresses an enhanced understanding of well-being in late adulthood (P. G. Reed, 2008), regarded as a sense of feeling whole and healthy, in accordance with one's own criteria for wholeness and health. Vulnerability reflects the existential experience of personal mortality. NH patients are considered a particular vulnerable population, while transcending many losses, illnesses, and facing death. Consequently, their self-transcending search for meaning, hope, and integrity is strongly challenged. Previous research has examined self-transcendence in relation to QoL (Hoshi, 2008; Runquist & Reed, 2007; Sharpnack, Benders, & Fitzpatrick, 2011; Thomas et al., 2010) and HRQoL (Bean & Wagner, 2006; Farren, 2010) showing statistically significant positive correlations. Accordingly, self-transcendence might provide a framework for nursing interventions promoting well-being/QoL in NH patients.

This study (Haugan, Rannestad, et al., 2012) demonstrated that self-transcendence (ST) comprises two main dimensions: an outwardly-labeled "interpersonal self-transcendence" (ST-1), and an inward aspect entailing the intrapersonal, the transpersonal and temporal self-transcendence dimensions, labeled "intrapersonal self-transcendence" (ST-2). By understanding the empirical links between self-transcendence and all facets of well-being among NH patients, we might be able to identify self-transcendence interventions that facilitate QoL among NH patients.

Nurse-Patient Interaction

Spiritual nursing care, that responds to patients' inner thoughts, emotions, and experiences can improve the patients' physical and mental well-being overall (Krupski et al., 2006). Hence, the nurse-patient interaction in NHs is important to NH patients' well-being and life satisfaction. Recent research demonstrates that older patients prefer and expect nurses to be caring, good listeners, and professional (Finch, 2005, 2006; Harrefors, Sävenstedt, & Axelsson, 2009; Haugan Hovdenes, 2002). Therefore, this chapter spotlights the nurse-patient interaction suggesting this component to be crucial to QoL in cognitively intact NH patients.

The nursing discipline's understanding of how the nursing process is manifested has shifted. The mid-20th century's rather mechanistic conception of nursing as a process external to patients and conducted by the nurse has been replaced by the view of nursing as a relational process and practice (P. G. Reed, 2009b). The importance of establishing the nurse-patient relationship as an integral component of nursing practice has been well documented

(Halldorsdottir, 2008; Nåden & Eriksson, 2004; Rchaidia, Dierckx de Casterlé, De Blaeser, & Gastmans, 2009). International well accepted nursing theorists describe nursing as a participatory process that transcends the boundaries between patient and nurse and can be learned and knowingly deployed to facilitate and improve QoL (Neuman, 1995; P. G. Reed, 2009b; Travelbee, 1979; Watson, 1988).

Theory of Human Caring

Well-acknowledged theories of human caring are based on a holistic approach and perceive human beings as connected to each other in the caring process. Central to this holistic perspective of caring is the question of how one defines what it means to be human, what it means to care, and what it means to heal. There is a science of caring with ethical and philosophical implications central to the basics of nursing, implying intrinsic aspects of nursing that produce therapeutic results and well-being in the person being served (P. G. Reed, 2009b; Travelbee, 1979; Watson, 2007). Caring involves a conscious intentional responsibility involving sensitivity, respect and a high moral and ethical commitment. The postmodern era of practice has transformed nursing from acts of doing (tasks and technology) and knowing how, to acts of engaging in a caring relationship that integrates the doing and knowing with the primary focus of attending to the meaning of being as experienced by the individuals (Arman, 2007; Lukose, 2011; S. M. Reed, 2010; Warelow, Edward, & Vinek, 2008). Thus, because caring is central to all that nurses do, then all nurses need to address the being aspect of practice. Consequently, the focus is on individuals; what is meaningful for the patients, and their thriving and well-being. The emphasis of care is on the nurse-patient relationship (Halldorsdottir, 2008; P. G. Reed, 2009b; Walker, 2009; Watson, 2007). The consciousness and intentionality of how a NH nurse chooses to be present in a caring moment are guided by the values of human care within the context of the NH facility.

Caring and the Nurse-Patient Interaction

The caring relationship between the nurse/healthcare personnel[1] and the patient is fundamental to nursing theory and practice; it is a special kind of human care relationship, a union with another person that shows a high regard for the whole person and his/her being-in-the-world (Travelbee, 1979; Watson, 2007). Caring nurses engage in person-to-person relationships with the patients as unique persons. Good nursing care is defined by the nurses' way of "being present" with the patient while performing nursing activities, in which attitudes, morals, and competence are inseparably connected (Halldorsdottir, 2008; Levy-Malmberg, Eriksson, & Lindholm, 2008; Liveng, 2011; Watson, 2007). The caring nurse is present and respectful, sincere, friendly, sensitive and responsive to the patient's feelings of vulnerability; the nurse-patient interaction intends to help patients gain a sense of wholeness, hope, faith, trust, comfort, safety, and enhanced well-being (P. G. Reed, 2008; Watson, 2008). The nurses' recognition of patients' feelings leads to self-actualization through self-acceptance for both the nurse and the patient. As nurses acknowledge their sensitivity and feelings, they become more genuine, authentic, and sensitive to others (Haugan Hovdenes, 2002; Watson, 1979).

[1] This chapter uses the notions of nurse, health care personnel, caregivers and NH staff as synonymous; these terms include the professional as well as the non-professional health care professionals in the NHs.

The development of a helping-trust relationship between the nurse and the patient is crucial for caring. A trusting relationship promotes and accepts the expression of both positive and negative feelings. It involves congruence, empathy, non-possessive warmth, positive regard, empowerment and effective communication (Halldorsdottir, 2008; Haugan Hovdenes, 2002; Medvene & Lann-Wolcott, 2010; Nåden & Eriksson, 2004). Congruence involves being real, honest, genuine, and authentic. Empathy is the ability to experience and thereby understand the other person's perceptions and feelings, and to communicate that understanding. Non-possessive warmth is demonstrated by a moderate speaking volume, a relaxed open posture, and facial expressions that are congruent with other communications. Effective communication has cognitive, affective, and behavior response components (Watson, 2008). Thus, nurses must recognize that intellectual and emotional understandings of a situation may differ.

As the main nursing focus in NHs is well-being and life satisfaction, NH caring is less dependent on curing. This focus on well-being allows the patient to determine personal needs and provides opportunities for personal growth. Feeling listened to is a lived experience of human-becoming, and has been found to be significant to health and well-being (Finch, 2006; Kagan, 2008). Non-judgmental recognition, by which patients feel valued and loved in spite of the always-present possibilities of rejection and hurt, is described as the essence of feeling listened to (Haugan Hovdenes, 2002; Kagan, 2008). Through active listening and being authentically present, the nurse can come to know the patients and their families in relation to what they believe is important to them. Presence, intentionality, and conscious choice of action are key elements embedded in each caring moment (Haugan Hovdenes, 2002; Watson, 2008). The staff nurses' way of being present when interacting with the patients, results in very different patient experiences; it gives the patients either a sense of fulfillment and growth or a sense of stagnation and elimination (Haugan Hovdenes, 2002). NH patients often reveal feelings of fear and desperation over the actions of the staff; the patients experience suffering and insult resulting from a lack of dialogue about how to best meet their needs and desires (Franklin et al., 2006; Haugan Hovdenes, 2002). Hence, maintaining dignity in the relationships with staff nurses is a main QoL domain for NH patients (Burack et al., 2012; Hall, Longhurst, & Higginson, 2009; Medvene & Lann-Wolcott, 2010).

To sum up, meaning, hope, self-transcendence and nurse-patient interaction have been seen to be vital resources for humans' psycho-social functioning and QoL, serving as buffers to individuals' reactions to stress and difficult circumstances, particularly when facing illness or loss, and at the end of life. Thus, supporting individuals and their families not only in coping with illness and suffering but also in transcending the self, finding hope and meaning in these experiences (Dossey & Keegan, 2009; Starck, 2008; Travelbee, 1979) is important for NH patients' QoL. Several nursing theories highlight hope and meaning as being crucial to all human beings, as well as serving as vital resources for health and QoL (Hodge et al., 2012; Hodges, 2009).

AIMS

Based on this literature review, the main aims of this study were to examine:

1. The level of symptom severity and multidimensional well-being (physical, emotional, social, functional and spiritual) among cognitively intact NH patients (Haugan, 2013a; Haugan, Rannestad, et al., 2013; Haugan et al., 2014).
2. The associations between self-transcendence and multidimensional well-being among cognitively intact NH patients (Haugan, Rannestad, et al., 2013; Haugan et al., 2014).
3. The associations between meaning-in-life and multidimensional well-being among cognitively intact NH patients (Haugan, 2014b).
4. The possible impact of nurse-patient interaction on cognitively intact NH patients' perceived hope, meaning-in-life, self-transcendence, anxiety and depression (Haugan, 2013b, 2014c; Haugan, Hanssen et al., 2012, Haugan, Hanssen et al. 2013, Haugan, Moksnes et al., 2014; Haugan, Hanssen, et al., 2013; Haugan, Innstrand, et al., 2013; Haugan, Moksnes et al. 2013).
5. The psychometric properties of the scales used (Haugan, 2014a; Haugan & Drageset, 2014; Haugan, Hanssen, et al., 2012; Haugan & Moksnes, 2013; Haugan, Rannestad, et al., 2012; Haugan, Utvær, et al., 2013) since they had not been previously applied in a NH population.

