

## The Effectiveness of Spiritual-Religion Psychotherapy on Mental Distress (Depression, Anxiety and Stress) In the Elderly Living In Nursing Homes

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### Abstract

**Background and Objectives:** Being away from the familiar surroundings and family supports, decline in capabilities and skills, and age-related failures can lead to mental problems in the elderly living in nursing homes. This study was conducted with the aim of investigating the effectiveness of spiritual-religious psychotherapy on mental distress in the elderly in nursing homes.

**Methods:** The study population of this semi-experimental study with control group and pretest-posttest, consisted of all elderly living in the nursing home of Bandar Abbas, southern Iran in 2016. Samples (n: 28) were selected by convenience sampling and then randomly divided into two groups, experimental and control. Experimental group received spiritual-religion psychotherapy. Data collection instrument was Depression, Anxiety and Stress Scales. Data analysis was conducted by multivariate analysis of variance in the SPSS version 22.

**Results:** Spiritual-religious psychotherapy had significant effect in improving depression ( $F=138.47$ ,  $p<0.05$ ), anxiety ( $F=34.57$ ,  $p<0.05$ ), and stress ( $F=87.30$ ,  $p<0.05$ ).

**Conclusion:** Spiritual-religious psychotherapy can serve as an effective approach to improve mental distress in the elderly.

**Keywords:** Spiritual psychotherapy, religion, depression, anxiety, stress, elders.

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### Introduction

Ageing is associated with a wide range of physiological and psychological changes that lead to decline in quality of life and mental health (1). It has been projected that the world population will reach 7.823 billion by 2025, 10.4% of whom are the elderly (2). It has been also estimated that the elderly population of Iran will reach over 26 million by 2050, comprising approximately 23% of the national population (3).

Mental dimension is one of the important areas of elderly health that requires further attention to prevent mental distress such as depression, anxiety, and stress (3). Around 15-20% of the elderly have serious mental health issues (4, 5). Increasing age, the loss of loved ones especially the spouse, being away from children, chronic physical diseases, the use of various drugs, cognitive decline, and natural and biological factors are certain factors that predispose the elderly to developing mental

distress (6).

Depression is one of the most common psychiatric disorders and risk factors for suicide among the elderly particularly women, representing the cause of 24% of all successful suicide attempts in this age population (7). The prevalence of depression is 1% in the general population while 24% of the elderly population develop subclinical depression (8, 9). The study of Foroughan et al. indicated that one third of the elderly outpatients referring to the health facilities suffered from mental distress. Anxiety and stress are also prevalent among the elderly (10). The elderly particularly those who live in nursing homes are predisposed to comparatively more severe stress and anxiety because of decrease in self-confidence, physical inactivity, loss of friends and relatives, decrease in fiscal and physical autonomy, and development of chronic diseases (11). The prevalence of depression in

the elderly varies between 4% and 6% (12). When the elderly are exposed to intensified stress and anxiety, the incidence of different diseases such as respiratory and heart diseases increases in them and their immune system is suppressed (13).

Given the aging-related issues that have so far been addressed, it is important to develop interventions that can deal effectively with these issues. Spiritual-religious interventions represent an effective approach to decrease mental distress (14). Religion and spirituality are two of the cultural factors that integrate humans' experiences, behaviors, and values into a coherent structure (15). As an efficient skill to cope with psychological tensions, increase self-confidence, induce optimism, give meaning to life, and satisfy intrinsic needs such as establishing a positive relationship with others by adopting a healthy lifestyle, spiritual and religious beliefs lead to the promotion of physical and mental health (16). Studies have shown that spirituality- and religion-based interventions can be used to prevent and treat mental distress (17-19). Barrera et al. (20) and Stanley et al. (21) have reported that that spiritual-religious treatments are efficient to decrease anxiety and depression. Studies in Iran have also shown that spiritual-religious interventions lead to decrease in mental distress (15) and death anxiety (22) as well as decrease in the psychological symptoms in schizophrenia patients (23).

