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Improving the quality of life for older adults in guardianship

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Abstract:

Aging is a natural and virtually inevitable process, and as a chronological marker is of central importance in society. Now, the world is facing a situation without precedent; it is on the brink of a demographic milestone "Older people are a rapidly growing proportion of the world's population". People are living longer, but that does not necessarily mean that they are living a good quality of life. As the population ages, guardianship is the most profound course of action when determining that an older adult lacks decisional capacity. So, this study is aimed at improving the quality of life for older adults in guardianship through a clinical spiritual program. Effectiveness of the professional intervention program in improving quality of life indicators; the general percentage of change was 34.83%, and 38.18%, 36.36%, 31.27% in "general health", "psychological health" and "Social life" indicators respectively. comprehensive and deep clinical assessment of guardianship cases; written clinical evidence guidelines about guardianship; program about guardianship cases management; future studies about how a person adjusts to old age is largely a product of quality of life; developing scales to measure the rights of older adults in guardianship; integrating the professional practice of clinical social work with older adults in guardianship into legal contexts, and adopting a new perspective in clinical social work based on 'critical gerontology', a value committed approach that seeks not only to understand social ageing but also to change it for the better.

Keywords: Quality of life- Older adults- Guardianship

Introduction:

The world is facing a situation without precedent; it is on the brink of a demographic milestone. The number of people aged 65 or older will outnumber children under age 5, and is projected to have grown by nearly 1.5 billion by 2050, with the largest increase being in developing countries (Global Health and Aging, WHO 2011). The world's older population continues to grow at an unprecedented rate: "Older people are a rapidly growing proportion of the world's population". People are living longer, but that does not necessarily mean that they are living more healthily. The increase in our aging population presents many challenges that we need to prepare for (National Institutes of Health –NIH, 2016).

Jones (2009) states that "As the population ages, there seems to be a strong trend towards seeking surrogate decision-makers for individuals who appear unable to manage their lives and make clear choices, older adults make up the majority of persons adjudicated incapacitated and, in turn, are assigned guardians". Guardianship is the most profound course of action when determining whether an older adult lacks decisional capacity (Gavisk & Greene 2007, Drogin 2007, Jones 2009, Parry 2010, Drogin & Barrett 2015). Ellor, Harris, Myers, Russell 2009 suggest that "guardianship is at once a legal and social[1] issue (p.596-609)."

Guardianship is defined as "the most inclusive method of substitute decision-making for persons who have been adjudicated incompetent" (Drogin 2007, pp. 553-564). Guardianship can be summarized as a "legal relationship which authorizes one individual to become a substitute decision-maker for another" (Bloom 2009, pp.961-962). Guardianship is a relationship created by state law in which a court gives one person or entity (the guardian) the duty and power to make personal and/or property decisions for another (the ward). Guardianships were designed to protect the interest of incapacitated adults and elders in particular (Uekert & Dibble 2008). Elderly Guardianship in this study is defined as: 'a court-imposed process by which an older person is relieved of the right to make personal life decisions and another is appointed to make those decisions on that person's behalf, the other person/ guardian is a family member'.

There is limited research on clinical social work with older adult guardianship; Ellor et al (2009, pp. 596-609) state that "legislative change, ethical dilemmas, and client management issues were all faced by social work. Jones explored 2009 if social workers can serve in the role of guardian ad litem, appointed by the court to represent the interests of older adults in guardianship, in an effort to complete comprehensive clinical assessments for older adult guardianship petitions to provide a clearer picture of the individual in guardianship, his or her needs, supports. Social work information, facts and topics (SWIFT) 2010 states that" The social worker in a

[1] In the Eastern and Arab communities including Egypt, whether Muslims or Christians, the elderly enjoy high social status to the extent that children are considered ungrateful or abusive if he/she places one or both parents under guardianship for whatever reason, notwithstanding the relative acceptance of guardianship in urban communities compared to rural/nomadic communities. Thus, based on the prevailing culture in Egypt, guardianship tends to be viewed as abuse rather than a protective measure.

multi-disciplinary setting is often the professional who will be asked to make an application for a guardianship for an older person or to assist a family through this process. Social workers stand professionally in a unique relationship with their clients. It is an ethical responsibility for social workers to advocate for their clients' rights, and to understand and honestly represent their clients' history, needs, wishes, and values". Therefore, this study may be considered opportune because of the increased longevity of the population with greater numbers of older adults entering the guardianship system, and the need for older adult guardianship for protective services, as well as the importance of comprehensive clinical assessments for capturing the dimensions of quality of life relevant to this population.

Conceptualizing **quality of life** among older adults in guardianship is very important**,** Svare, Anngela-Cole (2010) explored definitions of quality of life, and focus groups were conducted with specialist law attorneys and guardians (N = 21). Analysis yielded seven themes. Participants identified choice as central to quality of life. Choice allowed incapacitated older adults to engage in relationships and activities that are important to them and thereby increase hope, purpose, and meaning in life. Theofilou (2013, p151) states that "the concept of quality of life broadly encompasses how an individual measures the standard of multiple aspects of his/her life. A distinction is made between social indicators and psychological indicators of quality of life. Thus, for each dimension, one should be able to evaluate the condition or experience itself (social indicator) as well as the individual's feelings about the condition (psychological indicator) (Sharon 1992, p56). There is no consensus on a definition of quality of life in older age. Quality of life assessment in frailer, older people should include physical functioning and symptoms, emotional, behavioral, cognitive and intellectual functioning, social functioning and the existence of social support, life satisfaction, health perceptions, economic status, ability to pursue interests and recreation, sexual functioning, energy, vitality and income (Brown, Bowling, Flynn, 2004, p.8). In this study, quality of life of older adults in guardianship refers to "The sense of life satisfaction as it is, in guardianship state, measured by indicators of general health quality, psychological health quality, and social/ family life quality**".** To improve quality of life, it is necessary to narrow the gap between hopes and aspirations, and actual occurrences, and to protect the

physical, emotional, cognitive, behavioral, spiritual, and social well-being of elderly people in guardianship. Quality of life can vary considerably over time and/or changes in circumstances.

