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A CROSS-SECTIONAL STUDY ON SPIRITUAL INTELLIGENCE AND ITS RELATIONSHIP WITH QUALITY OF LIFE AMONG MEDICAL STUDENTS

Ram Naresh Reddy Telluri[1], Raghava Rao Ullamgunta[2], Tara Rompicherla[3], Suganya Velusamy[4], Sravani Addagada[5]

[1]*Assistant Professor, Department of Psychiatry, Government Siddhartha Medical College, Vijayawada, Andhra Pradesh, India.*
[2]*Professor & HOD, Department of Psychiatry, Government Siddhartha Medical College, Vijayawada, Andhra Pradesh, India.*
[3]*Associate Professor, Department of Psychiatry, Government Siddhartha Medical College, Vijayawada, Andhra Pradesh, India.*
[4]*Consultant Psychiatrist, DR MIND Clinic, Vijayawada, Andhra Pradesh, India*
[5]*Senior Resident, Department of Psychiatry, Govt. Siddhartha Medical College, Vijayawada, Andhra Pradesh, India*

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Corresponding Author:
Dr. Ram Naresh Reddy Telluri
Assistant Professor, Department of Psychiatry, Government Siddhartha Medical College, Vijayawada, Andhra Pradesh, India.
Email: ramnaresh42@gmail.com

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ABSTRACT

Background: Medical education is associated with considerable academic, psychological and interpersonal demands. Medical students are exposed to academic competition, examinations, clinical responsibilities, uncertainty and exposure to illness and suffering. These factors can influence their quality of life. Spiritual intelligence, which encompasses existential thinking, meaning-making, transcendental awareness and conscious state expansion, has been proposed as a psychological resource that may help individuals adapt to stressful experiences. However, evidence regarding the relationship between spiritual intelligence and multidimensional quality of life among medical students remains limited, particularly in the Indian context. The aim is to assess spiritual intelligence among medical students and determine its relationship with quality of life.

Materials and Methods: A cross-sectional questionnaire-based study was conducted among undergraduate medical students at Government Siddhartha Medical College, Vijayawada, Andhra Pradesh. Data were collected through an online Google Forms questionnaire. Spiritual intelligence was assessed using the Spiritual Intelligence Self-Report Inventory-24 (SISRI-24) and quality of life using the World Health Organization Quality of Life-BREF (WHOQOL-BREF). Sociodemographic information was also collected. Responses from participants who did not provide consent were excluded. Pearson correlation was used to examine the relationship between spiritual intelligence and quality-of-life domains. One-way analysis of variance was used to compare scores across years of medical education. Multiple linear regression was performed to examine the independent association between spiritual intelligence and quality of life after adjustment for age, gender and year of study.

Results: Of 223 responses received, 210 participants (94.2%) provided consent and were included in the primary analysis. The mean age was 20.35 ± 2.08 years, and 128 (61.0%) participants were female. The mean total SISRI-24 score was 46.88 ± 19.85. The SISRI-24 demonstrated high internal consistency in the present sample (Cronbach's α = 0.948). The mean WHOQOL-BREF domain scores, transformed to a 0–100 scale, were 51.79 ± 15.49 for physical health, 53.23 ± 14.54 for psychological health, 55.11 ± 20.79 for social relationships and 60.43 ± 16.22 for environmental quality of life. Overall perceived quality of life had a mean score of 3.55 ± 0.83. Spiritual intelligence demonstrated significant positive correlations with physical health ($r = 0.305$, $p < 0.001$), psychological health ($r = 0.441$, $p < 0.001$), environmental quality of life ($r = 0.301$, $p < 0.001$), and overall perceived quality of life ($r = 0.248$, $p < 0.001$). The correlation with social relationships was not statistically significant ($r = 0.142$, $p = 0.068$). In multivariable regression analysis, spiritual intelligence

remained independently associated with overall quality of life (standardized β = 0.259, p < 0.001), psychological quality of life (β = 0.449, p < 0.001) and environmental quality of life (β = 0.306, p < 0.001), after adjustment for age, gender and year of study.
Conclusion: Higher spiritual intelligence was associated with better perceived quality of life among medical students, particularly in the psychological and environmental domains. The findings suggest that spiritual intelligence may represent one of several psychosocial factors associated with student well-being. Longitudinal and multicentric studies are required to determine temporal relationships and whether interventions targeting meaning-making, reflection and related capacities can improve quality of life.
Keywords: spiritual intelligence; SISRI-24; quality of life; WHOQOL-BREF; medical students; medical education; psychological well-being.