METHODS

Participants

The total sample comprised 202 (81%) out of 250 long-term NH patients who met the inclusion criteria: (1) local authority's assignment to long-term NH care; (2) residential time of 6 months or longer; (3) informed consent competency recognized by a responsible doctor and nurse; and (4) capable of being interviewed; 19% declined to participate. Long-term NH care was defined as 24-hour care; short-term care patients, rehabilitation patients, and patients suffering from dementia were not included. The NH patients were approached by a head nurse they knew well. The nurse presented them with oral and written information about their rights as participants and their right to withdraw at any time. Each participant provided informed consent.

Procedure

A cross-sectional design was employed. Long-term NH care was defined as 24-hour care with duration of six months or longer. A minimum of 200 participants was desirable for this study. Two counties in central Norway were selected comprising 48 municipalities in total, of which 25 were invited to contribute. In total, 20 municipalities participated. All the NHs in each of the 20 municipalities were asked to participate. A total of 44 NHs took part in the study. Approvals were obtained from the Management Units at the 44 NHs, the Regional Committee for Medical and Health Research Ethics in Central Norway (Ref.nr.4.2007.645), and the Norwegian Social Science Data Services to maintain a register containing personal data (Ref.nr 16443).

The data collection was carried out from 2008–2009 in Norway. This population has problems completing questionnaires independently, therefore three trained researchers conducted one-on-one interviews in private. Researchers with identical professional background were selected (MA, RN trained, and experienced in communication with the elderly, as well as teaching gerontology at an advanced level) and trained to conduct the interviews as identically as possible. Inter-rater reliability was assessed by comparing mean scores between interviewers by means of Bonferroni-corrected one-way ANOVAs. No statistically significant differences were found that were not accounted for by known differences between the areas in which the interviewers operated. The questionnaires used were part of a questionnaire comprising 130 items; thus small breaks at specific points during the interview process were adopted to avoid tiring the participants. The interviews lasted for 1–2.5 hours. The interviewers held a large-print copy of questions and possible responses in front of the participants in an effort to avoid misunderstandings.

The data were analyzed by descriptive, exploratory factor analysis (EFA), correlational and regression statistics using SPSS version 20 (IBM), as well as confirmative factor analyses (CFA) and structural equation modeling (SEM) by means of LISREL 8.8 (Jøreskog & Sørbom, 1995). In CFA and SEM, the chi-square (χ^2) is the conventional overall test of fit; a small χ^2 and a non-significant p-value correspond to good fit (Jøreskog & Sørbom, 1995). The present investigations assessed model fit adequacy by χ^2-statistics and various fit indices. In line with the "rules of thumb" given as conventional cut-off criteria (Schermelleh-Engel, Moosbrugger, & Muller, 2003) the following fit indices were used: the Root Mean Square Error of Approximation (RMSEA) and the Standardized Root Mean Square Residual (SRMS) with values below 0.05 indicating good fit, whereas values smaller than 0.08 were interpreted as acceptable (Hu & Bentler, 1998; Schermelleh-Engel et al., 2003). Further, the Comparative Fit Index (CFI) and the Non-Normed Fit Index (NNFI) with acceptable/good fit set at 0.95/0.97 and above, the Normed Fit Index (NFI) and the Goodness-of-Fit Index (GFI) with acceptable/good fit at 0.90/0.95 were used. For the Adjusted GFI (AGFI) acceptable/good fit was set to 0.85/0.90.

The frequency distribution of all the measurements was examined to assess deviation from normality; both skewness and kurtosis were significant, therefore the Robust Maximum Likelihood (RML) estimate procedure was applied in all articles referred. When analysing continuous but non-normal endogenous variables, the Satorra-Bentler corrected χ^2 (Satorra & Bentler, 1994) should be reported (Kline, 2011). Before examining the hypothesized relationships, all the different measurement models were tested by CFA.

Measures

Symptom severity was assessed by the QLQ-C15-PAL, a core palliative care questionnaire (Groenvold et al., 2006). The QOL-C15-PAL is an abbreviated 15-item version of the EORTC QLQ-C30, made up of 2 multi-item functional scales (physical and emotional functioning), 2 multi-item symptom scales (fatigue and pain), 5 single-item symptom scales (nausea/vomiting, dyspnoea, insomnia, appetite loss, constipation), and 1 final question referring to overall QoL. Each item is rated on a numeric scale from 1 (not at all) to 4 (very much), except for the global QoL which is rated from 1 (very poor) to 7 (excellent) (ibid.). The EORTC QLQ-C30 scoring manual and the QLQ-C15-PAL scoring addendum (Fayers,

Aaronson, & K., 2001) were used to generate the QLQ-C15-PAL scores (0-100) for the 2-item and the single-item sub-scales[2]. In this study Cronbach's α was .78.

Multidimensional well-being was assessed by the FACT-G *(Functional Assessment of Chronic Therapy Quality of life-General)* QoL questionnaire (Cella et al., 1993; Webster, Cella, & Kost, 2003), comprising 27 items and four subscales of physical, social/family, emotional, and functional well-being[3]. Each item is rated on a 5-point Likert-type scale from 0 (not at all) to 4 (very much); higher scores indicate a greater degree of well-being[4]. The FACT-G, comprising the four latent constructs of physical, social, emotional and functional well-being, was tested and the number of items gradually reduced; three items (Social Well-Being 11,13,14) involving partner, sexual life, and family acceptance together with items regarding work (Functional Well-Being 21,22) were irrelevant. Examples of test items used for physical well-being were "I have lack of energy", "I have pain", and "I feel ill". Social well-being was measured by the indicators "I feel close to my friends", "I get emotional support from my family", and "I get support from my friends". Further, test items for emotional well-being were "I feel sad", "I feel nervous" and "I worry that my conditions will get worse", and, for functional well-being: "I am able to enjoy life", "I have accepted my life situation", and "I am content with the quality of my life right now" (Haugan, 2014b; Haugan, Rannestad, et al., 2013).

Spiritual well-being was assessed by the FACIT-Sp-12 *(Functional Assessment of Chronic Illness Therapy Spiritual Well-Being Scale)*. The FACIT-Sp-12 is part of the larger FACIT measurement system (Cella et al., 1993) and was developed to describe aspects of spirituality and/or faith that contributed to well-being (Peterman et al., 2002). Each item is rated on a 5-point Likert-type scale from 0 (*not at all*) to 4 (*very much*); with higher scores indicating healthier spiritual well-being. Test items included "I feel peaceful", "I have a reason for living", "I feel a sense of harmony within myself" and "My life lacks meaning and purpose". Cronbach's α was .80 in this study[5]. The recent published three-factor model was supported by these NH data (Haugan, 2014a) and was used for the SEM-analyses evaluate the relationships between self-transcendence and spirituality (Haugan et al., 2014).

Hope was measured using the Norwegian version of the HHIndex (HHI-N) (Wahl, Lerdal, & Knudsen, 2004). The HHIndex is based on the definition of hope developed by Dufault and Martocchio (1985) and was developed with the same three subscales as the HHScale, representing the three combined domains of the conceptual model, defined as follows: (1) temporality and future, (2) positive readiness and expectancy, and (3) interconnectedness (Herth, 1991). The HHIndex comprises 12 items using a 4-point Likert

[2] The QLQ-C15-PAL has demonstrated good content validity (Groenvold et al., 2006). A Norwegian version validated for cancer patients was used (ibid.).

[3] The FACT-G is a general QoL-measure considered appropriate for use with patients who have cancer and has also been used and validated in other chronic-illness conditions (e.g., HIV/AIDS, multiple sclerosis), as well as in the general population (using a slightly modified version).

[4] A review of 78 studies using the FACT-G QoL questionnaire reported an average Cronbach's α 0.88 (subscales ranged from 0.71-0.83); the FACT-G demonstrated acceptable reliability evidence across the observed studies, without substantial variability due to scale or demographic characteristics (Victorson, Barocas, Song, & Cella, 2008).

