RELATIONSHIP BETWEEN SPIRITUALITY AND QUALITY OF LIFE AMONG HEALTHCARE WORKERS: MODERATING ROLE OF EMOTIONAL INTELLIGENCE

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ABSTRACT

This study examined relationship between spirituality and quality of life among healthcare workers and investigated the moderating role of emotional intelligence. A total of 141 healthcare professionals (74 males, 67 females), aged 18–53 years, participated in the study. The sample consisted of 84 single, 55 married, and 2 divorced individuals. Participants completed the WHOQOL-BREF, the Schutte Self-Report Emotional Intelligence Test (SSEIT), and the Spiritual Index of Well-Being (SIWB). A correlational research design was adopted, and six hypotheses were tested using moderated multiple regression analysis. Results indicated that emotional intelligence did not significantly predict quality of life among healthcare workers. However, emotional intelligence significantly moderated the relationship between spirituality and quality of life. Of the emotional intelligence dimensions, utilizing emotion and managing others' emotions significantly moderated the spirituality–quality of life relationship, whereas emotional perception and managing self-relevant emotions did not. These findings highlight the value of integrating spirituality and components of emotional intelligence within healthcare settings. Programs that foster spiritual reflection, meaning-making, and emotional regulation may help reduce stress and burnout among healthcare providers. Furthermore, incorporating emotional intelligence and spirituality training into healthcare education curricula may enhance the development of self-awareness, empathy, and compassion among emerging profession. The study is limited by the sample size, its reliance on self-report measures, which may introduce social desirability bias, and by the use of a non-random, region-specific sample, which may restrict the generalizability of the findings to other healthcare populations.

Keywords: Emotion, Emotional intelligence, Healthcare, Quality of Life, Spirituality

INTRODUCTION

Healthcare workers face both physical and mental stress in discharge of their duties, and when they are unable to handle such stress, it affects their lives generally, and the quality of care they provide. Among healthcare workers, work-related stress is a known factor that leads to low quality of life (Chang et al., 2007). The World Health Organization describes Quality of life (QoL) as a subjective evaluation of one's perception of reality relative to one's goals as observed through the lens of one's culture and value system (Teoli & Bhardwaj, 2023). QoL is not just the absence of life threatening-illnesses, worries, and daily stresses, but the positive description that life is currently good. This implies that QoL is neither the achievements of good health in the past nor the hope of better life to come, rather the general life-interpretation of here and now. Low QoL and working conditions among healthcare providers have been found to predispose them to certain psychosocial conditions such as emotional exhaustion, depersonalization, low sense of personal accomplishment, tendency to leave a job, and high rate of job burnout (Shanafelt et al., 2009; Ziaei et al., 2015; Faraji et al., 2017). Similarly, studies have shown that burnout decreases professionalism and quality of patients' care, and leads to untimely retirement (Dyrbye et al., 2010); while emotional labor, litigation, role conflict, verbal and physical abuse by patients, bullying by colleagues, and caregivers' concern about medical errors are psychological factors associated with working in healthcare setting (Ruotsalainen et al., 2008). Conversely, these factors are likely to affect healthcare workers' sleep pattern, self-care, relationships with others, job satisfaction, and QoL. Across the globe, studies show inconsistency in healthcare providers' level of QoL as different levels were reported, ranging from low level to moderate to high (Alhani et al., 2013; Dargahi et al., 2017). These discrepancies may be linked to different factors such as age, years of experience, and some personal attributes of healthcare workers. However, there have been an established link between improved QoL and some culturally accepted phenomenon.