Spirituality is closely related to the quality of life for all older adults, but particularly those in guardianship. Various research investigates spirituality in older adults, yet it is important to understand the spiritual needs and resources of institutionalized elderly clients in an effort to provide holistic care. Richards (2005, pp. 173-183) states that "the spiritual aspect of care for elders in long-term care has only recently been re-affirmed." According to (Nelson-Becker 2005) spirituality is an important coping resource for many older adults. The contribution social work has made to the study of spirituality and religion in relation to aging, based on respect for their diverse expressions, is unique (Nelson-Becker & Canda 2008). Spirituality was defined as a relationship between a person and a higher power, the cosmos and/or another person. This relationship consisted of characteristics which centered on the concepts of relationship, courage, hope/trust, meaning and purpose, and honesty (Langston, 1997). The spirituality concept reviewed in this study agrees with the previous theoretical review of the concept: (Spirituality is an aspect of the person, along with biological and social aspects), or (Spirituality is a relationship between a person and a higher power). Spirituality is the main component in a clinical spiritual program aimed at improving quality of life for older adults in guardianship.

As Munson (2007) states in his Handbook of Clinical Social Work Supervision, **"**The National Association of Social Workers uses a definition: "Clinical social work shares with all other social work practice the goal of enhancement and maintenance of psychosocial functioning of individuals, families, and small groups." Based on the following considerations:

1. Scarcity of research on clinical social work with older adults in guardianship in general and the absence of any such research in Egyptian society,

2. Increasing numbers of older adults, [2]
3. Distinctiveness of this category (older adults in guardianship),
4. The assumption that being an older adult in guardianship should not necessarily interfere with his/her statuesque quality of life, similar to dying people and other critical categories where the practice must surpass the service request to service imposition. This means that clinical practice is required in all phases of the guardianship process. This could be achieved through creating professional programs and family court procedures that enable social work clinical practice before issues occur and other social institutions deal with issues when referred. In other words, this category would not be ignored by the profession.
5. Significance of spirituality in the life of older adults and its direct relationship with their quality of life especially those in guardianship,

This study aims at improving quality of life for older adults in guardianship by testing the following main hypothesis "professional intervention through a clinical spiritual program would improve the quality of life for older adults in guardianship", and testing the following sub-hypotheses:

1. Professional intervention through a clinical spiritual program would improve the general health quality for older adults in guardianship
2. Professional intervention through a clinical spiritual program would improve the psychological health quality for older adults in guardianship

[2] For the year 2000, the United Nations estimated that the world had 590 million people aged 60 years or older. By 2025, the number of persons 60 years or older is expected to reach one billion (Reichert, 2003, p.191). There are 25,000 centenarians in the United States today, and the Census Bureau estimates that by the year 2050 there will be one million people over the age of 100 (Farley, Smith& Boyle, 2006, p.278). Whereas, 22% of over-65s in EU countries are over 80 now, 35% will be over 80 in 2050 (Hill, 2006, p.255). The world population continues to grow older. When the global population reached 7 billion in 2012, 562 million (or 8.0 percent) were aged 65 and over. In 2015, 3 years later, the older population rose by 55 million and the proportion of the older population reached 8.5 percent of the total population. Thereafter, from 2025 to 2050, the older population is projected to almost double to 1.6 billion globally, whereas the total population will grow by just 34 percent over the same period (International Population Reports, NIH 2016). In Egypt, people over 60 years are estimated to be 4,884,000 out of a population of 80,410,000, equivalent to 6% of the total population according to 2010 census (CAPMAS 2012).

3. Professional intervention through a clinical spiritual program would improve the social life quality for older adults in guardianship.

Methodology: This quasi-experimental study measures the impact of an independent variable "clinical spiritual program" on a dependent variable "quality of life of older adults in guardianship". It has relied on the Solomon Four Group Design[3]: "two experimental groups and two control groups". And uses a short measure of quality of life in older age from the performance of the brief Older People's Quality of Life questionnaire (OPQOL-brief), due to the special nature of older adults in guardianship, in terms of health, psychological, cognitive, behavioral, social, and spiritual conditions which impact their quality of life indicators on the one hand, and their ability to respond to the scale on the other. Bowling et al (2013) stated that "the scale was a short version of the established Older People's Quality of Life questionnaire (OPQOL-brief). The full (OPQOL-35) was original in being developed from the perspectives of older people, assessed conceptually, and validated with a population sample using gold-standard psychometric assessment. The OPQOL-brief was also developed by asking older people to prioritize the most important items from the OPQOL-35, next assessed psychometrically with a population sample, and also statistically against the discarded 22 items." The OPQOL-brief is of value in assessment of interventions where a rigorously tested, short measure is required. The OPQOL-brief contains (13) positive statement: 'All items show positivity bias, which is usual in the assessment of QOL, as well as life satisfaction'. The theoretical range for the summed OPQOL-brief is 13–65 (13 items by their 5-point response scales, coded from 1 to 5); strongly Disagree=1, Disagree=2, neither agree nor Disagree=3, Agree=4, strongly agree=5. The minimum score was 13, average score was 39,