Given the above-mentioned, the elderly suffer from severe mental distress. Besides that, because the elderly population is increasing, it is essential to pay attention to distress of this age population to implement preventive and therapeutic interventions. Because spiritual health is being addressed as one of the dimensions of human health (24), interventions for this dimension of health can lead to the promotion of human health. Studies have also demonstrated that spiritual-religious treatment has optimal effects on individuals' life and health, and it is therefore necessary to investigate these interventions with respect to the native and cultural contexts of Iran to localize and then apply them to the elderly

population in Iran. Our aim was therefore to investigate the efficacy of spiritual-religious psychotherapy on the components of mental distress (depression, anxiety, and stress) among the elderly.

## Methods

The study population of this semi-experimental study with control group and pretest-posttest, consisted of all elderly living in the nursing home of Bandar Abbas, southern Iran in 2016. Samples (n: 28) were selected by convenience sampling and inclusion criteria. Then, they were randomly divided into two groups, i.e. experimental (n: 15) and control (n: 13). The inclusion criteria were living in nursing home, providing consent to participate in the study, lack of receiving psychotherapy and counseling services throughout the intervention in question, and the lack of substance dependency and psychological problems. The experimental group attended eight 2-hour psychotherapy sessions, one session per week. The psychotherapy intervention was a combination of previously studied protocols (15, 18, 22, 25) and approved by a number of psychology professors. The control group received no intervention.

The eight intervention sessions are summarized briefly as follows: First session 1: Welcoming; explaining the rationale for the study; determining the time and duration of the sessions; explaining the purposes of the study; discussing aging, mental distress as well as spirituality and religion and the impact of the relevant attitudes on life; second session: The role of trust in God in life, citing hadiths and narrations regarding the role of trust in God in the peace of mind; recital and prayer and their relationship with the peace and quality of life; Session 3: Self-awareness and relationship with self and listening to the inner voice, positive thinking, and patience and tolerance and their effects with reference to the hadiths and narrations; the fourth session: Discussing the role of Divinity in life, discussing the lack of disagreement between God's satisfaction and praying, and making attempt, teaching the ways to attain God's satisfaction, communicating with the sacred; the fifth

session: Discussing death and the meaning and purpose of life with reference to the relevant hadiths and narrations; the sixth session: Discussing and teaching the concepts about forgiving oneself and others, and altruism and its consequences; seventh session: Discussing the reality of the world, citing the hadiths and narrations regarding the realities of the world from a religious perspective, the role of hope and contentment in mental relaxation and citing the relevant hadiths and narratives; and the eighth session: Acknowledgment and thanksgiving for the Creator, reviewing the protocol and its purposes, reviewing the raised issues, eliciting the attendants' feedbacks, asking and answering questions, rounding up the whole sessions, distributing and completing the questionnaires, and closing the session.

#### Depression, Anxiety and Stress Scales (DASS)

DASS was developed by Lovibond and Lovibond to measure psychological problems. This questionnaire consists of three subscales [21 items (seven items for each of the depression, anxiety, and stress subscales) rated on a 4-point Likert scale (0-3)] and addresses the frequency of the symptoms in question in the past week (26). The reliability coefficients of this questionnaire was derived 0.70, 0.66, and 0.76 and its criterion validity coefficients with the Beck Depression Inventory reported 0.66, 0.67, and 0.49 for the depression, anxiety, and stress subscales, respectively, in a study with a general (400-individual) population in Mashhad, northeast Iran (27). This scale has been found to have acceptable validity and reliability; however, we investigated its face validity and five professors and Ph.D students of psychology confirmed its content validity. Regarding reliability, the Cronbach's alpha coefficients of the depression, anxiety, and stress subscales were derived 0.080, 0.69, and 0.76, respectively, and that of the whole DASS was derived 0.90.