Spirituality is one aspect of living that adds to life and fulfillment of purpose. It is very complex as it involves subjective belief systems. Spirituality captures a broader concept that may or may not include formal religious practices but rather involves a personal relationship with the sacred and the quest for purpose and understanding in life (Daniels, Glover, & Kyei, 2025). A growing body of literature submits that high levels of spirituality predict positive psychological outcomes such as high resilience to stress, adaptive coping response, high perceived social support, optimistic life orientation, peace of mind, and low anxiety levels (Are´valoa, 2008; Dewi & Hamzah, 2019). It has a positive significant relationship with QoL, better psychological competence, and coping better with an illness (LindanorJacó & Gil, 2014; Biccheri et al., 2016; Agli et al., 2018). Among healthcare workers, presence of spirituality improves physician-patient relationship, boosts mental health status, and lowers anxiety levels, compassion fatigue, burnout, and depression (Daniel, 2015; Kopel et al., 2019). However, while some substantial study outcomes indicate positive relationships between spirituality and QoL, others reported mixed outcomes in the relationship between spirituality and some psychological conditions such as anxiety and depression (Behere et al., 2013; Saini & Biswas, 2023).

Being emotionally competent among healthcare providers is likely to improve work performance and positively influence physician-patient relationship. Emotional intelligence (EI) is the ability to understand, utilize, and regulate our emotions and emotions of others while relating with them. It has continued to play vital roles in different spheres of life. Substantial evidences show that the presence of EI improves health-related quality of life (HRQoL), psychological well-being,

physical and mental well-being, helps in stress regulation, and increases with age, higher educational levels, and being married (Shahbazi et al., 2012; Lankashini et al., 2017; Mirzaei et al., 2019; Siddique & Mosanva, 2025). It creates great bond between physicians and patients only if the physicians show empathy and concern (Kadadi & Bharamanaikar, 2020). When present, EI plays pivotal roles among healthcare staff, as it fosters good relationship among nurses (Devi & Banerjee, 2024). Nevertheless, other studies have shown that there is no positive relationship between physician's EI and patient's satisfaction (Birks et al., 2009; Weng, 2011).

In exploring the correlation between EI and QoL, a positive relationship has been established between EI and psychological health of QoL in areas such as self-esteem, positive mood, low level of depression and anxiety, social functioning, and social role; while low level of EI triggers depression, poor social adjustment and functioning, poor mental health, poor impulse control, loneliness, stress, interpersonal relational difficulty, anxiety, suicidal thoughts, drug and alcohol consumption, aggressive behaviors, and low self-esteem (Hollander, 2002; Extemera & Berrocal, 2006; Gardner, 2006). Interestingly, studies show significant relationship among EI, spirituality, and religious views, in that high level of EI indicated increased belief in the existence of almighty God and his supreme controlling powers which help in stress management (Paek, 2006; Van Dyke & Elias, 2008; Karimi, 2014; Nesami et al., 2015). Also, among nurses, presence of deep belief in the existence of God was found to significantly correlate with caring behavior (Hameed et al., 2019). This implies that presence of EI plays vital roles in elevating individuals' spirituality which in turn helps in the management of some negative psychological outcomes like stress. On the other hand, insignificant correlation has been recorded in mediating role of EI on presence of spirituality, as well as the linear relationship between the two variables (Nesami et al., 2015; Hadi, 2017; Hameed et al., 2019). This inconsistency may result from diverse psychological instruments used in data collection in these studies, or the cultural backgrounds of participants.

Against this backdrop, the present study seeks to explore the moderating role of EI and its dimensions (emotional perception, utilizing emotion, managing self-relevant emotions and managing others' emotions), as moderators in the relationship between spirituality and QoL among healthcare workers. Hence, the following hypotheses were generated and tested:

1. Spirituality will significantly predict quality of life among health practitioners.
2. Emotional Intelligence will significantly moderate the relationship between spirituality and quality of life among health practitioners.
3. Emotional perception will significantly moderate the relationship between spirituality and quality of life among health practitioners.
4. Utilizing emotion will significantly moderate the relationship between spirituality and quality of life among health practitioners.
5. Managing self-relevant emotions will significantly moderate the relationship between spirituality and QoL among health practitioners.
6. Managing others' emotions will significantly moderate the relationship between spirituality and QoL among health practitioners.