[3] Two experimental groups were exposed to professional intervention at similar experimental conditions. There were two control groups with a pre-test administered on one, and post test on both for the purpose of internal validity. Pre-test often alerts subjects to the experiment and the nature of response "direction and magnitude". The significant statistical positive effect of the professional intervention on the experimental group that was not exposed to the professional intervention showed in the post measurement comparison between the four groups, and is thus considered a true indicator of internal validity from one side and the possibility to generalize results on any group of older adults in guardianship on the other hand. Meaning, the that the professional intervention effectively improves the quality of life of older adults in guardianship regardless of their score in quality of life scale prior to intervention.

full score was 65[4], and according to the positive direction of statements; higher scores indicate a better QOL of older adults in guardianship. OPQOL-brief validity in this study was tested through applying concurrent validity using two groups of older adults who meet the sample's criteria and are in 'guardianship statuses. Each group consisted of 30 older adults, one group was living a regular life and the second was under guardianship. The differences between the two groups were calculated and the result suggests that there are statistically significant differences between the two groups; Tcal. 21.961*[5], hence, supporting validity. OPQOL-brief reliability was tested through Test retest reliability. OPQOL-brief was applied for a second time on the same group of respondents within 'guardianship status' after 21 days and the Pearson correlation coefficient between the two results was calculated; and showed 0.959 **, thus reflecting reliability.

Access to subjects was through the Surrogate Council in Family Court. This council is the entity involved in guardianship/ incompetency issues and assignment of guardians. The subjects who took part in the study were (44) older adults, (32 male, 12 female) who don't have significant differences (P<0.05) between them on OPQOL-brief (T=zero N.S), randomly divided into four groups. Each group consisted of (11)[6], according the following table;

Type	Control groups		Experimental groups	
N.	Con. 1	Con. 2	Exp.1	Exp.2
Subjects	11	11	11	11

Older adults who met the following criteria: 1. Legally/entirely in guardianship under relatives. 2. Age between 65-74 years. 3. Physically and mentally capable of responding to the scale and participating in the program based on a treating physician's opinion. 4. Guardians' approved of their participation in the program. 5. Subjects of guardianship's consent to join the professional intervention program was secured. In order to get their consent, the purpose, duration, and the nature of the program was explained to them in a

[4] Calculated as: Number of item × minimum score of point response scales (13×1=13), Number of item × medium score of point response scales (13×3=39), and Number of item × maximum score of point response scales (13×5=65).

[5] *Significant (.05), ** Significant (.01).

[6] The number of subjects in each group is the maximum number of a treatment group in group case work. This is attributed to the need for promoting interaction in the first phase of intervention due to old age of the subjects and their decreased discourse.

number of meetings. Knowing that the program includes other individuals in similar conditions and that their completion of the program is based only on their own decision, helped the author in convincing the subjects to join the program. Two issues must be explained: the first is the majority of the subjects are males, demonstrating the prevailing 'Masculinity culture' of wealth concentration with males rather than females, and inheritance issues. In addition, the majority of guardians were also males, consisting mainly of sons or siblings, except when there are no sons or male siblings, unlike other communities were multiple guardians (private-family/paid guardian, public or state agency) may be common. The second issue is sample size in each group. This is closely related to the number of older adults in guardianship, society's prevailing attitude towards guardianship, guardians' consent, and the size of the treatment group in group case work.

The study was carried out at an older adults' club subordinated to the National Foundation for Family and Community Development in Alexandria, Egypt. The selection of this club was based on the approval of the guardians of older adults attending the club as a social and recreational place, as well as the approval and cooperation of club management. The experiment continued for three months (8, 9, 10/2016) two sessions/week, a maximum of one session/week for older adults in guardianship. The average time of each session was two hours. The total number of sessions was 32 sessions (12 sessions with the first experimental group, 12 sessions with the second experimental group, 4 sessions with guardians and 4 sessions with the staff).

The professional intervention program, designed by the author, focused on providing a holistic, culturally competent model, recognizing the important interaction of health, social and cultural factors (bio psychosocial approach), based on the following considerations: 1. The appreciation that an elderly person in guardianship is not merely a person waiting to die, instead, he/she is able to experience joy, meaningful relationships, a sense of worth, safety, justice, dignity and comfort, and other pleasures that together constitute quality of life, 2. Activation of the resources and potential of older adults in guardianship, 3. Promotion of competence, 4. Reinforcement of a sense of identity and purpose in later life, 5. Promotion of mental health and autonomous functioning, 6. Strengthening of family relationships 'family members are the most