INTRODUCTION

Medical education is a demanding period of professional and personal development. Students are expected to acquire a large body of theoretical knowledge while simultaneously developing clinical skills, professional attitudes and interpersonal competencies. The transition from preclinical learning to clinical exposure introduces additional demands, including responsibility for patient care, exposure to suffering and death, uncertainty in clinical decision-making, long working hours and frequent academic assessments. Previous research has demonstrated substantial psychological distress among medical students, including symptoms of depression, anxiety and burnout.[1,2]

Quality of life is a multidimensional construct that encompasses an individual's perception of physical health, psychological well-being, social relationships and environmental circumstances. The World Health Organization developed the WHOQOL-BREF as a shorter version of the WHOQOL-100 for situations in which a brief but multidimensional assessment of quality of life is required.[3] The WHOQOL-BREF evaluates four domains—physical health, psychological health, social relationships and environment—and also includes questions addressing overall quality of life and general health.[3,4]

Quality of life among medical students may be influenced by several factors, including academic workload, sleep, physical activity, social support, financial circumstances, learning environment and mental health. An Indian study conducted among medical students during the COVID-19 lockdown found that the psychological domain had the lowest WHOQOL-BREF score among the four domains, highlighting the vulnerability of medical students' psychological well-being.[5] Studies from other settings have similarly demonstrated that medical training can be associated with substantial stress and changes in quality of life.[6]

In addition to conventional psychological factors, increasing attention has been given to spiritual intelligence as a potential contributor to well-being. Spiritual intelligence is conceptually distinct from religious affiliation. It refers to capacities involving existential reflection, meaning-making, awareness of transcendence and the ability to access or regulate higher states of consciousness.[7,8]

Emmons proposed spirituality as a potential form of intelligence involving the use of spiritual resources in adaptive problem-solving and the pursuit of ultimate concerns.[7] Vaughan subsequently described spiritual intelligence in terms of awareness, integration and the ability to perceive deeper meaning and interconnectedness.[8]

King and DeCicco developed the Spiritual Intelligence Self-Report Inventory (SISRI-24) based on a four-factor model consisting of critical existential thinking, personal meaning production, transcendental awareness and conscious state expansion.[9] The final 24-item instrument demonstrated good psychometric properties, including high internal reliability and evidence supporting its construct validity.[9]

The concept of spiritual intelligence may be particularly relevant to medical education. Medical students frequently encounter situations that involve existential questions, suffering, uncertainty and ethical dilemmas. The capacity to derive meaning from challenging experiences may help students adapt to these demands. In a study of university students, Khosravi and Nikmanesh found that spiritual intelligence was positively associated with resilience and negatively associated with perceived stress.[10]

Research specifically involving students of medical sciences has also suggested an association between spiritual intelligence and positive well-being outcomes. Senmar et al., in a study among students of medical sciences, reported a significant positive relationship between spiritual intelligence and life satisfaction (r = 0.27, p < 0.05).[11] A recent cross-sectional study among 508 medical-science students similarly reported a positive relationship between spiritual intelligence and academic performance.[12]

However, life satisfaction and academic performance do not encompass the full multidimensional construct of quality of life. There is comparatively limited research examining the relationship between spiritual intelligence and the different domains of WHOQOL-BREF among medical students.

Understanding this relationship may have implications for medical education and student wellness. If spiritual intelligence is associated with

specific dimensions of quality of life, particularly psychological well-being, this may provide a basis for further research into reflective, meaning-centred and well-being-oriented approaches in medical education.

Therefore, the present study was undertaken to assess spiritual intelligence among medical students at Government Siddhartha Medical College and to examine its relationship with multidimensional quality of life.

AIM: To assess spiritual intelligence among medical students and determine its relationship with quality of life.

Objectives

1. To assess the level of spiritual intelligence among medical students using the Spiritual Intelligence Self-Report Inventory-24 (SISRI-24).
2. To assess quality of life among medical students using the WHOQOL-BREF.
3. To examine the relationship between spiritual intelligence and the physical, psychological, social and environmental domains of quality of life.
4. To assess whether the relationship between spiritual intelligence and quality of life persists after adjustment for age, gender and year of medical education.
5. To compare spiritual intelligence and overall perceived quality of life across different years of medical education.

MATERIALS AND METHODS

Study design: A cross-sectional, questionnaire-based observational study was conducted among undergraduate medical students.

Study setting: The study was conducted at Government Siddhartha Medical College, Vijayawada, Andhra Pradesh, India.