METHOD

Participants

The sample consisted of 141 healthcare practitioners residing and working in Owerri, Imo State, Nigeria. A purposive sampling technique was employed to recruit participants who met the study's

professional and demographic requirements. The sample comprised medical doctors, nurses, paramedics, and laboratory technicians, all of whom were active healthcare providers at the time of data collection. Participants included 74 males (52.5%) and 67 females (47.5%), with ages ranging from 23 to 60 years. Due to the demanding schedules of healthcare workers, data collection was conducted online. A Google Form link was disseminated through verified professional social media groups specific to each cadre (medical doctors, nurses, paramedics, and laboratory scientists). To be eligible, participants were required to be qualified healthcare professionals, aged 18 years or older, have access to the internet, and provide informed consent by selecting the *"I consent"* option on the online form. Exclusion criteria included non-healthcare workers, individuals below 18 years, and those who declined to provide consent. Data collection occurred over a three-month period, from June to August 2025.

Instruments

Quality of life was assessed using the World Health Organization Quality of Life–Brief Scale (WHOQOL-BREF; WHO, 1996). The instrument contains 26 items that evaluate individuals' perceptions of their quality of life, health, and general well-being. The scale comprises four subscales: Physical Health (Items 3, 4, 10, 15, 16), Psychological Health (Items 5, 6, 7, 11, 19, 26), Social Relationships (Items 20, 21, 22), and Environment (Items 8, 9, 12, 13, 14, 23, 24, 25). Items 1–25 are rated on a 5-point Likert scale ranging from 1 (strongly disagree) to 5 (strongly agree), whereas Item 26 is scored on a 6-point scale ranging from 1 (never) to 6 (always). Revalidation of the instrument using Nigerian samples showed internal consistency coefficient of high Cronbach Alpha .83 and data completeness of 100% indicating good acceptability and feasibility (Nkporbu, Ogaji, & Nduka, 2023), while in the current study, the items demonstrated strong internal consistency, showing a Cronbach Alpha of .86. Emotional intelligence was assessed using the 33-item *Schutte Self-Report Emotional Intelligence Test* (SSEIT; Schutte et al., 1998). The instrument comprises four subscales: emotional perception (Items 5, 9, 15, 18, 19, 22, 25, 29, 32, 33), utilizing emotions (Items 6, 7, 8, 17, 20, 27), managing self-relevant emotions (Items 2, 3, 10, 12, 14, 21, 23, 28, 31), and managing others' emotions (Items 1, 4, 11, 13, 16, 24, 26, 30). Items 5, 28, and 33 are reverse-scored. Responses are rated on a 5-point Likert-type scale ranging from 1 (*strongly disagree*) to 5 (*strongly agree*). In a Nigerian revalidation study, Aniemeka et al. (2020) reported strong psychometric properties, including a Cronbach's alpha of .91 and a Guttman split-half reliability coefficient of .91, with item–total correlations ranging from .60 to .83. In the present study, item analysis indicated good internal consistency, yielding a Cronbach's alpha of .84. Spirituality was assessed using the 12-item *Spiritual Index of Well-Being* (SIWB; Frey et al., 2005). The scale consists of two subscales: Self-Efficacy subscale (Items 1–6) and the Life Scheme subscale (Items 7–12). Items are rated on a 5-point Likert-type scale ranging from 1 (*strongly agree*) to 5 (*strongly disagree*). The SIWB has demonstrated strong psychometric properties, including good construct validity and reliability. Frey et al. reported an overall internal consistency coefficient of Cronbach's alpha = .91, with subscale alphas of .84 (Self-Efficacy) and .86 (Life Scheme).

Procedure

In designing the study, the researchers adhered to the ethical guidelines recommended by Rodham and Gavin (2006) for online data collection for psychological research. Following these guidelines, the researchers first contacted the heads of the various health professional groups: Medical Doctors, Nurses, Paramedics, and Laboratory Technicians, to introduce themselves and explain the purpose of the study. This step ensured that only verified members of these professional groups

would be granted access to the research materials. Upon reviewing the study information, the professional group leaders granted approval and agreed to share the link to the online questionnaire with their registered members. The researchers then created a Google Form that included an informed consent section, demographic items, and the study instruments. Participation was voluntary, and potential participants were required to indicate their willingness to participate before accessing the rest of the questionnaire. A total of 155 health professionals completed the online form. However, 8 respondents did not provide consent, while 5 didn't complete the questionnaire and were therefore excluded from the dataset. The remaining 141 professionals completed the questionnaire correctly, and their responses were retained and used for data analysis in the present study.