[5] Previous research demonstrates that the FACIT-Sp-12 is a psychometrically sound measure of spiritual well-being (Brady et al., 1999; Canada et al., 2008; Murphy et al., 2010; Peterman et al., 2002; Wahl, Lerdal, & Knudsen, 2004; Whitford & Olver, 2011). The original factor analysis of the FACIT-Sp-12 supported two factors; meaning/peace and faith. However, more recent investigations indicate that a three-factor construct, comprising meaning, peace, and faith, is psychometrically superior the original two-factor construct. Thus, some insecurity exists in respect to the dimensionality (Haugan 2014a).

response format (from strongly disagree to strongly agree) with possible scores ranging from 12 to 48; higher scores indicate greater hopefulness. Cronbach's α in the present study was .76. Test items included "I have a positive outlook toward life", "I feel alone", "I have a deep inner strength" and "I feel that my life has value and worth". The HHI was chosen for the present study because it is based on a universal concept of hope and designed for clinical settings such as older people care and cancer patients (Herth, 1992). Furthermore, the HHI is brief, has been translated into Norwegian and tested in the general Norwegian population (Wahl et al., 2004)[6], and found reliable in NH patients (Haugan, Utvær, et al., 2013).

Meaning-in-life was assessed by the Purpose-in-Life Test (PIL)[7]. Based on Frankl's theory, the PIL was designed to be a general tool assessing meaning (Crumbaugh & Henrion, 1988; Crumbaugh & Maholick, 1964, 1969, 1981) and has been commonly used[8] for this purpose (Frazier, Oishi, & Steger, 2003; Steger, Frazier, Oishi, & Kaler, 2006). Test items included questions such as 'My personal existence is very purposeful and meaningful' and 'In achieving life goals, I have progressed to complete fulfilment'. Each statement is scored from 1–7 where 4 represents a neutral value, whereas the numbers from 1–7 stretch along a continuum from one extreme feeling to the opposite kind of feeling. The range of possible scores is 20–140 and numerically higher scores reflect increased purposefulness (Crumbaugh & Maholick, 1969, 1981). The PIL-scores above 112 indicate the presence of definite meaning and purpose in life, scores between 92–112 are in the indecisive range, and scores below 92 indicate a lack of a clear purpose and meaning-in-life (ibid.). Cronbach's α was .82.

Interpersonal and intrapersonal self-transcendence were assessed by the Self-Transcendence Scale (STS) (P. G. Reed, 2008). The STS comprises 15 items reflecting expanded boundaries of self, identified by intrapersonal, interpersonal, transpersonal, and temporal experiences (P. G. Reed, 2009a), all of which are considered to be characteristics of a matured view of life. Each item is rated on a four-point Likert-type scale from 1 (not at all) to 4 (very much); higher scores indicate higher ST[9]. The ST-scale was translated into Norwegian for the purpose of this study (Haugan, Rannestad, et al., 2012).

The two-factor-construct of self-transcendence (Haugan, Rannestad, et al., 2012) was used[10]. The items "Having hobbies and interests I can enjoy," "Being involved with other people," "Sharing my wisdom or experience with others," "Helping others in some way," "Having an ongoing interest in learning," "Able to move beyond things that once seemed so important," and "Finding meaning in my spiritual beliefs" were indicators for interpersonal self-transcendence, while the items "Accepting myself as growing older," "Adjusting well to my present life situation," "Adjusting well to changes in my physical abilities," "Finding

[6] The HHI is psychometrically evaluated in different samples showing acceptable internal consistency with α's between .78–.97, but the factor structure appears to be unstable (Benzein & Berg, 2003; Herth, 1992; Phillips-Salimi, Haase, Kintner, Monahan, & Azzouz, 2007; Van Gestel-Timmermans, Van Den Bogaard, Brouwers, Herth, & Van Nieuwenhuizen, 2010; Wahl et al., 2004).

[7] The PIL consists of three parts; however, only the main part comprising 20 Likert-type attitude statements was used for the purpose of this study.

[8] The PIL is translated into Norwegian (Bondevik 1997) and has previously been used with elderly individuals up to 103 years old (Margareth Bondevik & Skogstad, 2000; Flood & Scharer, 2006). Concept and concurrent validity have been reasonably well established (Crumbaugh & Henrion, 1988; Haugan & Moksnes, 2013).

[9] In previous studies, Cronbach's α ranged from .80 to .88 (P. G. Reed, 1991a, 2009b; Runquist & Reed, 2007). Content validity is adequate, based on a thorough review of empirical and theoretical literature (P. G. Reed, 2008). Support for construct validity has been found in the relationships of self-transcendence scores compared to other measures (Coward, 1990, 1991b, 1996).

[10] The reversed item "letting go of my past losses" (ST15) loaded extremely low (λ=0.11, R^2=0.02), and was uncorrelated. Therefore, there might be some translation problems and this item was dismissed.

meaning in my past experiences," "Accepting death as a part of life," "Letting others help me when I may need it," and "Enjoying my pace of life" constituted the intrapersonal self-transcendence construct. Cronbach's α in the current study was 0.72 (all 14 items), while α for interpersonal self-transcendence (7 items) was .76, and α for intrapersonal self-transcendence (7 items) was .65 (Table 2).

Anxiety and depression were assessed by the Hospital Anxiety and Depression Scale (HADS), comprising 14 items, with subscales for anxiety (HADS-A; 7 items) and depression (HADS-D 7 items). Each item is rated from 0–3, where higher scores indicate more anxiety and depression. The maximum score is 21 on each subscale. The ranges of scores for cases are: 0–7 normal, 8–10 mild disorder, 11–14 moderate disorder, and 15–21 severe disorder (Snaith & Zigmond, 1994). Examples of sample-items for depression included: "I still enjoy the things I used to enjoy," "I can laugh and see the funny side of things," "I feel cheerful," "I have lost interest in my appearance," and "I look forward with enjoyment to things". Sample items for anxiety included: "I feel tense and wound up", "I get a sort of frightened feeling as if something awful is about to happen", "Worrying thoughts go through my mind", "I get a sort of frightened feeling like "butterflies" in the stomach", and "I get sudden feeling of panic". In order to increase acceptability and avoid individuals feeling as though they are being tested for mental disorders, symptoms of severe psychopathology have been excluded. This makes HADS more sensitive to milder psychopathology (Stordal, Mykletun, & Dahl, 2003). The HADS showed good to acceptable reliability and validity in this NH population (Haugan & Drageset, 2014; Haugan & Innstrand, 2012; Haugan, Innstrand, et al., 2013)[11].

Nurse-patient-interaction was assessed by the Nurse-Patient-Interaction Scale (NPIS) which was developed to identify important characteristics of NH patients' experiences of the nurse-patient interaction and validated in a NH population (Haugan, Hanssen, et al., 2012). The NPIS is a 10-point-scale from 1 (not at all) to 10 (very much); higher numbers indicate better nurse-patient-interaction. The NPIS comprises 14 items identifying essential relational qualities stressed in the nursing literature (Haugan, Hanssen, et al., 2012). Examples of items include "Having trust and confidence in the staff nurses", "The nurses take me seriously" and "Interaction with nurses makes me feel good", as well as having trust and confidence in the staff nurses and experiences of being respected and recognized as a person, being listened to and feeling included in decisions. The items were developed to measure the NH patients' ability to derive a sense of wellbeing and meaningfulness from the nurse-patient-interaction (Finch, 2006; Haugan Hovdenes, 2002; Hollinger-Samson & Pearson, 2000; Rchaidia et al., 2009). In this study Cronbach's α was .92[12].

Reliability for the latent constructs involved in this study was further investigated inside the CFA revealing acceptable to good values for composite reliability (Hair, Black, Babin, & Anderson, 2010).

[11] HADS has been extensively tested showing well-established psychometric properties (Herrmann, 1997, Norton et al 2013), and it has been translated into Norwegian and found to be valid for older people (Stordal et al., 2001; Stordal et al., 2003). The internal consistency of the scale in the present study was α=.78, whereas α was .79 and 0.66, respectively for anxiety and depression

[12] The NPIS has shown good psychometric properties with good content validity and reliability among NH patients (Haugan, 2013b; Haugan, 2014b; Haugan 2014c; Haugan, Hanssen, et al., 2013; Haugan, Hanssen, et al., 2012; Haugan, Innstrand, et al., 2013; Haugan, Moksnes, et al., 2014; Haugan et al., 2014).