Study population: The study population consisted of undergraduate MBBS students enrolled at Government Siddhartha Medical College, including students from the first, second, third and final years.

Sampling: A convenience sampling approach was used. The questionnaire was circulated electronically to eligible medical students through an online Google Forms platform.

Eligibility: Students enrolled in the undergraduate medical programme who were willing to participate and provided informed consent were included.

Responses from participants who did not provide consent were excluded from the primary analysis.

Data collection: Data were collected using a structured online questionnaire consisting of:

1. Sociodemographic information.
2. Spiritual Intelligence Self-Report Inventory-24.
3. WHOQOL-BREF.
4. Consent to participate.

Participants were informed about the purpose of the study and the voluntary nature of participation before completing the questionnaire.

Sociodemographic variables

The questionnaire collected information regarding:

- Age
- Gender
- Year of study
- Previous exposure to spiritual intelligence training

Assessment of spiritual intelligence: Spiritual intelligence was assessed using the Spiritual Intelligence Self-Report Inventory-24 (SISRI-24) developed by King and DeCicco.[9]

The SISRI-24 consists of 24 items scored from 0 to 4, giving a total possible score of 0–96, with higher scores indicating greater spiritual intelligence. The instrument consists of four dimensions:

- Critical Existential Thinking (CET): items 1, 3, 5, 9, 13, 17 and 21.
- Personal Meaning Production (PMP): items 7, 11, 15, 19 and 23.
- Transcendental Awareness (TA): items 2, 6, 10, 14, 18, 20 and 22.
- Conscious State Expansion (CSE): items 4, 8, 12, 16 and 24.

Item 6 is reverse scored before calculating the total score.[9]

In the present study, the SISRI-24 demonstrated high internal consistency, with Cronbach's alpha of 0.948.

Assessment of quality of life: Quality of life was assessed using the WHOQOL-BREF, developed by the World Health Organization.[3]

The WHOQOL-BREF consists of 26 items. Four domains are assessed:

- Physical health: 7 items
- Psychological health: 6 items
- Social relationships: 3 items
- Environment: 8 items

Items 3, 4 and 26 are reverse scored. Domain scores were calculated according to the WHOQOL-BREF scoring procedure and transformed to a 0–100 scale, with higher scores indicating better quality of life.[3,5]

The first WHOQOL-BREF item assesses overall perceived quality of life.

Data-quality issue concerning WHOQOL-BREF item 2: During data verification, it was identified that the response options programmed for WHOQOL-BREF item 2 in the Google Form did not correspond to the standard response options for the question assessing satisfaction with health. Therefore, this item was not included in the calculation of WHOQOL-BREF domain scores or inferential analyses. This deviation is reported transparently as a limitation of the study.

Statistical analysis: Data were entered and analyzed using statistical software.

Continuous variables were summarized using mean and standard deviation, while categorical variables were summarized using frequencies and percentages.

Internal consistency of the SISRI-24 and WHOQOL-BREF was assessed using Cronbach's alpha.

Pearson's correlation coefficient was used to assess the relationship between total spiritual intelligence score and WHOQOL-BREF domain scores and overall perceived quality of life.

One-way analysis of variance (ANOVA) was used to compare spiritual intelligence and overall quality of life across the four years of medical education.

Multiple linear regression was performed to assess the independent association between spiritual intelligence and quality-of-life outcomes after adjusting for age, gender and year of study.

A two-tailed p value <0.05 was considered statistically significant.

RESULTS

Participant characteristics: A total of 223 responses were received. Of these, 210 participants (94.2%) provided affirmative consent and were included in the primary analysis. Thirteen responses (5.8%) were excluded because consent was not provided.

The mean age of the participants was 20.35 ± 2.08 years (n=208), with an age range of 17–39 years.

There were 128 females (61.0%) and 82 males (39.0%).

Regarding year of study, 71 participants (33.8%) were from first year, 58 (27.6%) from second year, 41 (19.5%) from third year and 40 (19.0%) were final-year students.

Twenty-five students (11.9%) reported previous exposure to spiritual intelligence training, whereas 182 (86.7%) reported no previous training.

Table 1: Sociodemographic characteristics of study participants

Variable	Category	n (%)
Gender	Female	128 (61.0)
	Male	82 (39.0)
Year of study	1st year	71 (33.8)
	2nd year	58 (27.6)
	3rd year	41 (19.5)
	Final year	40 (19.0)
Spiritual intelligence training	Yes	25 (11.9)
	No	182 (86.7)
	Missing	3 (1.4)

Spiritual intelligence: The mean total SISRI-24 score was 46.88 ± 19.85, with a range of 5–95 among participants with complete SISRI-24 responses (n=194).