important supporters to the elderly', 7. Recognition of discrimination, ageism, and abuse against the elderly, who are considered the same despite different life histories, needs and expectations which limit experiences, expectations, relationships, and opportunities, 8. Adherence to the global primary objective of care programs for older people to maintain the individual in their chosen environment, most usually their own home, 9. Understanding that older people of the same age, from similar economic and social circumstances, will experience ageing in different ways, 10. Understanding social aging as explained by Morgan et al (1998) "That is a multidimensional and dynamic force, that includes the transitions into and out of roles, expectations about behavior, social allocation of resources and opportunities, negotiations the meaning and implications of chronological age and the experience of individuals traveling the life course and negotiating life stages", 11. Adoption of a new perspective based on 'critical gerontology', a value committed approach that seeks not only to understand social ageing but also to change it for the better, 12. The experience of ageing is the product not only of inevitable biological and psychological processes, nor even of the individual's particular life history and present circumstances, but also of the attitudes, expectations, prejudices and ideals of the societies and cultures in which people develop and grow, 13. Recognizing that the way a person adjusts to old age is largely a product (or extension) of quality of life, 14. Quality of life consists of multiple levels.

The program included spiritual/ religious/ numinous activities (prayer, narration of spiritual experiences in their lives, meditation), family participation of elderly peoples' activities and exchange of family news, and clinical participation of older adults in guardianship in self-help, life review, support, short-term psych educational groups while trying to make the group activities meaningful for older adults in guardianship by addressing some themes that came up prominently in group discussion including: continuity with the past, understanding the modern world, independence, physical and cognitive impairments, loss of family and friends, spouses environmental vulnerability adjustment, religious conviction and ethnic and leisure pursuits. The program has been implemented with the help of organization staff and guardians.

Intervention		
First stage	Second stage	Third stage
Started by working with guardians and staff of the older adults' club. This included discussion of the rationale of the professional intervention program and required roles of them. At this stage, the focus was on guardians' ideas, attitudes and behaviors which constitute their relationship with older adults in guardianship, and on teaching guardians how to perform a cognitive processing of their thoughts as a method to understand their behavior, as well as how to reach the cognitive content through thinking out loud and recording the activating event, belief and behavioral consequences. The guardians participated in sharing their experiences with each other during the sessions. This stage also included increasing motivation of the two experimental group members to participate in the program through life review sessions where they were able to tell their life experiences in their own	Focused on: 1. Participating in group social/ family activities where family members meet with subjects on a weekly basis, exchange family news and allow the subject to tell some of his/her past positive life experiences and to express vision about the world without the usual past complaints which some younger family members used to show toward the subject as a result of his/her repetitions of stories and slow narration. 2. Subjects share recreational activities with their families' 'short trips and visits'. 3. Family assistance enabling the subject to communicate with his/her remaining old friends. 4. Family helping the subject to review his/her photo album and personal belongings.	Included subjects' participation in group spiritual and religious activities such as prayer, religious preaching lessons and Quran reading and explanation. The life review sessions at this stage focused on past spiritual experiences and their impact on past and present life. The author trained subjects at psycho-educational sessions on meditation as a mindful and central practice to relieve the psychological stresses and disorders accompanying their age stage "fear of death"

way without interruption or suggestions. The author only showed sympathy and understanding, and made clarifications and explanations whenever needed in order to utilize life experience recovery and to relate it to the meaning of life they adopt. These sessions contributed to the clarification of many skills, competences, beliefs, values, obligations, meanings and relations in the subjects' lives.		
Qualitative indicators of professional intervention program according to its stages		
older adults can recognize and manipulate the forces of change in their lives, enhance their sense of identity, purpose of life and aging, and realize that the change in roles and transition into new roles does not undermine the value of the stage of life they are living(previous experiences-sensitive feelings towards grandchildren- skills-religious rituals-spirituality-meditation)	1.smiling, which is assumed to indicate raised levels of happiness 2.low rates of complaint 3.improved response speed to small matters which were strongly rejected in the past such as taking new drugs, eating healthy food or periodic visits to the doctor 4.asking about persons or matters which the subject had lost interest in 5.dialogue 6.participate family	1. the following convictions appeared; life has a purpose, sickness has a purpose, aging has a purpose, pain has a purpose 2. this convictions associated with the meaning of existence of man in life and his/her relationship with The Creator, and

	social occasions 7.A number of guardians expressed for: i. Qualifying for the late stages of human life provides protection against its risks (preventive social work). i. It is necessary for family members who have older adult relations to be prepared for such a stressful stage.	self and social environment 3. guardians realized; using the program as a training tool on the lifestyle of older people in general and older adults in guardianship in particular, in addition to program development as older adults undergo change in different aspects

Ethics Approval; the guardians gave their written consent after being informed about the research objective, research stages, research tools, professional intervention program period, basics for their choice, and limits of the activities required for the research. They were assured that elderly guardianship participation shall be safe, in their presence, and that they could opt-out during the first stage of the research.

Statistical processors; Data were statistically analyzed using T pairs and T groups to compare the differences between pre and post for the same group, and post and post for the two different groups. Also, analysis of the variance was carried out to detect the differences between six groups followed by the least significant difference test at 0.05 probability level (L.S. D 0.05) to compare the difference between the six groups' means.