Table 1. Means, standard deviations *(SD)*, Cronbach's alpha and correlations between the study variables

				Correlation coefficients Pearson's r^2											
	M	*SD*	Cronbach's α (nb.of items)	QoL	HADS-A	HADS-D	PWB	SWB	EWB	FWB	SPWB	HOPE	PIL	ST-1	ST-2	NPIS
QoL	4.93	1.420	0.00 (1)	1												
HADS-A	2.39	0.374	0.79 (7)	-.291**	1											
HADS-D	1.06	0.429	0.66 (7)	-.233**	.254**	1										
PWB	2.81	1.046	0.70 (4)	.435**	.159*	-.073	1									
SWB	1.94	0.962	0.60 (4)	.130	-.059	-.186**	.026	1								
EWB	3.13	0.773	0.67 (3)	.434**	-.475**	-.128	.356**	-.086	1							
FWB	2.23	0.796	0.65 (3)	.378**	-.243**	-.351**	.172**	.222**	.223**	1						
SPWB	2.20	0.629	0.80 (12)	.268**	-.304**	-.377**	.149	.323**	.306**	.547**	1					
HOPE	2.93	0.348	0.77 (12)	.346**	-.240**	-.457**	.168*	.381**	.292**	.489**	.760**	1				
PIL	4.72	0.691	0.71 (8)	.460**	-.406**	-.483**	.205*	.223**	.402**	.524**	.608**	.660**	1			
ST-1	2.54	0.557	0.76 (7)	.174*	-.046	-.317**	.101	.385**	.021	.336*	.530**	.598**	.428**	1		
ST-2	3.06	0.343	0.64 (7)	.325**	-.301**	-.227**	.740**	.193**	.241**	.473**	.481**	.463**	.372**	.309**	1	
NPIS	8.13	1.630	0.92 (14)	.325**	.159*	-.237**	.203**	.132	.228**	.313**	.222**	.245**	.365**	.093	.236**	1

Note. *significant at the 5% level **significant at the 1% level. QoL=quality-of-life. HADS-A=Anxiety. HADS-D=Depression. PWB=Physical well-being. SWB=Social well-being. EWB=Emotional well-being. FWB=Functional well-being. SPWB=Spiritual well-being. PIL= Purpose-in-Life, ST-1=Interpersonal self-transcendence. ST-2=Intrapersonal self-transcendence. NPIS=nurse-patient-interaction.

RESULTS

Participants' age was 65-104, with a mean of 86 years (SD=7.65). The sample comprised 146 women (72.3%) and 56 men (27.7%), where the mean age was 87.3 years for women and 82 years for men. A total of 38 (19%) participants were married/cohabitating, 135 (67%) were widows/widowers, 11 (5.5%) were divorced, and 18 (19%) were single. Duration of time of NH residence when interviewed was at mean 2.53 years (SD 2.25) (range 0.5–13 years); 117 were in rural NHs, while 85 were in urban NHs. Table 1 shows the means, standard deviations, Cronbach's alpha and correlation coefficients for the study variables. The correlations between the measures were moderate to high and were in the expected direction. The various measures showed an acceptable level of interitem consistency with Cronbach's α coefficients of .60 and higher. Since the measure of global QoL comprised only one item it did not have an α value.

Symptom Severity

The prevalence of symptoms is displayed in Table 2, showing that fatigue (56%), pain (49%), constipation (43%) and dyspnoea (41%) were the most common physical plagues (Haugan, 2013a). Further, 38 percent reported insomnia, 25 percent suffered from lack of appetite, and 18 percent had nausea/vomiting. Thus, cognitively intact NH patients reported a fairly high level of physical symptoms, indicating a great need for nursing care requiring highly competent staff nurses.

Table 2. Prevalence of common symptoms in NH patients; means and standard deviations (*SD*)

	Males N=56		Females N=146		Total sample N=202	
QLQ-C15-PAL Sub-scales	Mean	*SD*	Mean	*SD*	Mean	*SD*
QLQ Physical functioning	18.809	24.941	22.649	25.692	21.585	25.483
QLQ Fatigue	28.170	31.287	34.245	30.123	32.560	30.494
QLQ Nausea and vomiting	2.384	8.064	5.940	15.005	4.954	13.519
QLQ Emotional functioning	89.729	15.887	80.936	24.203	83.373	22.521
QLQ Pain	18.446	30.059	25.640	29.863	23.646	30.016
QLQ Dyspnoea	18.452	31.088	28.311	35.524	25.578	34.560
QLQ Insomnia	22.024	30.001	20.920	31.413	21.227	30.956
QLQ Appetite loss	13.690	28.268	14.612	27.396	14.612	27.573
QLQ Constipation	23.214	30.431	28.241	36.412	26.833	34.840
HADS-Anxiety	3.03	2.903	2.99	3.383	3.03	2.903
HADS-Depression	8.59	5.079	8.40	6.078	5.57	3.238

Note: Common symptoms assessed by the QLQ-C15-PAL questionnaire and the Hospital Anxiety and Depression Scale (HADS).

Patients' physical functioning was low, but their emotional functioning assessed by the QLQ-15-PAL was quite sound, suggesting that tension and a depressive mood were scarcely prevalent (Haugan 2013a). However, the prevalence of depression measured by the HADS questionnaire indicated that 30 percent were depressed, and 12 percent experienced anxiety. This is in accordance with previous studies reporting a prevalence rate of anxiety between 14-31% (Smalbrugge, et al., 2005, Barca et al., 2007) and a rate between 14–42% for depressive symptoms in institutional living (Djernes, 2006). Also, depression prevalence is found to be 3–4 times higher in institutionalized elders than among community-dwelling older individuals (Jongenelis et al., 2004). Table 2 presents the prevalence of physical and emotional symptoms assessed by the QLQ-C15-PAL items 1–14 and the Hospital Anxiety and Depression Scale (HADS). The mean for overall QoL was 4.93 (SD=1.42).

HOPE

The global Herth Hope Index mean-score was 35.14 (SD=4.18), which is close to previous results among NH patients with hope mean-score=35.8 (Touhy, 2001), and inside the range of previous studies reporting means from 34-41. Independent t-tests for mean differences in hope, meaning, interpersonal (ST-1) and intrapersonal (ST-2) self-transcendence (data not shown) revealed no significant differences between females and males.

Moving to a NH is usually a result of facing disabilities, illnesses, and mortality; thus, it might prove difficult to gain a sense of hope or a positive life outlook as well as expectations in one's daily life. Nevertheless, hope has been found to be associated to connectedness and relationships. Therefore, a hypothesized association between nurse-patient interaction and hope was tested by means of SEM-analysis, revealing a significant association from the nurse-patient interaction to NH patients' hope (Haugan, Moksnes, et al., 2013). The results indicated that caregivers offering connectedness, fully accepting, supporting, and empowering the patients' inner thoughts, feelings, and concerns, positively would influence NH patients' hope (Haugan, Moksnes, et al., 2013). In spite of disabilities and illnesses NH patients' hope can be supported by means of caregivers' positive reappraisal empowering patients' sense of worthiness (Duggleby et al., 2012).

Meaning-in-Life

Concerning meaning-in-life, 8.9% (18) of the NH patients reported high meaning, 45% (91) reported indecisive meaning, and 43.6% (88) reported low meaning (Table 3). The PIL-scores ranged from 43-131 with a mean of 93.09 (SD=14.85). Females scored (93.6, SD=15.10) slightly higher than the males (91.75, SD=14.22), but mean differences between men and women were non-significant. The PIL mean score decreased marginally with age, showing means of 95.5 in patients >80 years old, 91–97 in the group aged 80–89, and 93.32 for those 90 years and older. The total PIL mean score (93.09) was in accordance with previous research (Bondevik & Skogstad, 2000), indicating that NH patients suffer from lack of meaning. The present mean score was somewhat lower than previous studies reporting

scores in older people, which had means of 105 (Hedberg, Gustafson, & Brulin, 2010), 99-106 (Sarvimäki & Stenbock-Hult, 2000) and 106-113 (Krawczynski & Olszewski, 2000).

Table 3. Purpose in Life (PIL): High, Indecisive, and Low PIL: frequency, means and standard deviation (*SD*)

	Frequency	*Percent*	*Mean*	*SD*
High PIL	18	8.9	120.25	9.85
Indecisive PIL	91	45.0	100.00	5.71
Low PIL	88	43.6	80.124	9.85

Note: High PIL= PIL scores from 113-140. Indecisive PIL = PIL scores from 92-112. Low PIL = PIL scores from 1-91.

Relationships between Meaning-in-Life, Symptoms and QoL

Considerable correlations between physical health, emotional adjustment and meaning-in-life in older adults have been demonstrated (Isaia, Parker, & Murrow, 1999). Furthermore, meaning has been described as a mediator for physical health. Therefore, this study examined the relationships between meaning, symptoms and QoL. The correlations between symptoms and meaning were moderate and in the expected directions. Pearson's correlational coefficient (r) displayed significant values for the PIL-construct to all symptoms except pain, appetite loss and constipation (Haugan, 2013a). The highest correlations were found, as expected, between PIL and depression (r=-0.555), overall QoL (r=0.457) and emotional functioning (r=0.326). Although moderate values, significant correlations were disclosed between meaning and physical symptoms such as nausea/vomiting (r=-0.310), insomnia (r=-0.281), fatigue (r=-0.172) and dyspnoea (r=-0.156). To explore whether meaning was more fundamental than other closely related aspects such as hope or inter- and intra-personal self-transcendence, these constructs were included in the correlational analysis, demonstrating meaning (PIL) as the most significant correlation with the common symptoms assessed (Haugan, 2013a). Consequently, meaning-in-life seemed to be crucial to NH patients' QoL.