The mean scores for the individual SISRI-24 dimensions were:

- Critical Existential Thinking: 14.09 ± 6.56
- Personal Meaning Production: 10.44 ± 4.71
- Transcendental Awareness: 14.36 ± 5.69
- Conscious State Expansion: 7.80 ± 5.17

Table 2: SISRI-24 scores

SISRI-24 measure	n	Mean ± SD	Range
Total SISRI-24	194	46.88 ± 19.85	5–95
Critical Existential Thinking	204	14.09 ± 6.56	0–28
Personal Meaning Production	205	10.44 ± 4.71	0–20
Transcendental Awareness	202	14.36 ± 5.69	2–28
Conscious State Expansion	203	7.80 ± 5.17	0–20

The SISRI-24 showed high internal consistency in the present sample (Cronbach's α = 0.948).

Quality of life: The mean WHOQOL-BREF domain scores after transformation to a 0–100 scale were:

- Physical health: 51.79 ± 15.49
- Psychological health: 53.23 ± 14.54
- Social relationships: 55.11 ± 20.79
- Environmental quality of life: 60.43 ± 16.22

The mean overall quality-of-life rating was 3.55 ± 0.83 on the 1–5 scale.

Table 3: WHOQOL-BREF scores

Domain	n	Mean ± SD
Physical health	204	51.79 ± 15.49
Psychological health	204	53.23 ± 14.54
Social relationships	176	55.11 ± 20.79
Environment	205	60.43 ± 16.22
Overall quality of life	210	3.55 ± 0.83

The WHOQOL-BREF demonstrated high internal consistency in the available dataset (Cronbach's α = 0.916 when the incorrectly formatted item 2 was numerically coded according to its ordered response options).

Relationship between spiritual intelligence and quality of life: Total spiritual intelligence

demonstrated a statistically significant positive correlation with several quality-of-life domains.

The strongest association was observed with the psychological domain ($r = 0.441$, $p < 0.001$).

Spiritual intelligence also demonstrated significant positive correlations with:

- Physical health: $r = 0.305$, $p < 0.001$
- Environmental domain: $r = 0.301$, $p < 0.001$
- Overall quality of life: $r = 0.248$, $p < 0.001$

The correlation with the social relationships domain was positive but did not reach statistical significance ($r = 0.142$, $p = 0.068$).

Table 4: Correlation between spiritual intelligence and WHOQOL-BREF

WHOQOL-BREF outcome	n	Pearson's r	p-value
Physical health	188	0.305	<0.001
Psychological health	189	0.441	<0.001
Social relationships	166	0.142	0.068
Environment	189	0.301	<0.001
Overall quality of life	194	0.248	<0.001

Spiritual intelligence and year of medical education: There was no statistically significant difference in total SISRI-24 scores across years of medical education ($F = 0.546$, $p = 0.651$).

The mean SISRI-24 scores were:

- First year: 49.22 ± 20.54
- Second year: 45.71 ± 18.40
- Third year: 47.11 ± 18.02
- Final year: 44.41 ± 22.75

Table 5: Spiritual intelligence according to year of study

Year	n	SISRI-24 mean ± SD
1st year	63	49.22 ± 20.54
2nd year	56	45.71 ± 18.40
3rd year	38	47.11 ± 18.02
Final year	37	44.41 ± 22.75
ANOVA		F = 0.546, p = 0.651

There was also no significant difference in overall perceived quality of life across years of study ($F = 0.113$, $p = 0.952$).

The mean overall quality-of-life scores were 3.52 ± 0.86, 3.57 ± 0.80, 3.51 ± 0.95 and 3.60 ± 0.71 among first-, second-, third- and final-year students, respectively.

Multiple linear regression: Multiple linear regression was used to assess whether spiritual intelligence remained associated with quality-of-life outcomes after adjustment for age, gender and year of study.

Spiritual intelligence remained independently associated with overall perceived quality of life (standardized $\beta = 0.259$, $p < 0.001$), explaining approximately 7.0% of the variance in the model ($R^2 = 0.070$).