Data analysis was conducted by descriptive statistics [mean and standard deviation (SD)] and inferential statistics [multivariate analysis of variance (MANOVA)] in the SPSS version 22.

## Result

The mean ( $\pm$ SD) age of the experimental group was  $59.46 \pm 11.49$  years and that of the control group was  $64.69 \pm 9.86$  years.

The mean ( $\pm$ SD) pretest scores on the depression, anxiety, and stress subscales were 12.26 ( $\pm 4.81$ ), 11.33 ( $\pm 6.22$ ), and 16.26 ( $\pm 3.95$ ), respectively, and that on the whole DASS was 39.86 ( $\pm 13.41$ ). The mean ( $\pm$ SD) post-test scores on the depression, anxiety, and stress subscales were 6 ( $\pm 2.75$ ), 7.66 ( $\pm 4.08$ ), and 6.73 ( $\pm 3.23$ ), respectively, and that on the whole DASS was 20.40 ( $\pm 8.22$ ). There were significant differences between the mean pretest scores and the corresponding post-test scores in the experimental group, but the corresponding differences in the control group were not significant (table 1).

Table 1. Descriptive statistics of control and experimental groups

Experimental Group					
Variable	Test state	Mean	SD	Min	Max
Depression	Pre-test	12.26	4.81	4	20
	Post-test	6	2.75	1	12
Anxiety	Pre-test	11.33	6.22	3	21
	Post-test	7.66	4.08	2	14
Stress	Pre-test	16.26	3.95	7	20
	Post-test	6.73	3.23	14	2
Mental distress	Pre-test	39.86	13.41	14	61
	Post-test	20.40	8.22	9	40
Control group					
Depression	Pre-test	17.15	2.88	11	21
	Post-test	17.69	2.46	14	21
Anxiety	Pre-test	14.15	2.40	10	18
	Post-test	15.23	2.35	9	18
Stress	Pre-test	16.69	2.42	13	21
	Post-test	16.68	2.21	13	20
Mental distress	Pre-test	48	5.08	39	58
	Post-test	49.61	3.64	42	54

The use of MANOVA requires certain assumptions. If the assumptions are confirmed, MANOVA will be used. Therefore, we first investigated these assumptions.

The normal distribution of scores is one of the assumptions to conduct MANOVA. Shapiro-Wilk test was used to investigate the distribution normality of the scores. The significance levels (p values) for all variables were over 0.05, indicating that the post-test scores on depression, anxiety, and stress were

normally distributed in both the experimental and control groups.

Another assumption to conduct MANOVA is homogeneous variances in the variables in question between the two groups of the study. The F values were not derived significant for stress, anxiety, and depression ( $p < 0.05$ ) and therefore the assumption of the equality of variances was confirmed.

There were significant differences in stress ( $F = 87.30$ ,  $p < 0.001$ ), anxiety ( $F = 34.57$ ,  $p < 0.001$ ), and depression ( $F = 138.47$ ,  $p < 0.001$ ) between the experimental and control groups (Table 4). There were significant differences between the mean pretest scores and the corresponding post-test scores in the experimental group, but the corresponding differences in the control group were not significant (Table 2). Therefore, our hypothesis stating that spiritual-religious psychotherapy causes relief of depression, anxiety, and stress in the elderly was confirmed.

Table 2. Results of multivariate analysis of variance on test effect on mental distress components

Variable	Source	SS	df	MS	F	P
Stress	Intercept	3821.72	1	3821.72	483.05	.001
	Group	690.72	1	690.72	87.30	.001
	Error	205.70	26	7.91		
Anxiety	Intercept	3651.32	1	3651.32	316.82	.001
	Group	369.46	1	398.46	34.57	.001
	Error	299.64	26	11.52		
Depression	Intercept	3909.23	1	3909.23	568.55	.001
	Group	952.08	1	952.08	138.47	.001
	Error	178.76	26	6.87		

## Discussion

The current study was conducted to investigate the efficacy of spiritual-religious psychotherapy on the components of mental distress (depression, anxiety, and stress) in the elderly. Our results showed that the group spiritual-religious psychotherapy effectively improved the components of mental distress, i.e. depression, anxiety, and stress. The study of Stanley et al. with 66 older people showed that the spiritual-religious psychotherapy was highly effective to decrease depression and anxiety in their participants and that they preferred to undergo this type of psychotherapy (21).