To further explore the importance of meaning-in-life among NH patients, a SEM-model testing the possible relationships between meaning and physical, emotional, social and functional well-being was applied (Haugan, 2014b). A good-fitting SEM-model revealed significant effects on all the QoL-dimensions of physical, emotional, social and functional well-being (Haugan, 2014b). The PIL-construct, comprising facets of meaning such as either having clear goals or experiencing life to be empty and hopeless, experiencing life as stimulating and finding meaning in the present situation or perceiving every day to be exactly the same and one's daily tasks to be painful and boring, significantly and directly influenced NH patients' emotional and functional well-being, whereas significant indirect impact on social and physical well-being was disclosed (Haugan, 2014b).

Self-Transcendence (ST)

The self-transcendence mean-score was lower than formerly reported among older populations, with means of 49 (P. G. Reed, 1991a), 48 (Upchurch, 1999), 47 (Nygren et al., 2005) and 46 (Klaas, 1998). Also, an inverse relationship between self-transcendence and age

was revealed, with ST mean score=45 for the group ages 65–75, which is more in line with those reported previously, whereas groups ages 76–90 (ST mean 42.9) and 91–104 (ST mean 41.25) reported considerably lower self-transcendence. Although the participants in Reed's study (1991a) were ages 85–100, their reported ST-level was 49. Similarly, Upchurch (1999) reported a self-transcendence level for 48 adults ages 65–93 and Klaas (1998) studied older people 75 years and more, reporting a mean of 46. This supports the idea that not age, but rather a poorer self-transcendence capacity, explains the lower ST-score among NH patients.

The NH setting might represent fewer possibilities for developing and preserving self-transcendence than are found among same-aged older adults living at home (Nygren et al., 2005; P. G. Reed, 1991a). An investigation of the factor structure of the self-transcendence scale revealed two factors termed inter-personal (ST-1) and intra-personal (ST-2) self-transcendence (Haugan, Rannestad, et al., 2012). Further, the age-effect was particularly associated with the inter-personal self-transcendence aspect involving hobbies, interests, involvement with and helping others, learning, and sharing wisdom (Haugan, Rannestad, et al., 2013). Hence, interpersonal self-transcendence might require a certain level of energy and thus less fatigue, physical illness and impairment which might explain the age-effect found associated with patients' self-transcendence-score (Haugan, Rannestad, et al., 2013).

Nevertheless, significant relations from self-transcendence to all dimensions of well-being were disclosed, suggesting interpersonal and intrapersonal self-transcendence to be vital resources for social, emotional, physical, functional and spiritual well-being (Haugan, Rannestad, et al., 2013; Haugan et al., 2014). In consequence, the potential for self-transcendence and well-being are important considerations in NH care; most patients have suffered numerous losses that challenge their self-transcending capacity and QoL, increasing their vulnerability. Because of physical decline and other limitations, most of the NH patients are in need of care and assistance. Self-acceptance and adjustment, which are essential aspects of intrapersonal self-transcendence, are necessary for well-being (Ryff et al., 2004). Facing advanced age, few remaining social contacts, other losses, and physical decline requiring NH care, individuals may experience threats to their connectedness, representing life experiences that manifest existential suffering and feelings of loneliness and worthlessness. Hence, it might prove difficult to maintain one's self-acceptance, representing a core intra-aspect of self-transcendence.

Intrapersonal Self-Transcendence

The intra-personal self-transcendence (ST-2) entails acceptance of the self, death, and the slower pace of life, adjustment to one's life situation and physical disabilities, finding meaning in previous experiences and letting others help; all of which support NH patients' ability to cope when facing numerous losses, impairments and plagues. Intrapersonal self-transcendence related directly to the patients' experience of their overall QoL, their ability to enjoy life, and acceptance of their situation (Haugan, Rannestad, et al., 2013). This directional influence on QoL seems evident and in accordance with previous research (Hjaltadóttir & Gústafsdóttir, 2007; Tester, Hubbard, & Downs, 2004; Wadensten & Ahlström, 2009). If a NH patient doesn't accept, adjust, and let others help, enjoying life in the NH will be difficult.

Also, intrapersonal self-transcendence clearly affected the peace factor belonging to spiritual well-being (Haugan et al., 2014). Consequently, the experience of inner peace and harmony was closely related to intrapersonal self-transcendence which connects to the QoL domain of "being-in-the-world" (Raphael, Brown, Renwick, Cava, et al., 2010; Raphael,

Brown, Renwick, & Rootman, 2010). Inner peace and harmony result from self-acceptance and adjustment, hence intrapersonal self-transcendence contributes to the ability of enjoying one's "being" or "who I am" (Harrefors et al., 2009; Hjaltadóttir & Gústafsdóttir, 2007).

Previous research suggests that emotional and spiritual well-being are resources for maintaining physical well-being (Kirby et al., 2004; Ryff et al., 2004). Accordingly, the present study displayed a significant influence of intrapersonal self-transcendence on physical well-being, mediated by emotional and functional well-being (Haugan, Rannestad, et al., 2013). Meanwhile, adjusting well to one's disabilities and life situation (ST-2) requires energy; transformation and adjustment are exhausting, particularly in very old age. This is important to bear in mind when caring for older NH patients.

Interpersonal Self-Transcendence

The present study also brought to light the notion that interpersonal self-transcendence is a vital resource for social, emotional, physical, and spiritual well-being among cognitively intact NH patients (Haugan, Rannestad, et al., 2013; Haugan et al., 2014). Besides, interpersonal self-transcendence was significantly associated with intrapersonal self-transcendence. Hence, facilitating hobbies, involvement, helping others, learning, and sharing wisdom (ST-1) could increase meaning-in-life, inner peace, and acceptance of self, helping individuals to adjust well to their life situation (ST-2). However, the more "outgoing mind-set" of interpersonal self-transcendence, comprising involvement with other people, sharing wisdom, and helping others in some way, along with involvement in hobbies, interests, and learning, might require a certain level of energy and therefore less physical illness and impairment. The patients' scores on self-transcendence indicated a decrease with higher age (Haugan, Rannestad, et al., 2013), mostly related to the inter-personal aspects. Simultaneously, fatigue, pain and dyspnoea were common symptoms in this NH population. In accordance to these results, it seems evident that the life situation of NH patients is demanding with regard to both the patients and the caregivers. So, when facilitating interpersonal and intrapersonal self-transcendence staff nurses have to be aware of physical conditions such as patients' fatigue and pain as well as their emotional state.

Nurse-Patient Interaction

Spiritual nursing care, responding to the patients' inner thoughts, emotions and experiences can improve the patients' physical and mental well-being overall (Upchurch 1999, Wright, et al., 2011). Accordingly, the staff nurses' way of being present when interacting with the patients has been found to result in very different experiences: the patients experience either a sense of growth, fulfillment and well-being, or a sense of stagnation and elimination (Haugan Hovdenes, 2002). Therefore, the present study investigated the impact of the nurse-patient interaction on NH patients' anxiety and depression, hope, meaning-in-life, and self-transcendence (inter- and intra-personal). The perceived nurse-patient interaction showed a significant influence on patients' hope (Haugan, Moksnes, et al., 2013), meaning-in-life (Haugan, 2013c), self-transcendence (Haugan, Hanssen, et al., 2012), anxiety and depression (Haugan, Innstrand, et al., 2013). Given that self-transcendence (Haugan, Rannestad, et al., 2013) and meaning-in-life (Haugan, 2014b) demonstrated significant effects on all dimensions of QoL (physical, emotional, functional, social and spiritual), the nurse-patient interaction might impact QoL multidimensionally, by

enhancing patients' sense of meaning and self-transcendence (Haugan, 2013b; Haugan, Rannestad et al., 2013). However, when planning and performing NH care, knowledge about what is the most important for NH patient's QoL is crucial. In consequence, to support QoL, which dimension should be given the main focus in clinical NH care?

Hope, Meaning, Self-Transcendence and Nurse-Patient Interaction - Which Is the Most Important to QoL?

Finding effective interventions to foster QoL in NH patients requires insight about how these variables might affect NH patients' QoL. Therefore, we investigated the associations between hope, interpersonal and intrapersonal self-transcendence, meaning, nurse-patient-interaction and QoL in this population (Haugan, Moksnes et al., 2014). In accordance with previous research and theory, all of these scales were expected to be significantly related to QoL. However, we did not know if they were equally important or if any of them were more outstanding and therefore should be given the main focus when attempting to increase QoL among cognitively intact NH patients. Thus, we intended to test their individual association with QoL by controlling for the other scales.