Design and Statistics

Correlational design was used for the study. Moderated multiple regression was used for analysis of the data obtained from the study. This was done using Statistical Package for Social Sciences, SPSS (version 26.0), with Hayes Process Macro (version 5).

Results

Table 1: Demographic Information

Demographics		N	%
Age	18-35 years	82	58.20
	36-53 years	59	41.80
Gender	Male	74	52.50
	Female	67	47.50
Marital Status	Single	84	59.60
	Married	55	39.00
	Divorced	2	1.40
Occupation	Medical Doc.	40	28.40
	Nurses	30	21.30
	Paramedics	25	17.70
	Lab Technicians	46	32.60

The demographic characteristics of the participants indicated that majority of the participants were between 18 and 35 years (58.2%), with the remaining 41.8% aged 36–53 years. The sample comprised slightly of males (52.5%) than females (47.5%). In terms of marital status, majority of the participants were single (59.6%), followed by married participants (39.0%), and a small

proportion were divorced (1.4%). Regarding occupation, 28.4% were medical doctors, 21.3% were nurses, 17.7% were paramedics, and 32.6% were laboratory technicians.

Table 2: Summary of Descriptive Statistics

	N	Mean	Std. Dev.
Quality of Life	141	91.65	9.25
Spirituality	141	46.91	7.24
Emotional Intelligence	141	127.42	10.45
Emotion perception	141	37.21	4.08
Utilizing emotions	141	23.57	2.72
Managing self-relevant emotions	141	35.16	4.28
Managing others' emotions	141	31.49	3.07

The following are range of scores obtained for Quality of Life, Spirituality, Emotional Intelligence and its 4 dimensions (Emotion perception, Utilizing Emotions, Managing Self-Relevant Emotions and Managing Others' Emotions): 62-115, 18-60, 97-157 (24-47, 17-30, 25-44, 22-40) respectively. The means and standard deviations obtained are shown on the descriptive statistics table.

Table 3: Model Summary of Analyses

Model	R	R^2	ΔR^2	*F*	*df1*	*df2*	P
1	.240[a]	.058	.058	8.522	1	139	.004
2	.259[b]	.067	.009	1.398	1	138	.239
3	.309[c]	.095		4.816	3	137	.003
4	.281[d]	.079		3.927	3	137	.010
5	.334[e]	.111		5.725	3	137	.001
6	.282[f]	.080		3.945	3	137	.010
7	.297[g]	.088		4.421	3	137	.005

- Criterion: Quality of Life

A hierarchical multiple regression was conducted to examine the predictors of quality of life. In Model 1, spirituality significantly predicted quality of life ($R^2 = .058$, $F (1, 139) = 8.52$, $p < .05$). In Model 2, emotional intelligence was added to the model, but this did not result in a significant increase in explained variance ($\Delta R^2 = .009$, $F (1, 138) = 1.40$, $p > .05$). Model 3 introduced the interaction term of Spirituality and Emotional Intelligence, which resulted in a significant improvement in the model ($R^2 = .095$, $F (3, 137) = 4.82$, $p < .05$). In Models 4 – 7, the overall interactions of spirituality with 4 dimensions of emotional intelligence were examined. Model 4, which examined the interaction of Spirituality and Emotional Perception was significant ($R^2 = .079$, $F (3, 137) = 3.93$, $p < .50$), though it explained slightly less variance than Model 3. In Model 5, the interaction of Spirituality and Utilizing Emotions accounted for the highest proportion of variance among all models ($R^2 = .111$, $F (3, 137) = 5.73$, $p <.05$). In Model 6, The interaction of Spirituality and Managing Self-relevant Emotions, also showed a significant contribution to the variance in Quality of Life ($R^2 = .080$, $F (3, 137) = 3.95$, $p < .05$). Finally, Model 7 showed that the interaction of Spirituality and Managing Others' Emotions, was also statistically significant, ($R^2 = .088$, $F (3, 137) = 4.42$, $p < .05$).

