

The effect of spiritual–religious psychotherapy on enhancing quality of life and reducing symptoms of anxiety and depression among the elderly

Mahboobeh Askari¹, Hossein Mohammadi^{2*}, Hamed Radmehr², Amir Hosein Jahangir³

1- Department of Clinical Psychology, Azad University of Marvdasht, Marvdasht, Iran.

2- Students Research Committee, Department of Psychology, Faculty of Medical School, Shahid Beheshti University of Medical Sciences, Tehran, Iran.

3- Department of Clinical Psychology, Medical School, Shahid Beheshti University of Medical Sciences, Tehran, Iran.

*Correspondence should be addressed to Mr. Hossein Mohammadi; Email: Mohamadi.h@tak.iums.ac.ir

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Abstract

Background and Objective: Aging is associated with a variety of challenges and tensions which could possibly affect life quality of older people. This study was conducted to examine the effect of spiritual–religious psychotherapy on enhancing quality of life and reducing symptoms of anxiety and depression among the elderly.

Method: The current study was a clinical trial including a treatment group which was exposed to spiritual-religious psychotherapy and a control group. A quasi-experimental pretest-posttest design was adopted in the study, with the participants being randomly assigned to either of the groups. More specifically, the sample of the study consisted of 40 (men= 29 and women= 11) old people who were selected through random sampling method. Half of them (n=20) were randomly assigned to the experimental group and the rest were assigned to the control group (n=20). Participants in the experimental group received treatment of spiritual–religious psychotherapy for 12 sessions (each 90 minutes). Data collection instruments included Beck Anxiety Inventory (BAI), Beck Depression Inventory (BDI), and Short-Form health survey questionnaire (SF-36). The data were analyzed through utilizing descriptive and inferential (analysis of covariance/ANVOCA) procedures. All ethical issues were observed in the study and the authors declared no conflict of interests.

Results: The results showed that spiritual–religious psychotherapy has a significant effect on increasing life quality and reducing anxiety and depression in the elderly. The effect size of experimental group on life quality among physical and mental variables was 0.25 and 0.81, respectively. Further, 60 percent of changes in depression and 54 percent of anxiety were related to the spiritual–religious intervention.

Conclusion: Elderly are facing several physical and emotional crises that lead to reduced quality of life and more psychological symptoms. At this stage of life, religious and spiritual strategies can improve the elderly's mental health.

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Summary

Background and Objective: Population aging, which is one of the greatest humanitarian achievements, is one of the most fundamental problems of today's world

too (1). Elderly people face various illnesses and disabilities, including fears of death, suicidal thoughts, changes in sleep pattern, thinking and memory problems, anxiety, feeling of frustration, feelings of being guilty, fatigue, forgetfulness due to physiological changes, loss of loved ones, stresses, etc. (2). Another

common psychological problem among the elderly is death anxiety, which involves thoughts, fears, and emotions associated with the end of life (3).

Spiritual factors, including religious thoughts, religious attitude, attachment to God, life satisfaction, and religion, reduce death anxiety in the elderly. These factors play an essential role in the quality of life of the elderly (4). In the natural growth of the elderly, faith and spirituality culminate in a deeper connection with the goal of mediating symbols and ritual worship; it also leads one to exceed the boundaries of intellectual / thoughtfulness (5).

According to Ericsson, elderly people face psychological and social problems of desperation. They try to inject meaning to their lives, and thereby cope with death as an inevitable phenomenon (6). With regard to the effectiveness of spiritual-religious psychotherapy on the quality of life, anxiety, and depression in elderly people, one can mention the researches of Famil Ahmari, and khodabakhshi koolae (2015) and Sartipzadeh, Ali-Akbari, and Tabaian (2016). They demonstrated that spiritual and religious psychotherapy had significant effects on reducing psychological symptoms among the elderly (7-8).

Method: In this study, a quasi-experimental, pretest-posttest design was adopted with a treatment group (which received spiritual-religious psychotherapy) and a control group (which received no treatment. Forty elderly (29 males and 11 females) were selected and randomly assigned to the experimental and control groups (n=20) and the control group (n=20). Participants in the experimental group received 12 sessions (90 minutes each session) of spiritual and religious psychotherapy. Data were analysed by using descriptive and inferential statistics (analysis of covariance).

The data gathering tools in this research are:

1) Demographic feature checklist:

The personal information questionnaire included age, academic degree, marital status, history of physical illness, history of neuropsychiatric disorders, history of using nonprescription drugs, history of alcohol and drug use, duration of illness, and stage of the disease.

2) Short-Form health survey questionnaire (SF-36):

The questionnaire has 36 questions that examine 8 major health concepts. To score Sf36 questions, a score of 0 to 100 is used. This scoring procedure is derived from the standard Sf36 standard measure. The questionnaire was tested in the United Kingdom in 1993 by Brazier et al. To determine the reliability of the questionnaire, the results showed that Sf36 reliability was 85% based on Cronbach's test (9). Also, in Montazeri's research, the questionnaire had acceptable reliability and validity (10).

3) Beck Anxiety Inventory (BAI) :

This questionnaire was designed by Beck to measure the amount of anxiety; it contains 21 statements that are scored on a 4-point Likert scale (0-3), and the total score ranges from 0 to 63. The results of Kaviani and Mousavi's research showed that Beck anxiety test was

valid ($r= 0.72$, $p < 0.001$), reliable ($r=0.83$, $p < 0.001$) and internally consistent ($\alpha=0.92$) (11).

4) Beck Depression Inventory (BDI)

This test consists of a total of 21 section related to depression symptoms and, when administered, the subject is asked to rate the severity of these symptoms based on a four-level scale of 0 to 3. Dobson and Mohammad Khani reported a high reliability index (0.913) for the 21 sections of Beck Depression Inventory (12).

Results: The findings of this study indicate that spiritual-religious psychotherapy has led to a significant increase in the quality of life of the elderly. The effect level of the experimental group (practical significance) on the variables of physical and psychological components was 0.25 and 0.81, respectively. For example, 81% of the total variance or individual differences in the psychological components of the elderly quality of life in the experimental group was related to the effect of intervention. Also, the findings of the study showed that spiritual-religious psychotherapy caused a significant reduction in the symptoms of depression and anxiety in the elderly. In fact, 60% of changes in the depression variable and 54% in the anxiety scores were related to spiritual-religious intervention.

Conclusion: The results of this study show the effectiveness of spiritual-religious psychotherapy on improving quality of life and reducing anxiety and depression. Older people who adhere to spiritual values and religious beliefs are less likely to face internal conflicts, vanity, emptiness, despair, dissatisfaction, and disappointment in the face of crises, and endure deprivations and disadvantages (13).

The results of this study are consistent with Farahani Nia, John Mohammadi and Haqqani's new findings. In general, the results of this research, in line with previous research, show the connection between spirituality, life satisfaction, and happiness. These studies show that religion and spirituality are effective therapies for increasing satisfaction with life and happiness (14). In explaining this result, it can be argued that spiritual-religious psychotherapy is the ability to utilize spiritual resources and assets to solve problems and improve life quality.

Limitations of the study:

One of the limitations of this research is the use of self-reported tools, which increases the probability of measurement error. I particular, some respondents might have failed to provide true answers to the questionnaire items. Moreover, in this research, a follow-up test was not used; hence, the long-term effect of the intervention could not be estimated. It was also not possible to control the religious level of the participants, which would increase the likelihood of error and reduce the accuracy of the measurements.

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