Controlling for gender, age, and residential time, bivariate associations between each of the scales and QoL as well as multivariate associations were assessed in proportional odds logistic regression analyses (Table 5). Actually, the intra-part of self-transcendence (ST-2) had an exceptional position among the scales included: ST-2 emerged as a distinct and main asset for QoL (Haugan, 2013b; Haugan, Moksnes et al., 2014; Haugan, Hanssen, et al., 2013), and in particular, a vital resource for emotional and spiritual well-being (Haugan, Rannestad, et al., 2013; Haugan et al., 2014). Bivariate analyses (left side of Table 5) showed that participants scoring high on hope or ST-2 were 8 times more likely to report better QoL than those who scored low on hope or ST-2, respectively (Haugan, Moksnes et al., 2014). Participants who scored high on the other scales were 2–4 times more likely to report better QoL than participants who scored low on the respective scales. All associations were highly significant (p-values <0.01). Intra-personal self-transcendence (ST-2) presented a very high odds ratio in the bivariate analysis, and did also expose the strongest association with QoL in the multivariate analysis, closely followed by the PIL scale (Table 4).

Table 4. Proportional odds ordinal regression with Quality of Life as dependent variable

	Bivariate analyses		Multivariate analysis	
Variables	Odds ratio (95% CI)	p-value	Odds ratio (95% CI)	p-value
HOPE	8.25 (3.70 to 18.40)	<0.001	1.56 (0.47 to 5.12)	0.466
ST-1	1.89 (1.18 to 3.04)	0.008	0.81 (0.45 to 1.46)	0.488
ST-2	8.04 (3.59 to 18.00)	<0.001	3.74 (1.52 to 9.16)	0.004
PIL	3.95 (2.60 to 5.99)	<0.001	2.65 (1.54 to 4.57)	<0.001
NPIS	2.81 (0.88 to 8.98)	<0.082	1.20 (1.00 to1.43)	0.047

Note: All models adjusted for gender, age, and residential time. Hope=Herth Hope Index. ST-1= Interpersonal self-transcendence. ST-2=Intrapersonal self-transcendence. PIL=purpose and meaning-in-life. NPIS=Nurse-Patient-Interaction.

Former studies have emphasized meaning as a core resource for QoL for many older adults (Hedberg et al., 2011; Hedberg et al., 2010; Knestrick & Lohri-Posey, 2005; Wallace & O'Shea, 2007), showing significant correlations with physical and emotional symptoms in NH patients, as well as acting as a mediating variable in both psychological (R. T. Ho, Potash, Fu, Wong, & Chan, 2010; Kleftaras & Psarra, 2012; Westerhof et al., 2010) and physical health (Canada et al., 2008; Vance et al., 2008). Meaning (Bekelman et al., 2007; Danhauer et al., 2005; Krause, 2007) and intrapersonal self-transcendence (Haugan & Innstrand, 2012) have demonstrated negative relations to depression, predicted higher psychospiritual functioning and offered potential buffers for an individual's reactions to stressful life experiences (Bauer-Wu & Farran, 2005; Krause, 2007). When individuals are accepting of themselves and adjusting well (ST-2), they experience more inner peace (Haugan et al., 2014). Given that inner peace is seen to be strongly and significantly related to meaning (Peterman et al., 2002; Peterman et al., 2011), the present results seem plausible and theoretically meaningful. Thus, the idea that intrapersonal self-transcendence and meaning act as notable QoL-resources is sound. Accepting death and accepting oneself growing older are considered inner aspects related to personal maturity (P. G. Reed, 2008) and intrapersonal dignity (Pleschberger, 2007). Accordingly, intrapersonal self-transcendence is part of an individual's personality and personal maturity, but still, it is a resource which can be supported and strengthened from the outside, by means of e.g., the nurse-patient interaction.

Interestingly, when the other scales were adjusted for, the nurse-patient interaction (NPIS) also contributed individually to QoL; participants with high scores on nurse-patient interaction were 1.2–1.3 times more likely to report higher QoL than those reporting low scores on nurse-patient interaction (Table 4). On the other hand, hope and interpersonal self-transcendence (ST-1) showed no individual contributions to QoL in the multivariate analysis (Haugan & Drageset, 2014). This indicates that NH patients experiencing good nurse-patient interaction, such as being respected, acknowledged, confirmed, listened to and taken seriously, were 1.2–1.3 times more likely to perceive a better QoL. In former studies, the nurse-patient interaction has been found to be critical to NH patients' sense of dignity, self-respect, feelings of self-worth, meaning, and QoL (Harrefors et al., 2009; Haugan Hovdenes, 2002; Heliker, 2009).

In addition, NH patients' dignity has been differentiated into intrapersonal and relational dignity; the latter socially constructed by the act of recognition (Erikson, Erikson, & Kivnick, 1986; Pleschberger, 2007). Therefore, nurse-patient interaction can positively or negatively affect NH patients' QoL. Using the nurse-patient interactions to facilitate patients' sense of being taken seriously and understood, recognized, respected and confirmed as a unique person may well support and strengthen patients' sense of dignity, self-worth, and thereby global QoL (Haugan & Drageset, 2014), as well as reducing depression (Haugan, Innstrand, et al., 2013) and enhancing physical well-being (Haugan, 2014b; Haugan, Rannestad, et al., 2013).

Figure 1 portrays the broad picture depicting the significant associations demonstrated in the present sample of cognitively intact NH patients. The nurse-patient interaction displayed a significant influence on hope (Haugan, Moksnes, et al., 2013), meaning (Haugan, 2013c) and intra- and inter-personal self-transcendence (Haugan, Hanssen, et al., 2012) (illustrated by the thick green arrows).

In particular, meaning and intra-personal self-transcendence exposed substantial influence on functional, emotional and physical well-being (Haugan, 2014b; Haugan,

Rannestad, et al., 2013). Moreover, inter-personal self-transcendence revealed a weighty impact on social and emotional well-being (Haugan, Rannestad, et al., 2013), with the latter demonstrating a vital effect on physical well-being (Haugan, 2014b; Haugan, Rannestad, et al., 2013). Thus, the nurse-patient interaction might influence all the QoL-domains by affecting meaning, hope and self-transcendence. These indirect associations are exposed by means of the slim red arrows in Figure 1, and in details documented in the respectively publications.

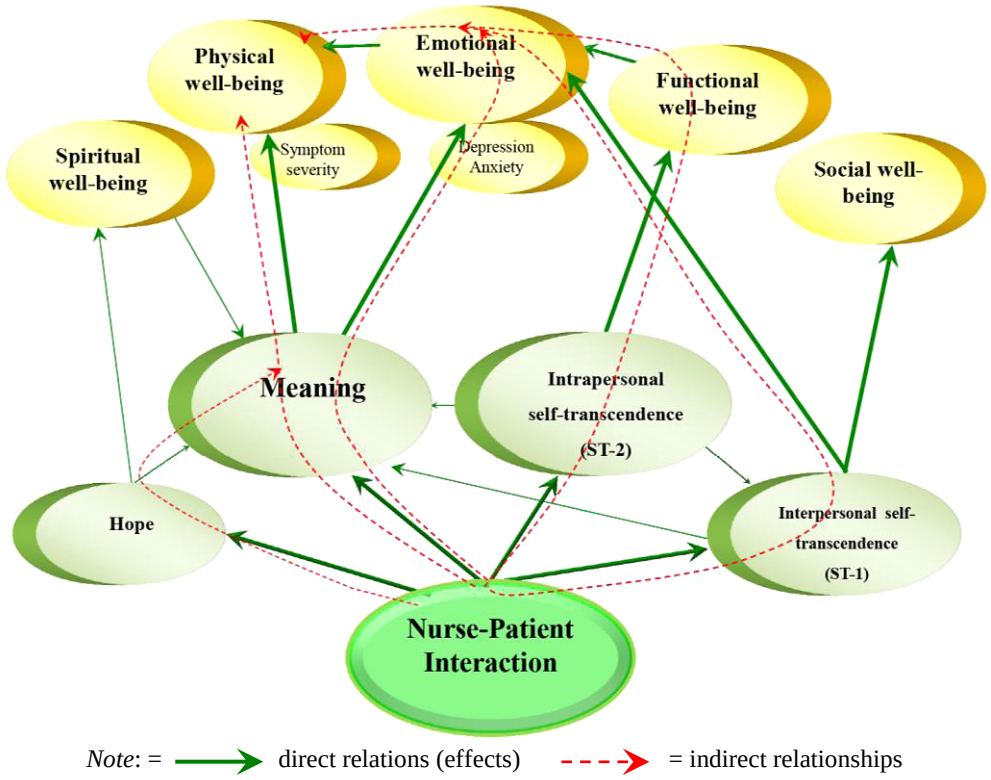

Figure 1. Relationships between nurse-patient interaction and meaning, intra-personal self-transcendence, hope, inter-personal self-transcendence, physical well-being and symptom severity, emotional well-being and anxiety and depression, functional, social and spiritual well-being in cognitively intact NH patients.