Results and discussion[7]**:** The results included the following:

Target	Groups		variables
Measuring differences (T-test)	Con.	Exp.	General health quality
	Con.	Exp.	Psychological health quality
	Con.	Exp.	Social life quality
	Con.	Exp.	Quality of life
Measuring improvement rate		Exp.1	General health quality
		Exp.1	Psychological health quality
		Exp.1	Social life quality
		Exp.1	Quality of life
Variance analysis(ANOVA)		Exp.1	Measurements of experimental and control groups according least significant difference
Measuring improvement arrange		Exp.1	Quality of life indicators and cases

1- **Sample description:** The results shown in table No.1 suggest the following characteristics of older adults in guardianship: male ratio 63.64%, female ratio 36.36%, 81.82% are between 70 to74 of age, 18.18% are between 65 to 69 of age, 54.55% of subjects were educated and 45.45% were illiterate. 72.73% were widows, 18.18% were singles, 9.09% were divorced. 45.45% were in guardianship for one year, 36.36% for two years, and 18.18% for three years. In 54.55% the guardians were sons, 36.36% were male siblings, and 9.09% were daughters. The vast majority of guardians (90.91%) were educated, 9.09% were illiterates, 90.91% were married and 9.09% were divorced.

The descriptive results of subjects show that male older adults in guardianship outnumber female older adults by 27.28%. This is significantly due to the previously cited issues related to gender inasmuch as the prevailing culture Society Masculinity, fortune accumulation in male possession and inheritance issues. The age of 81.82% of subjects was between 70 to 74 years, which indicates the possibility that guardianship may increase with aging of older adults

[7] R.S: Relative strength.

and their need for an authorized legal guardian to make decisions on their behalf. This is supposedly related to older adults' need for care and protection due to their social, cognitive, psychological, and health conditions. Two problematic issues are posed here. 1. The Eastern culture arising from the heavenly messages of Islam, Christianity and Judaism calls for older adults' care at home without the need for mandate. Guardians in Egyptian society were mainly relatives while multiple guardians were only rare. 2. Government aged care homes of nominal costs were full of poor older adults – ill older adults who are abandoned by their families. This raises a significant question: Does guardianship apparently involve 'protection and care'; while in reality "money is its essence'? Financial or material exploitation is defined as the illegal or improper use of an elder's funds, property, or assets. A number of elders become victims of financial exploitation simply because they lack capacity and are unable to participate in their own decision making. It is the misuse of one's role and power to exploit the trust, dependency, and fear of another to deceptively gain control over that person's decision making can also manifest in the suspect's manipulation of the elder based on relationship between the two (Bradl,B.& et al,2007,p.30). The answer to this question probably requires further investigation into guardianship and the risks older adults may be exposed to which might include physical, psychological, sexual abuse and neglect in addition to racism, exclusion and discrimination. Repeatedly confirmed risk factors associated with community base domestic elder care settings include living arrangement, cognitive or physical impairment, mental illness and substance abuse characteristics among perpetrators, and caregiver social or emotional or financial dependency on the elderly person. These represent clusters of risk that pertain to the elder's condition, specific characteristics of the harming caregiver, and the historical and current relationship between them (Jonson- Reid, 2008, p.113).

The close ratio of educated compared to illiterate older adults may indicate that older adults' guardianship may not be related to education, contrary to the effect of social status where the absence of a spouse increases the probability of guardianship. All older adult subjects in guardianship had no spouses. The majority of guardians were married, educated sons and male siblings. The educational level of guardians significantly explains their positive cooperation with author (Note: Although such description is related to the first experimental group on which the most measures were performed,

except for the comparison between the two experimental groups and two control groups for control purposes, all older adults in guardianship, distributed between the four groups (N=44), shared the same characteristics).

2- Older adults in guardianship quality of life indicators (pre and post) intervention:

2-1 General health quality: The results shown in table No.2, which is related to the general health quality of older adults in guardianship, suggest that there are significant differences (Tcal.10.096**) in members of the first experimental group attributed to professional intervention. The rates of change were 50.91%, 34.55%, 29.09% in those enjoying overall life; being healthy enough to have independence, and healthy enough to get out and about respectively. The relative strength for this category also increased in the general health indicator (R.s= 64.85 %). The variability coefficient decreased to (C.V=12.99%) post professional intervention which indicates the effectiveness of professional intervention in improving general health quality of older adults in guardianship. During the professional intervention program, the subjects attended older adults club, went out for family visits and short trips with their families after long periods of remoteness and lack of practicing of activities except doctor visits. Subjects also enjoyed a sense of relative independence in performing some of their daily personal needs at home like room tidying, bathing, drinks preparation and sitting in balconies. The modality indicators of such matters appeared in verbal expressions like: "Thank God - I am in better conditions than other people – Every age has its own limitations, at least I can go out".

2-2 psychological health quality: The results shown in table No.3, which is related to the psychological health quality of older adults in guardianship, suggest that there are significant differences (Tcal.8.434**) in members of the first experimental group attributed to professional intervention. The rates of change were 41.28%, 34.55%, 27.27% and 21.82% in older people looking forward to things, feeling lucky compared to most people, trying to stay involved with things, and feeling safe respectively. The rates of change were higher in looking forward to things, feeling lucky compared to most people, and feeling safe. The relative strength for this category also increased in the psychological health indicator for older people to (R.s= 69.45 %). Variation coefficient decreased to (C.V=12.99%) post professional intervention which indicates the effectiveness of

professional intervention in improving the psychological health quality of older adults in guardianship. Anxieties of old age included having enough money for food, housing, and medical care; coping with increasing illnesses, physical deterioration, and sensory debilities; facing the deaths of spouse. To these worries add fears of mental decline and stagnation, losses in intellect and intelligence, and Alzheimer's disease. These foreboding preoccupations, lead to the elderly's "disengagement" from life, a self-protective distancing from feelings, other people, and activities that result in personal and social isolation (Lindauer, 2003, p.4). For these reasons, the profession intervention included subjects' retrieval of life experiences. Indictors of psychological health improvement included their conventions that life has a purpose, sickness has a purpose, aging has a purpose, pain has a purpose and all such matters are associated with the meaning of existence of man in life and his/her relationship with The Creator, self and social environment.