Table 4: Regression Coefficients

	Model	B	SE	β	T	p	LLCI	ULCI
1	(Constant)	77.251	4.989		15.485	.000		
	Spirituality	.307	.105	.240	2.919	.004		
2	(Constant)	67.846	9.387		7.228	.000		
	Spirituality	.252	.115	.197	2.190	.030		
	Emotional Intelligence	.094	.080	.106	1.182	.239		
3	(Constant)	179.871	55.009		3.270	.001	71.093	288.648
	Spirituality	-1.987	1.089		-1.824	.070	-4.141	.167
	Emotional Intelligence	-.806	.442		-1.820	.071	-1.681	.069
	Interaction 1	.018	.009		2.066	.041	.001	.035
4	(Constant)	129.059	38.232		3.376	.001	53.459	204.660
	Spirituality	-.905	.784		-1.154	.250	-2.454	.645
	Emotional Perception	-1.393	1.047		-1.330	.186	-3.464	.677
	Interaction 2	.032	.021		1.527	.129	-.010	.074
5	(Constant)	187.540	40.138		4.672	.000	108.170	266.911
	Spirituality	-2.091	.845		-2.475	.015	-3.761	-.420
	Utilizing Emotions	-4.736	1.725		-2.746	.007	-8.146	-1.325
	Interaction 3	.102	.036		2.849	.005	.031	.174
6	(Constant)	121.471	38.545		3.151	.002	45.250	197.692
	Spirituality	-.791	.799		-.991	.324	-2.370	.788
	Managing Self-relevant Emotions	-1.219	1.128		-1.081	.282	-3.449	1.011
	Interaction 4	.030	.023		1.313	.191	-.015	.076
7	(Constant)	192.311	58.998		3.260	.001	75.648	308.975
	Spirituality	-2.124	1.187		-1.790	.076	-4.471	.222
	Managing Other's Emotions	-3.610	1.861		-1.940	.054	-7.291	.071
	Interaction 5	.076	.037		2.044	.043	.002	.150

- Dependent Variable: Quality of Life

Analyzing the associations of Spirituality and Emotional Intelligence (and its subdomains), with Quality of Life, the following results were obtained from the 7 models of analyses. In Model 1, a simple linear regression was conducted to examine the relationship of spirituality with quality of life. The results indicated that spirituality significantly predicted quality of life, ($\beta = .24$, $t = 2.92$, $p < .05$). In Model 2, after adding emotional intelligence as a predictor, the model showed that spirituality remained a significant predictor of quality of life ($\beta = .20$, $t = 2.19$, $p < .05$). However, emotional intelligence was not a significant predictor, ($\beta = .11$, $t = 1.18$, $p > .05$). In Model 3, the interaction between spirituality and emotional intelligence was tested. The interaction term was significant ($B = 0.018$, $t = 2.07$, $p < .05$), indicating that emotional intelligence moderates the relationship between spirituality and quality of life. In Model 4, the interaction between spirituality and emotional perception was not significant, ($B = 0.032$, $t = 1.53$, $p > .05$). In Model 5, the interaction between spirituality and utilizing emotions was significant ($B = 0.102$, $t = 2.85$, $p < .05$). Both spirituality ($B = -2.09$, $p < .05$) and utilizing emotions ($B = -4.74$, $p < .05$) were also significant negative predictors. In Model 6, the interaction between spirituality and managing self-relevant emotions was not significant ($B = 0.030$, $t = 1.31$, $p > .05$). In Model 7, a significant interaction was found between spirituality and managing others' emotions ($B = 0.076$, $t = 2.04$, $p < .05$) suggesting moderation. The main effects of spirituality ($p > .05$) and managing others' emotions ($p > .05$) were marginally non-significant.