OLDER PEOPLE NURSING – HEALTH AND QOL PROMOTION

The results based on the present sample of cognitively intact NH patients, presented in a number of different articles (Haugan, 2013a, 2013b, 2014a, 2014b, 2014c; Haugan & Drageset, 2014; Haugan, Hanssen, & Moksnes, 2013; Haugan, Hanssen, Rannestad, & Espnes, 2012; Haugan & Innstrand, 2012; Haugan, Innstrand, & Moksnes, 2013; Haugan & Moksnes, 2013; Haugan, Moksnes, & Espnes, 2013; Haugan, Moksnes, & Løhre, 2014; Haugan, Rannestad, Garåsen, Hammervold, & Espnes, 2012; Haugan, Rannestad, Hammervold, Garåsen, & Espnes, 2013, 2014; Haugan, Utvær, & Moksnes, 2013), revealed lower means for meaning and self-transcendence than formerly reported among old individuals. This finding indicates that perceived meaning and self-transcendence are scarcely

prevalent in NH patients. Moreover, these results are noteworthy because they suggest that self-transcendence and meaning affect all dimensions of QoL, including physical well-being. Furthermore, perceived nurse-patient interaction demonstrates significant impact on hope, meaning and self-transcendence. Consequently, these results indicate that nurses can influence NH patients hope, meaning, self-transcendence, anxiety and depression, and thereby QoL, by means of the nurse-patient interaction. How might NH patients benefit from these insights? What actions should be directed in particular? How should NH caregivers act? In the following section, this chapter underlines some central aspects in promoting health and QoL in long-term NH care.

Pain and Symptom Management

These results suggested that the NH patients were marked by physical and emotional symptoms which were detrimental to their QoL. Consequently, highly competent staff nurses providing palliative care are needed in NHs. However, generally, staff members are poorly trained in pain and symptom management. Therefore, providing staff with developmental programs, followed by regular repetitions, seems needed. Likewise, "on-the-job-training" should be provided involving training the NH health care personnel in alleviating common symptoms such as pain, fatigue, dyspnoea, constipation, sleeplessness, depression and anxiety, as well as «on-the-job mentoring» to provide supervision and opportunities for participating in group reflections (Dyer, 2008; Levy-Storms, 2008).

The "Joy-of-Life-Nursing-Home"-concept (JLNH) is a national strategy for care quality and good working cultures in Norwegian NHs (Ministry of Health Care Services, 2012-2013). This JLNH national strategy implies an implementation of a "Joy-of-life"-philosophy and working strategy. In accordance with recent research this JLNH strategy emphasizes the integration of culture, activity, connectedness, relationships, enjoyment and spiritual/existential needs to be essential parts of the NH care. As a consequence, several NHs have conducted a JLNH-teaching program and reached a certification as a JLNH, implying a kind of status and good reputation. At the present, no data exist showing the possible effects of such programs; but studies are coming. Nevertheless, the idea of highlighting competence, resources and QoL more than impairments and losses is in accordance with a health promoting perspective on NH care, which is a step in the right direction. The NH staff is in need of relevant knowledge, supervision, and training in pain and symptom management as well as in nurse-patient interaction. Health care personnel should pay attention to how the patient experiences his/her pain and other common symptoms, and be able to effectively handle the patients' different complaints. The fact that the staff nurses really make an effort to relieve problems enhances patients' trust in the nurses. The nurse-patient relationship is created and significantly influenced by the nurse's way of being present together with the old NH patient, and is generated by trust resulting from staff nurses' caring attitudes and competent performance.

Moreover, significant correlations between meaning and symptoms were demonstrated in this study, the most significant of which regarded the physical symptoms of dyspnoea and insomnia (Haugan, 2013a). Also, the symptom profiles of groups of NH patients based on PIL scores showed that a high PIL score was followed by lower symptom severity, and better physical and emotional functions were significantly influenced by meaning (Haugan, 2013a).

Further, the SEM-analyses investigating the relationships between meaning-in-life and physical, social, emotional and functional well-being exposed significant impacts of meaning on all dimensions of QoL (Haugan, 2014b), including the physical. Accordingly, meaning-in-life and intrapersonal self-transcendence appeared to be vital resources for global QoL. Also, meaning and intrapersonal self-transcendence revealed a significant impact on physical well-being, mediated by emotional and functional well-being (Haugan, 2014b; Haugan, Rannestad, et al., 2013). Therefore, providing effective pain management requires highly competent caregivers enabled to effectively handle pain- and plagues and providing skilled nurse-patient interaction.

Centering (The Essence of the Person)

This study showed that the nurse-patient-interaction is vital for patients' intrapersonal self-transcendence. However, facilitating the self-transcendence intra-aspect requires that the nurse-patient interaction involves personal closeness and dialogue on a deeper meaningful level. The staff nurses have to be more deeply involved with their patients, engaging in their patients' inner experiences, thoughts and emotions. Hence, providing communication training programs for staff seems necessary. The nurse-patient-interaction is a potential resource for connectedness, supporting NH patients' self-acceptance, adjustment and QoL.

In this study, being subjected to high-quality nurse-patient interaction represented a potential resource for patients' hope (Haugan, Moksnes, et al., 2013), meaning (Haugan, 2013c) and in particual the intrapersonal part of self-transcendence (Haugan, 2013b; Haugan, Hanssen, et al., 2012), as well as decreasing anxiety and depression (Haugan, Innstrand, et al., 2013). The exellence in the caregivers' interaction with their patients appeared to substantially inspire hope, meaning and self-transcendence and thus QoL in cognitively intact NH patients. Furthermore, investigations showed that intrapersonal self-transcendence (ST-2), meaning and nurse-patient interaction were the most outstanding variables, representing promising key assets for NH patients' QoL (Haugan & Drageset, 2014; Haugan, Hanssen, et al., 2013). Therefore, offering connectedness should be a central and integral aspect of NH care.

Accordingly, NH care is determined by the way professional caregivers are using their knowledge, attitudes, behaviour, and communication skills in appreciating the uniqueness of the person being cared for (Warelow, Edward, & Vinek, 2008b). The relational qualities created by means of the nurse-patient interaction have been shown to affect NH patients' sense of self-worth, self-confidence, perceived hope, meaning, self-transcendence, anxiety and depression, implying that these experiences directly affect the older individuals' QoL. Therefore, highlighting the relational qualities seems principal. Concentrating on the patient's *«life story beyond the illness story»* might help as «words of wisdom» for NH caregivers. Further, a rule of thumb for good NH care is to focus on *«the essence of the person»* more than centering on the body's illnesses and impairments.

Nursing is materialized in a unique human care relationship and is a union with the other person with a high regard for the wholeness of his/her "being-in-the-world". Professional nursing care is grounded in a "Being-in-Relation within a caring paradigm", meaning that caring nurses engage in person-to-person relationships with the patients as unique persons, producing therapeutic results and well-being in the person being served (Watson, 1988). By means of listening, communicating and treating the patients with respect, by using empathic

understanding and acknowledging him/her as a person who is to be taken seriously and attended to, caregivers will promote meaning, self-transcendence and hope and thereby inner strength, coping, and wellbeing.

Thus, NH patient's dignity, identity, and integrity will be preserved (Burack et al., 2012; Coughlan & Ward, 2007). As a consequence, trust, confidence and an efficient nurse-patient relationship will emerge, all of which have been seen to be essential to care quality and NH patients' QoL. The nurse-patient interaction shall encourage good feelings such as trust, confidence, self-worth and well-being—and thereby will support hope, meaning and self-transcendence, and the NH patient's QoL will be boosted.

Confirmation of the Patient's Worthiness or Worthlessness

Nevertheless, generally NH patients are characterized by infirmity, inability and incapacity, all of which distress an individual's sense of worthiness and increase their sense of vulnerability. Therefore, frequently the NH patient interprets the caregivers' attitude, appearance and behavior as a confirmation of the patient's worthiness or worthlessness (Haugan Hovdenes, 2002; Hedelin & Jonsson, 2003). When NH patients experience not being attended to or being treated with indifference, these patients describe feeling meaninglessness and suffering (Finch, 2005, 2006; Haugan Hovdenes, 2002). The nurse-patient interaction might be crucial to NH patients' feeling valued and appreciated, or worthless and vulnerable (Haugan Hovdenes, 2002; Hedelin & Jonsson, 2003).

Accordingly, the relational qualities of the nurse-patient interaction appear to be essential. Performing nursing care in a respectful, attentive and empathic manner facilitating NH patients' experiences of being taken seriously, being understood and paid attention to as a unique person, might support and motivate patients' search for hope and meaning-in-life. Such a care might encourage intrapersonal self-transcendence including e.g., acceptance of self, death and the slower pace, as well as adjusting well to one's impairments and life situation.