2-3 Social life quality: The results shown in table No.4, which is related to the social life quality of older adults in guardianship suggests that there are statistical significant differences (Tcal.8.558**) in members of the first experimental group attributed to professional intervention. The rates of change were 41.82%, 34.55%, 32.73% , 27.27% and 20.0% in having social or leisure activities/hobbies which they enjoy, taking life as it comes and doing the best things, having enough money to pay for household bills, receiving family, friends or neighbors help in case of need, and gaining pleasure from the home respectively. The rate of change appeared to be higher in practicing social and recreational activities and hobbies, doing the best things, financial self-sufficiency and gaining pleasure from the home. The relative strength for this category also increased in the social life quality indicator (R.s=74.55%). Variation coefficient decreased to (C.V=16.43%) post professional intervention which indicates the effectiveness of professional intervention in improving the social life quality of older adults in guardianship.

The professional intervention program had a clear impact on social life quality indicator of older adults in guardianship. At this stage, qualitative indictors surfaced that were monitored by guardians at their reports including Smile – low rates of complaint, subject relatively improved response speed to small matters which were strongly rejected in the past such as taking new drugs, eating healthy food or periodic visits to doctor, asking about persons or matters

which the subject had lost interest in. Hence, a relative shift in quality of life indicators of older adults in guardianship attributed to family members' roles was observed.

2-4 Quality Of Life: The results shown in table No.5, which is related to the life quality of older adults in guardianship, suggests there are significant differences (Tcal.13.814**) in members of the first experimental group attributed to professional intervention. The highest rate of change was 50.91% in enjoying life generally, followed by looking forward things, and having social or leisure activities /hobbies which they enjoy doing. The lowest rates of change were 21.82% for people feeling safe and 20.0% for people getting pleasure from the home. The relative strength for this category also increased in the life quality indicator of older adults to (R.s= 70.35%). Variation coefficient decreased to (C.V=14.25%) post professional intervention indicating the effectiveness of professional intervention in improving life quality for older adults in guardianship, which confirms the importance of clinical social work in dealing with older adults in guardianship and their families.

The most common form of social work intervention with the elderly population is generalist practice at the micro- level. This includes working with older adults and their families on specific problems, such as enhancing personal adjustment, securing resources to meet their needs, providing emotional support in decision making, dealing with death and dying, and managing family conflict. Intervention often employs counseling and guidance approach, stresses problem clarification and the development of options and priorities, and provides an opportunity for the client to express anxiety and emotion (Ambrosino, 2008, p.429).

3- Hypothesis: The results shown in table No.6 suggest that there are no significant differences ($P<0.05$) between the results of pre and post measurement of life quality between the first control group members (T= 0.670 N.S), nor between the first and second control groups (T= 0.692 N.S) after receiving a similar three month period of professional intervention. Differences between the pre-measurement of the first experimental group and post-measurement of the second control group did not reach a significant level (T=1.855 N.S), whilst differences between pre and post professional intervention measurements in the first experimental group were highly significant (T=34.091**). Post intervention differences between the two experimental groups did not reach a significant level (T= 0.121 N.S).

This indicates the positive effectiveness of professional intervention which resulted in improving the mean of life quality of subjects by (34.83%). The consistent results of the first and second experimental groups show the effectiveness of professional intervention in improving the life quality of older adults in guardianship and consequently support the validity of the main hypothesis of this research: "Professional intervention through a clinical spiritual program would improve the quality of life for older adults in guardianship".

4-Analysis of variances (ANOVA): The results shown in table No. 7 suggest that there are significant differences (f=235.694**) according to variance analysis between the six measurements of experimental and control groups. The results shown in table No. 8 show the sequence of variance in the six measurements, in accordance with the least significant difference, which were as follows: The post measurement of the first experimental group (45.64 a) and the post measurement of the second experimental group (45.673 a) occupy the first rank suggesting the highest improvement rate in the two post measurements of the two experimental groups. The pre measurement (22.91 b) and post measurement (23.18 b) of the first control group and post measurement (24.01 b) of the second control group and pre measurement (24.01 b) of the first experimental group occupy the second rank suggesting non-significance of differences between the four measures where the subjects were not exposed to professional intervention. This confirms the effectiveness of professional intervention in improving the quality of life for older adults in guardianship.

5- Change arrangement in quality of life indicators and cases: The results in table No. 9 show the categorization of differences in quality of life indicators of older adults in guardianship. The general health quality indicator (38.18%) came in the first category, psychological life quality indicator (36.36%) in the second and social life quality indicator 31.27% in the third category. The general rate of change in life quality of older adults in guardianship was 34.83%. The results in table No. 10 show the degree of subjects' improvement. Subject number 7 showed the highest improvement by (42.22%), followed by subject number 9 by (40%) then subject number 11 by (36%). The overall rates of change in subjects ranged from 31.11 to 42.22%. It should be noted that two of the three highest improving subjects were female, although the number of female

subjects in the first experimental group was only four. This may be attributed to a number of factors which were monitored during professional intervention sessions, including guardians' commitment to sessions, their roles in the intervention program and their desire to know about aging. Other factors were related to the subjects, including stable health conditions, positivity, enthusiasm, motivation, and strong participation in experience discussions.