The study of Barrera et al. showed that a 12-session spiritual-religious psychotherapy intervention caused decrease in the main symptoms of anxiety such as worry in the elderly. That study also showed that the assumptions and religious attitudes and practices had a direct correlation with the reduction of anxiety (20). The study of Bagheri et al. with the wives of the substance-dependent people showed that the spiritual-religious psychotherapy led to decrease in depression, anxiety, and stress (15).

Different dimensions of spirituality and religion can play significant roles in the stability of the people's emotional well-being with respect to their cognitive, behavioral, emotional, and ontological components. Individual skills such as prayer, recital, and engagement in pleasurable spiritual activities lead to favorable mood and behavioral changes.

Rahmati et al. reported that spiritual-religious treatment had optimal effects on severe psychiatric disorders such as schizophrenia, and improved such patients' conditions (23). In addition to affecting psychological dimension, spirituality and religion can also influence the body such that enhanced levels of spirituality and related experiences significantly decreases blood pressure in the hypertensive people and mortality in the cardiovascular disease patients (28). Spirituality can even lead to adaptation and endurance of physical and mental suffering (29, 30). In fact, spirituality makes a man see his life as meaningful and be persuaded to tolerate the problems, adopt a positive attitude, and interpret the life events optimistically. In other words, spirituality leads to finding meaning in negative experiences and looking at them from a positive perspective, enduring suffering, believing in the existence of a spiritual and powerful source, adopting a moral orientation, cooperating with the people, and increasing life expectancy (30).

In our community, religion accompanies the individuals from the very beginning of their lives; the whisper of the adhan in the ears of the baby undoubtedly fits in the baby's brain and is consciously or unconsciously integrated with the feelings of the child. The existence of



religious places and the recourse of people, under all circumstances, to these places indicate the power of religion in the relaxation of individuals. In fact, religion is considered one of the psychological supports of individuals. Kim and Seidlitz consider religion and spirituality a form of coping and argue that human beings use their spiritual and religious capacities to cope with the tensions and stress in life (16). Reviewing 130 articles about spiritual-religious coping strategies, Pargament and Raiya reported that 34% of the studies reported positive results regarding spiritual-religious coping and that the most successful type of spiritual-religious coping was perceived God's assistance or guidance and shared coping in which decisions were made with hope for God's assistance and the help of religious guidance (31).

Salajegheh and Raghobi reported that spiritual-religious treatment increased the capability of coping with death anxiety among the patients with cancer by reinforcing cognitive abilities (22). Indeed, the elderly can use their spiritual-religious capacities to cope with physical and mental illnesses.

## Conclusion

Taken together, spiritual religious psychotherapy effectively helps the elderly control and cope with the tensions and stress in life by providing strategies and strengthening the religious and spiritual foundations for them, and therefore their psychological distress is improved. The results of this study should be generalized cautiously. Because of certain limitations, including the lack of adequate time, we could not follow up our participants. Officials should pay further attention to mental distress among the elderly due to the high frequency and severity of this issue in this age population.

Therefore, identifying the sources of mental distress in the elderly and implementing early interventions such as spiritual-religious treatment according to the religious context of the community can be an important step to providing mental health for this honorable age group. Therefore, policymakers and planners, as well as physicians, counselors, psychologists and other health professionals are advised to apply this

therapeutic approach according to the research findings so that the elderly can live a happy life and improve the quality of their lives by reducing mental distress.

## Conflict of interest

The authors declare no conflict of interest.

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