When taking time to listen with interest to the NH patients' inner thoughts, feelings and life experiences, caregivers might accelerate patients' self-acceptance and sense of self-worth and thus their hope and meaning-in-life. Paying attention to the patient as a unique person, communicating and interacting respectfully and empathically, while making all possible efforts to relieve the old patient's plagues, appear to be relational qualities enabling NH patients' confidence in the caregivers, as well as encouraging personal goals, values and coherence.

Accepting Death as a Natural Part of Life

When old NH patients are talking about death, this should not be regarded as a sign of mental illness or something unwanted. Acceptance of one's death as a natural part of one's life is a central aspect of intrapersonal self-transcendence, and thus well-being. Hence, engagement in and thoughts about death might be sound and should not be rejected or distracted. Often, NH patients experience caregivers' avoidance of talking about death and

other difficult life themes, and express that they feel such avoidance as being eliminated or let down (Haugan Hovdenes, 2002).

Intrapersonal Self-Transcendence Requires Private Time in Silence

Self-transcendence is considered to be a general human developmental process of personal maturity. Providing space and time for NH patients' self-awareness and self-reflection represents a vital aspect in enhancing self-transcendence. Hence, in order to increase intra-personal self-transcendence NH patients need time in silence on their own, talking to themselves, reflecting and sorting out their inner thoughts and emotions. Therefore, if NH patients want to sit alone in silence, this might not be a sign of depression or anything negative but rather an indicator of the sound process of self-transcendence, which is shown to facilitate QoL. Since silence, space and time in private seem to be a necessity, radios, TVs, etc., should from time to time be shut off.

The Past Is Lengthy, While the Future Is Short

Individuals reaching old ages (+80) living in NHs, represent a substantial past, whereas their future is relatively short. In line with this, engaging in the past and exposing somewhat blurred boundaries between the past and the present are described as normal features of self-transcendence (Wadensten, 2007, 2010). Caregivers should therefore not be too quick to correct the old person when he or she is blurring the present together with the past. As an alternative, they should rather seek to understand their patient's feelings and what life theme he/she is concerned with at the moment and concentrate on acknowledging, accepting and respecting his/hers "being-in-the-world".

Facilitating Connectedness – QoL Promoting Groups

Interpersonal self-transcendence, comprising the intra-aspects, also displayed a significant relationship to well-being in this NH population. Thus, involvements with others, learning something, helping others and sharing one's wisdom are potential resources for QoL. Facilitating different kinds of "QoL promoting communities" at the NH ward seems needed. In order to facilitate meaningful relations and communication among the NH patients, the health care personnel might invite and support the residents to participate in different group activities such as "Reading newspapers", "Singing group", "Reading poetry", "Literature group", "Good memories group", "Faith-and-doubt-group", "Men's club" etc. The crucial point is to create a scene in which the participants might experience a meaningful dialogue, connection and communication; a setting which provides opportunities to express oneself and to connect and share one's experiences, thoughts and emotions in a confident and positive context. Such settings might be termed "QoL promoting groups".

Facilitating Connectedness - Contact with Family and Friends

The NH staff nurses may also promote interpersonal self-transcendence by facilitating connections with family and friends. Inviting relatives into encounters with caregivers in NHs is found to be positive (Westin, Ohrn, & Danielson, 2009), giving relatives positive feelings when visiting the NH; they felt valuable in their roles as relatives and even felt a sense of community with the nurses (Westin et al., 2009). Therefore, facilitating the relatives' dialogue and communication with the staff appears to be a health-promoting resource.

Though some NH patients have reported positive peer relationships (Bergland & Kirkevold, 2006), in general NH patients may have infrequent contact with friends and family members and thus suffer lack of attachment, connectedness and involvement. Attachment and communication with others are seen to be crucial for NH patients' thriving, emotional health and QoL (Bergland & Kirkevold, 2005; Drageset, Eide, & Nygaard, 2009; Drageset, Espehaug, & Kirkevold, 2012). Generally, the NH daily life provides scarce possibilities for connectedness and communicating. Therefore, the NH health care professionals might be important providers of connection and reinforcement (Drageset et al., 2012; Haugan, Moksnes, et al., 2013; Haugan Hovdenes, 2002). Commonly, few meaningful activities are provided in NHs, and the patients do not perceive their daily life to be exciting or meaningful. The nurse-patient-interaction might serve as a vital resource of human involvement and interaction and thus as a facilitator of meaning-in-life as well as a meaningful in-house activity (Haugan 2014c, Haugan 2013b; Haugan Hovdenes, 2002).

Interpersonal Self-Transcendence Might Require a Certain Level of Energy

Individuals living in NHs are experiencing disabilities, frailty, mortality, powerlessness and dependency. Thus, participating in meaningful activities might be difficult due to poor function and plagues. NH patients participating in the present study demonstrated a heavy symptom burden, with 56% fatigue, 49% pain and 41% dyspnoea etc. (Haugan, 2013a). Consequently, their energy will be affected by these states. Interpersonal self-transcendence might require a certain level of energy; given high scores on fatigue, pain and dyspnoea, involving, learning, helping and sharing might be too energy-demanding. Therefore, NH caregivers have to be aware of the patient's shape the actual day, and not only aiming at activating the residents, pushing them to transcend the self by involving and taking part in appropriate group activities, trips and so on.

Professional nursing care is determined by the way caregivers use their knowledge, attitudes, behavior and communication skills to appreciate the uniqueness of the person being cared for (Warelow et al., 2008b), which is shown to be fundamental for NH patients' dignity (Burack et al., 2012), meaning (Haugan, 2013b; Haugan Hovdenes, 2002), hope (Haugan, Moksnes, et al., 2013), self-transcendence (Haugan, Hanssen, et al., 2012), anxiety and depression (Haugan, Innstrand, et al., 2013), and thereby QoL (Haugan, Moksnes et al., 2014).

FURTHER NURSING RESEARCH AND EDUCATION

Nursing research and education should largely pay attention to spirituality as a salutogenic resource and the nurse-patient interaction as a fundamental part of caring, promoting hope, meaning, self-transcendence and well-being. This should be done to develop a more comprehensive and practice-based view of good nursing care. Insights into the potential for pain and symptoms release, hope, meaning, self-transcendence and QoL might inspire NH caregivers when performing their daily care practices. NH patients are not expected to be healed or get healthier; they will get even older and they will die. In the present study, the mean age was 86 years and average residential time was 2.6 years.

Therefore, finding ways to advance NH caregivers' interactive skills and to increase caregivers' awareness of the significance and value of their nurse-patient interaction seem imperative. Providing continuing educational programs for NH caregivers (Williams, 2006) focusing on how to interact with patients in a health-promoting and hopeful manner, and advancing the staff nurses' attendance and way of being present together with the patient, is essential. NH staffs should be given opportunities to participate in practical training communicating programs involving topics such as authentic presence, non-judgmental recognition, active listening, and conscious choices of communicative actions, along with supervision from trained nurses as well as theoretical perspectives on QoL, hope, meaning, self-transcendence, vulnerability, self-worth, dignity and nurse-patient interaction. Helping staff nurses to understand their value and importance as caregivers might generate value and meaning in their daily work. Advancing the caregivers' presence with the patient might contribute to increased hope, meaning, and worthiness for the NH patients as well as for the staff members.

CONCLUSION

Knowledge of body-mind-spirit-interaction inspires nurses in their health-promoting efforts to improve QoL in the "fruitless" patients, those who cannot be cured or be sent back to productive work engagements. Caring for such patient groups has tended to be termed "fruitless care", pointing at the "unsuccessful patients" being cared for without getting healthier. In a holistic perspective, no patients are unsuccessful, because all can be helped to increase a sense of meaning, hope, self-transcendence and thus QoL, in spite of illnesses and disabilities. Nursing is an art that intends to increase the well-being of those being cared for.

To promote hope, meaning and self-transcendence is to foster individuals' health and life quality. These constructs of hope, meaning and self-transcendence and the relationship between them (Haugan, 2014c), form a fruitful theoretical perspective for health promotion in NHs, and should therefore be given a central position in health and nursing educations. Quality of NH care requires: (1) expertise in pain and symptom management, (2) health-promoting interactions that affect individuals' well-being physically, emotionally, socially, functionally and spiritually, and (3) organizing safeguarding venues where NH residents can share their thoughts, experiences and wisdom and learn from each other by listening and sharing. NHs should offer living spaces where the "essence of the person" can have a place in the NH daily life. Having a focus on the patients' relationships with themselves, peers,

friends, family, and a higher being is therefore a key health concern. Nurse-patient interaction can be used to strengthen the patient's self-transcendence, hope and meaning, and thus strengthen old people's health and QoL. This indicates that a nurse-patient relationship born of respect, empathy and warmth, where the patient's experiences are acknowledged, listened to, taken seriously and included in the relevant decisions has a positive impact, not only on emotional, social, functional, and spiritual well-being, but on physical well-being as well.

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