The association was stronger for the psychological domain (standardized $\beta = 0.449$, $p < 0.001$; $R^2 = 0.206$) and remained significant for the environmental domain (standardized $\beta = 0.306$, $p < 0.001$; $R^2 = 0.097$)

Table 6: Multiple linear regression models

Outcome	n	Standardized β for SISRI-24	p-value	R^2
Overall quality of life	192	0.259	<0.001	0.070
Psychological domain	187	0.449	<0.001	0.206
Environmental domain	187	0.306	<0.001	0.097

DISCUSSION

The present study examined the relationship between spiritual intelligence and quality of life among undergraduate medical students at Government Siddhartha Medical College. The principal finding was that higher spiritual intelligence was associated with better quality of life, particularly psychological, physical and environmental quality of life, as well as overall perceived quality of life. The strongest association was observed between spiritual intelligence and psychological quality of life.

The mean total SISRI-24 score in the present study was 46.88 ± 19.85. The instrument demonstrated high internal consistency, with Cronbach's alpha of 0.948, which is comparable with the strong reliability reported for the original SISRI-24.[9] King and DeCicco developed SISRI-24 as a four-factor measure consisting of critical existential thinking, personal meaning production, transcendental awareness and conscious state expansion.[9]

A recent cross-sectional study among 508 medical-science students reported a mean SISRI-24 score of 53.84 ± 16.68 and found a significant positive relationship between spiritual intelligence and academic performance.[12] The mean score in the present study was somewhat lower. Differences in cultural environment, institution, participant characteristics and educational context may account

for this variation. Importantly, both studies suggest that spiritual intelligence is measurable and variable among students undergoing medical education.

The present study also demonstrated a positive association between spiritual intelligence and quality of life. The strongest correlation was observed with the psychological domain ($r = 0.441$, $p < 0.001$). This finding is theoretically plausible because several components of spiritual intelligence involve meaning-making, existential reflection and awareness of one's internal experiences. These capacities may help individuals interpret stressful experiences in a broader framework and may contribute to adaptive psychological functioning.

Previous research provides support for a relationship between spiritual intelligence and psychological coping. Khosravi and Nikmanesh studied 307 university students and reported a positive relationship between spiritual intelligence and resilience and a negative relationship between spiritual intelligence and perceived stress.[10] Their findings provide a possible explanatory pathway for the current observation: spiritual intelligence may be associated with psychological resources that facilitate adaptation to stressful experiences.

The relationship between spiritual intelligence and life satisfaction has also been reported in students of medical sciences. Senmar et al. found a significant positive correlation between spiritual intelligence and life satisfaction ($r = 0.27$, $p < 0.05$) among students of Qazvin University of Medical Sciences.[11] The correlation with overall perceived quality of life in the present study was similar in magnitude ($r = 0.248$), supporting the possibility that spiritual intelligence is associated with subjective evaluations of well-being.

An important finding of the current study was the significant association between spiritual intelligence and physical quality of life ($r = 0.305$, $p < 0.001$). Although spiritual intelligence is primarily conceptualized in psychological and existential terms, it is possible that psychological resources associated with meaning-making and adaptive coping may indirectly influence perceptions of physical well-being. However, because the present study is cross-sectional, the mechanism underlying this association cannot be established.

Spiritual intelligence was also positively associated with the environmental domain ($r = 0.301$, $p < 0.001$). The environmental domain encompasses aspects such as safety, financial resources, access to information, opportunities for recreation, living conditions, healthcare access and transportation.[3] This relationship may partly reflect the possibility that students with greater psychological resources perceive and interact with their environment differently. Alternatively, students with more favourable environmental circumstances may have greater opportunities for reflection and personal development. Longitudinal research would be required to determine the direction of this association.

In contrast, the relationship between spiritual intelligence and social relationships did not reach statistical significance ($r = 0.142$, $p = 0.068$). This suggests that spiritual intelligence may not have a uniform relationship with all domains of quality of life. Social quality of life among medical students is likely to be influenced by numerous factors, including peer relationships, family support, social networks, personality and the institutional environment. These factors were not comprehensively assessed in the present study.

The absence of a significant difference in spiritual intelligence across academic years is also noteworthy. Although first-year students had the highest mean SISRI-24 score and final-year students had the lowest mean score, the overall difference was not statistically significant. Similarly, overall perceived quality of life did not differ significantly across years of medical education.

These findings suggest that spiritual intelligence and quality of life may not necessarily change in a simple linear fashion as students progress through medical education. Individual differences, family environment, coping mechanisms, social support and personal experiences may be more important determinants than academic year alone.