Conclusions: There is a positive effect of professional intervention in improving quality of life of older adults in guardianship with an average of (34.83%); general health quality 38.18%, psychological health quality 36.36%, social life quality 31.27 %. This was suggested by the highly significant differences (T=34.91**); general health quality (T=18.840**), psychological health quality (T=18.163**), social life quality (T=24.056**) between means of the first experimental group members before and after professional intervention, whereas the differences between means of the second experimental group after intervention were not significant. Significant differences (f=235.694**) between the six measurements of experimental and control groups indicate consistency of professional intervention results of the first and second experimental groups. Hence, the validity of three sub hypothesis, and the validity of the main hypothesis: "Professional intervention through a clinical spiritual program would improve the quality of life for older adults in guardianship" was supported.

Recommendations: The study recommends employment of clinical social workers at Family Courts in order to perform comprehensive and deep clinical assessment of guardianship cases, including psychological and social status, family relationships, abilities, and recourses, needs, and guardians' conditions. Family court clinical social workers would also develop subsequent care plans for older adults after guardianship adjudication in order to protect their rights and avoid abuse, discrimination and exclusion, through safe and tailored guardianship. In general, the professional practice in guardianship needs further research to enhance clinical workers efforts and support the draft of written clinical guidelines about guardianship. It is also required to include guardianship skills training, and knowledge in clinical social work courses. The study also recommends the consideration of spirituality for older people in general and older adults in guardianship, in particular at the levels of practice, research and education. Spirituality has a great impact on

positive practice with older adults in guardianship which was clearly evident during the professional intervention sessions. Special attention should be paid to consolidating spiritual approach techniques in a continuous, purposeful and transitional context that supports effective and culturally-sensitive spiritual practice. Finally, the research recommends conducting future studies to investigate the effectiveness of rehabilitation programs in improving the quality of life of older adults; assessing psychological and social needs of older adults in guardianship; developing scales to measure the rights of older adults in guardianship; and integrating the professional practice of clinical social work with older adults in guardianship into legal contexts.

Limitations: The author faced various challenges; the most difficult one was accessibility to older adults in guardianship. Many care institutions had no older adults under guardianship. The work of these institutions is based on social guardianship (guarantor framework). Information about whether or not their elderly residents are under legal guardianship was not available because it is enclosed with strict confidentiality in Egyptian society due to "ingratitude to parents" that will stigmatize the guardians who adopt such procedures. Access to subjects was possible through the Surrogate Council in Family Court. This council is the entity involved in guardianship/ incompetency issues and assignment of guardians. The electronic database was not available at the Surrogate Council, data is saved in paper files which require significant effort and time to search, and many guardians refused to cooperate. This impacted the size of the sample as previously detailed.

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Tables:

Table1: Sample description

Variable	Variables level	Frequency	%
Gender	Male	7	63.64
	Female	4	36.36
	ε	11	100
Age	65-69	2	18.18
	70-74	9	81.82
	ε	11	100
	Illiterate	5	45.45
	ε	11	100
Social status	Single	2	18.18
	Married	-	-
	Widower	8	72.73
	Divorced	1	9.09
	ε	11	100
Guardianship period	Year	5	45.45
	2 years	4	36.37
	3 years	2	18.18
	ε	11	100
	Son	6	54.55
Guardian	Daughter	1	9.09
	Brother	4	36.36
	ε	11	100
Educational Status for guardians	Illiterate	1	9.09
	Illiterate	10	90.91
	ε	11	100
Social status for guardians	Single	-	-
	Married	10	90.91
	Widower	-	-
	Divorced	1	9.09
	ε	11	100

Table2: General health quality among older adults in guardianship according intervention

Statements	Pre-test			Post-test			D	D %
	εx	$\bar{x}_w$	Rank	εx	$\bar{x}_w$	Rank		
1. I enjoy my life overall.	13	1.18	3	41	3.73	1	28	50.91
4.I am healthy enough to get out and about	17	1.55	1	33	3.0	2	16	29.09
7. .I am healthy enough to have my independence	14	1.27	2	33	3.0	2	19	34.55
ε	44			107				
$\bar{X}_w$ For Category	1.33			3.24				
S.D for Category	0.19			0.42				Tcal.10.096**
Relative Strength	26.67%			64.85%				
C.V	14.47%			12.99%				

Table3: Psychological health quality among older adults in guardianship according intervention

Statements	Pre-test			Post-test			D	D%
	εx	$\bar{x}_w$	Rank	εx	$\bar{x}_w$	Rank		
2. I look forward to things	13	1.18	5	36	3.27	3	23	41.82
6. I try to stay involved in things	21	1.91	2	36	3.27	3	1	27.27
8. I can please myself with what I do	19	1.73	3	42	3.82	2	23	41.82
9. I feel safe where I live	32	2.91	1	44	4.0	1	12	21.82
12. I feel lucky compared to most people.	14	1.27	4	33	3.0	4	19	34.55
ε	99			191				
$\bar{X}_w$ For Category	1.80			3.47				
S.D for Category	0.69			0.42				Tcal.8.434**
Relative Strength	36.0%			69.45%				
C.V	38.43%			12.09%				