Summary of Findings

1. Spirituality significantly predicted Quality of Life among health practitioners
2. Emotional Intelligence (overall) significantly moderated the relationship between spirituality and QoL among
3. Emotional perception did not significantly moderate the relationship between spirituality and QoL among health practitioners
4. Utilizing emotion significantly moderated the relationship between spirituality and QoL among health practitioners
5. managing self-relevant emotions did not significantly moderate the relationship between spirituality and QoL among health practitioners
6. managing others' emotions significantly moderated the relationship between spirituality and QoL among health practitioners

DISCUSSION

The study explored the relationship between spirituality and quality of life (QoL) among healthcare workers, while exploring the moderating role of emotional intelligence (EI) and its subdimensions. The results revealed that there is a relationship between spirituality and QoL, whereas overall EI did not directly predict QoL. However, EI significantly moderated the relationship between spirituality and QoL, suggesting that emotional intelligence strengthens the positive influence of spirituality on the well-being of healthcare practitioners. Among the dimensions of EI, utilizing emotions and managing others' emotions significantly moderated the relationship between spirituality and QoL, while emotional perception and managing self-relevant emotions did not.

The finding that spirituality significantly predicted QoL aligns with previous studies that emphasize spirituality as a strong determinant of well-being and psychological adjustment (Are´valoa, 2008; LindanorJacó & Gil, 2014; Dewi & Hamzah, 2019; Siddique & Mosanva, 2025). Healthcare practitioners who exhibit higher levels of spirituality may find meaning, purpose, and a sense of inner peace, which enhances their resilience to occupational stress and burnout. Spirituality provides coping mechanisms through hope, acceptance, and compassion, thereby improving emotional stability and satisfaction with life (Agli et al., 2018).

In the demanding environment of healthcare delivery, spirituality may serve as a buffer against emotional exhaustion and moral distress, promoting empathy and improving the quality of patient care. This finding underscores the role of spiritual beliefs and practices as protective factors in maintaining optimal mental and emotional health among healthcare providers.

Contrary to the hypothesized expectation, overall emotional intelligence did not significantly predict QoL. This outcome diverges from earlier reports (Shahbazi et al., 2012; Mirzaei et al., 2019) that associate higher EI with improved psychological health, job satisfaction, and general well-being. One possible explanation is that the impact of EI on QoL may be indirect, operating through mediating factors such as social relationships, stress management, or spiritual beliefs. Another consideration is that healthcare workers, despite possessing emotional skills, may still experience work-related pressures and resource constraints that limit the direct effect of EI on their perceived QoL.

Nevertheless, the moderation effects observed indicate that EI still plays an important role when interacting with spirituality — not as an independent predictor, but as a strengthening factor that enhances the benefits of spirituality.

The findings of this study also showed that EI significantly moderated the relationship between spirituality and QoL. This finding suggests that healthcare workers with higher levels of EI are better able to harness their spiritual beliefs to improve life satisfaction and emotional well-being. Emotional intelligence may enhance the way individuals interpret and apply their spiritual beliefs, thereby reinforcing the positive effects of spirituality on QoL. This result is consistent with the works of Paek (2006) and Van Dyke & Elias (2008), which suggest that individuals high in EI tend to display greater spiritual awareness and utilize it in managing stress and interpersonal relationships.

Among the sub-dimensions, utilizing emotions and managing others' emotions significantly moderated the spirituality–QoL relationship. This indicates that being able to use emotions constructively (for motivation and optimism) and effectively manage the emotions of others (e.g., patients, colleagues) enhances the beneficial effects of spirituality on overall well-being. These competencies likely help healthcare professionals channel their spiritual strength into positive work attitudes and interpersonal harmony, thereby promoting both personal and professional fulfillment.

Implications of Findings

The findings of this study carry several theoretical, practical, policy and educational implications.