Nevertheless, previous literature demonstrates that medical education can adversely affect student well-being. Dyrbye et al. have documented substantial psychological distress among medical students,[1] while studies examining medical student quality of life have identified the psychological domain as an important area of vulnerability.[5] In the present study, the psychological domain was also strongly related to spiritual intelligence, suggesting that meaning-oriented psychological resources may be particularly relevant to medical student well-being.

The multivariable regression findings strengthen the interpretation of the bivariate correlations. After adjustment for age, gender and year of study, spiritual intelligence remained independently associated with overall quality of life, psychological quality of life and environmental quality of life.

The strongest adjusted association was observed with the psychological domain ($\beta = 0.449$). However, the cross-sectional design means that these findings should be interpreted as associations rather than evidence that spiritual intelligence causes improved quality of life.

The R^2 values also demonstrate that spiritual intelligence accounts for only a proportion of the variability in quality of life. For example, the model containing spiritual intelligence, age, gender and year of study explained approximately 20.6% of the variance in psychological quality of life. Therefore, many other factors are likely to contribute to quality of life among medical students.

Potentially relevant factors include academic stress, sleep quality, physical activity, financial circumstances, family support, depression, anxiety, burnout, personality traits and the quality of the

educational environment. These variables were not comprehensively measured in the present study.

The findings may nevertheless have implications for medical education. Contemporary medical education increasingly recognizes the importance of reflective capacity, professionalism, empathy and psychological well-being alongside academic achievement. Spiritual intelligence, particularly the capacities involving meaning-making and existential reflection, could potentially be explored within broader student-wellness and reflective-learning programmes.

Such approaches should remain inclusive and non-denominational. Spiritual intelligence as measured by SISRI-24 should not be equated with adherence to a particular religion. Rather, the construct encompasses existential reflection, meaning, transcendence and consciousness.[9]

Importantly, the current study does not demonstrate that introducing spiritual intelligence training will improve quality of life. Intervention studies are necessary before such programmes can be recommended as an evidence-based strategy.

Strengths Of The Study: The study has several strengths.

First, it included students from all years of undergraduate medical education, allowing examination of whether spiritual intelligence and quality of life varied across different stages of medical training.

Second, standardized instruments were used to assess both constructs. The SISRI-24 provides a multidimensional assessment of spiritual intelligence, while WHOQOL-BREF evaluates multiple domains of quality of life.[3,9]

Third, the study included both correlation and multivariable regression analyses, allowing assessment of the relationship between spiritual intelligence and quality of life while accounting for basic demographic variables.

Fourth, the internal consistency of the SISRI-24 and WHOQOL-BREF was high in the present sample.

Limitations: The study has several limitations.

First, its cross-sectional design prevents conclusions regarding causality or temporal direction. Higher spiritual intelligence may contribute to better quality of life, but it is equally possible that better psychological well-being facilitates greater meaning-making or spiritual awareness.

Second, the study was conducted at a single medical college, which limits generalizability to medical students from other institutions and regions.

Third, participants were recruited through convenience sampling using an online questionnaire, which may have introduced selection bias.

Fourth, both major study variables were assessed using self-report measures, which may be affected by social desirability and response bias.

Fifth, potentially important confounding factors such as depression, anxiety, burnout, sleep, academic stress, physical activity, socioeconomic status and social support were not comprehensively assessed.

Sixth, some questionnaire items were incompletely answered, resulting in different sample sizes for individual analyses.

Finally, an important data-collection issue was identified in the Google Form: WHOQOL-BREF item 2 was presented with response options that did not correspond to the standard WHOQOL-BREF response format. Consequently, this item was not used in the calculation of the WHOQOL-BREF domain scores or the main inferential analyses. This issue should be corrected in any future replication.

CONCLUSION

The present study demonstrated a significant positive relationship between spiritual intelligence and quality of life among medical students at Government Siddhartha Medical College.

Higher spiritual intelligence was associated particularly with better psychological quality of life, and significant positive associations were also observed with physical health, environmental quality of life and overall perceived quality of life. The association with social relationships was not statistically significant.

Spiritual intelligence remained independently associated with overall, psychological and environmental quality of life after adjustment for age, gender and year of study.

These findings suggest that spiritual intelligence may represent one potentially relevant psychosocial factor in the well-being of medical students. However, spiritual intelligence should be considered one component of a much broader network of factors influencing quality of life.

Longitudinal, multicentric and interventional studies are required to determine whether spiritual intelligence changes over the course of medical education and whether interventions designed to enhance meaning-making, reflective capacity and related psychological resources can improve students' quality of life.

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