Table4: Social life quality among older adults in guardianship according intervention

Statements	Pre-test			Post-test			D	D %
	∑x	$\bar{x}_w$	Rank	∑x	$\bar{x}_w$	Rank		
4. My family, friends or neighbors would help me if needed	34	3.09	1	49	4.45	1	15	27.27
5. I have social or leisure activities /hobbies that I enjoy doing	21	1.91	3	44	4.0	2	23	41.82
10. I get pleasure from my home	33	3.0	2	44	4.0	2	11	20.0
11. I take life as it comes and make the best of things	16	1.45	4	35	3.18	3	19	34.55
13. I have enough money to pay for my household bills.	15	1.36	5	33	3.0	4	18	32.73
∑	119			205				
$\bar{x}_w$ For Category	2.16			3.73				
S.D for Category	0.83			0.61				Tcal. 8.558 **
Relative Strength	43.27 %			74.55%				
C.V	38.54 %			16.43%				

Table5: Quality of life among older adults in guardianship according intervention

Statements	Pre-test			Post-test			D	D %
	∑x	$\bar{x}_w$	Rank	∑x	$\bar{x}_w$	Rank		
1. I enjoy my life overall.	13	1.18	10	41	3.73	4	28	50.91
2.I look forward to things	13	1.18	10	36	3.27	5	23	41.82
3.I am healthy enough to get out and about	17	1.55	6	33	3.0	7	16	29.09
4..My family, friend or neighbors would help me if needed	34	3.09	1	49	4.45	1	15	27.27
5.I have social or leisure activities /hobbies that I enjoy doing	21	1.91	4	44	4.0	2	23	41.82
6.I try to stay involved in things	21	1.91	4	36	3.27	5	15	27.27
7.I am healthy enough to have my independence	14	1.27	9	33	3.0	7	19	34.55
8.I can please myself with what I do	19	1.73	5	42	3.82	3	23	41.82
9.I feel safe where I live	32	2.91	3	44	4.0	2	12	21.82
10.I get pleasure from my home	33	3.0	2	44	4.0	2	11	20.0
11.I take life as it comes	16	1.4	7	35	3.18	6	19	34.5

and make the best of things		5						5
12. I feel lucky compared to most people.	14	1.27	9	33	3.0	7	19	34.55
13. I have enough money to pay for my household bills.	15	1.36	8	33	3.0	7	18	32.73
ε	262			503				
$\bar{X}_w$ For Category	1.83			3.52				
S.D for Category	0.711			0.50				T cal. 13.814 **
Relative Strength	36.64 %			70.35%				
C.V	38.80 %			14.25%				

Table 6: differences between groups in quality of life

No	Control Groups			Experimental Groups			Change %
	Group1		Group2	Group1		Group2	
	Pre	Post	Post	Pre	Post	Post	
1	27	24	26	25	45	45	30.77
2	13	13	24	23	45	44	33.85
3	23	23	23	21	44	48	35.38
4	24	24	24	22	44	44	33.85
5	25	26	24	24	45	48	32.31
6	26	27	26	24	44	45	30.77
7	24	24	22	22	49	47	41.54
8	24	26	23	22	44	45	33.85
9	21	21	25	22	48	44	40.0
10	22	24	23	24	47	45	35.38
11	23	23	24	24	47	48	35.38
$\bar{x}$ w	22.91	23.18	24.01	23.0	45.64	45.73	34.83
T cal.	0.670 N.S			34.091**			
		0.692 N.S			0.121 N.S		
			1.855N.S				

Table 7: Analysis of variances for quality of life indicators of subjects

S.O.V	D.F	S.S	M S.	F cal.	F tab.
Between groups	5	7356.486	1471.297	235.694**	3.51
Between categories	60	374.5446.242			
Total	65	7731.030			

Table 8: Comparison between groups means

Groups	Control Groups			Experimental Groups		
	Group1		Group2	Group1		Group2
	Pre	Post	Post	Pre	Post	Post
Mean	22.91 b	23.18 b	24.01b	24.01 b	45.64 a	45.73 a

(L.S. $D_{0.05}$) =2.13, Means followed by the same letter (s) are not significantly different according to L.S. $D_{0.05}$ value.

Table 9: change arrangement in quality of life Indicators

Indicators	%	Rank
General health Quality	38.18	1
Psychological health Quality	36.36	2
Social life quality	31.27	3
Quality of life	34.83	-

Table 10: percentage of change in quality of life of older adults in guardianship

No	general health Quality	psychological health Quality	Social life quality	Average of percentage change	Rank
1	40.0	28.0	28.0	32.0	9
2	46.67	36.0	24.0	35.56	4
3	33.33	40.0	32.0	35.11	5
4	46.67	32.0	28.0	35.56	4
5	33.33	36.0	28.0	32.44	8
6	33.33	28.0	32.0	31.11	10
7	46.67	44.0	36.0	42.22	1
8	33.33	32.0	36.0	33.78	7
9	40.0	44.0	36.0	40.0	2
10	26.67	48.0	28.0	34.22	6
11	40.0	32.0	36.0	36.0	3