1. Theoretically it implies that this study contributes to the body of knowledge on positive psychology by validating the theoretical link between spirituality, emotional intelligence, and quality of life. The results support the Broaden-and-Build Theory of Positive Emotions (Fredrickson, 2001), which posits that positive emotions broaden individuals' thought–action repertoires and build lasting psychological resources. In this study, spirituality evokes positive emotions such as peace and purpose, while emotional intelligence facilitates the management of those emotions, collectively enhancing well-being.
2. Practically the results of this study highlight the importance of integrating spirituality and emotional intelligence in healthcare settings. Programs that help healthcare workers reflect on their spiritual values, meaning, and emotional regulation can reduce stress and burnout. Furthermore, promoting emotional intelligence skills can amplify the benefits of spirituality, helping workers maintain calmness and empathy even in demanding circumstances.
3. It also implies that policymakers should recognize spirituality and emotional intelligence as vital components of employee well-being. Policies that support emotional intelligence training, spiritual support services, and staff therapy programs can lead to improved job satisfaction, lower turnover, and higher productivity among healthcare workers.
4. Training institutions should embed emotional intelligence and spirituality modules into healthcare education curricula. This will help upcoming professionals cultivate self-awareness, empathy, and compassion early in their careers.
5. For Researchers, this study establishes a foundation for further exploration of how spirituality and emotional intelligence jointly influence quality of life. It also suggests the need to investigate the multidimensional roles of EI components to develop more targeted psychological interventions for healthcare professionals.

Suggestions for Further Studies

1. Future studies should include larger and more geographically diverse samples to enhance generalizability.
2. Explore other moderators and mediators such as resilience, social support, organizational culture, job satisfaction and coping mechanisms that may influence the relationship between, spirituality and quality of life.
3. Investigate if gender, age and years of work experience will show a significant difference in a person's quality of life in relation to spirituality.
4. Compare different healthcare professions to determine variations in how spirituality and EI influence quality of life.
5. Cross-Professional Comparison: Comparing doctors, nurses, and allied health professionals may reveal profession-specific dynamics in the spirituality–EI–QoL relationship.
6. Conduct comparative studies across different cultural and religious settings to understand how beliefs shape well-being outcomes as this study was conducted among healthcare workers in Owerri, Imo State, Nigeria. Similar research should be extended to other regions or countries to compare cultural and institutional influences.
7. Employ longitudinal designs to examine how changes in spirituality and emotional intelligence over time affect quality of life.

Recommendations

Based on the findings of this study, the following recommendations are proposed:

1. Healthcare facilities should have structured spiritual based programs to enhance workers' wellness such as chaplaincy support and reflective practices.
2. Inclusion of Spiritual and Emotional Well-being in Policies. That is, health institutions should incorporate spiritual and emotional wellness components into occupational health and employee assistance programs to enhance workers QoL.
3. There is need for curriculum integration of spiritual and emotional intelligence training in medical school programs to prepare future professional health workers holistically.
4. The relevance to conduct periodic wellness assessment of workers emotional and spiritual health.
5. Regular EI training workshops and professional development programs, focusing on emotion regulation, empathy, interpersonal skills and reflective practices should be regularly organized to enhance healthcare professionals' ability to manage emotional stressors.
6. Healthcare leaders should receive training on emotional and spiritual competencies that fosters compassion, empathy, and emotional awareness which can positively influence the morals of their teams' also improve workplace culture and staff morale.
7. Administrators should promote supportive work environment by creating psychologically safe spaces where healthcare workers can express emotions, share challenges, and access spiritual or counseling support services without stigma.
8. Implement flexible schedules, adequate rest periods, and recognition systems to prevent burnout and enhance job satisfaction and to promote work-life balance.
9. Encourage team-based reflection and peer-support groups where healthcare workers can discuss emotional challenges and share coping strategies.

Conclusion

This study concludes that spirituality is a significant predictor of quality of life among healthcare workers, confirming its vital role in promoting well-being amidst occupational stress. While emotional intelligence did not directly predict QoL, it significantly moderated the relationship between spirituality and QoL, suggesting that emotionally intelligent healthcare practitioners are better able to translate spiritual beliefs into improved life satisfaction, resilience, emotional competence, psychological balance and fulfillment. While spirituality provides meaning, purpose, and inner peace, emotional intelligence enables individuals to manage and express those emotions effectively in professional and interpersonal contexts. Together, these factors contribute to improved mental health, job satisfaction, and overall quality of life. Therefore, efforts to enhance healthcare workers' wellness should adopt a holistic approach that integrates spiritual enrichment and emotional intelligence development. Such an approach will not only benefit healthcare workers but also improve patient care outcomes and organizational effectiveness.

Ethical considerations: This study involved human elements, therefore, ethics for human subjects were observed incompliance with Rodham and Gavin, (2006) criteria.

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