Original Article

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Effect of Religion-Based Spirituality Education on Happiness of Postmenopausal Women: An Interventional Study

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Abstract

Background and Objectives: Psychological health in postmenopausal women is important. For this reason, to enhance their sense of biological happiness, religion-based spiritual therapy has been sought as a way to create happiness. This study was conducted to determine the effect of religion-based spirituality education on the happiness of postmenopausal women.

Methods: This randomized interventional study was performed on 70 postmenopausal women in 2019. They were randomly allocated into two groups (35 control and 35 intervention). Spirituality therapy was held in six 90-minute sessions once a week, through interactive lectures, group discussion, brainstorming, memory and storytelling, and feedback. Demographic data and the Oxford happiness questionnaire were used for data collection. These questionnaires were completed by both groups before, immediately after, and one month after the intervention, with the researcher's presence to answer the research questions. The obtained data were analyzed using the Chi-square, independent t test, and Analysis of Variance (ANOVA) with repeated measure in SPSS 16.

Results: The mean score of happiness in postmenopausal women was significantly higher in the intervention groups immediately ($P<0.001$) and one month after the intervention ($P=0.04$) compared to the control group. The effect size of intervention on happiness was 0.123.

Conclusion: Religion-based spirituality education is recommended as a practical and straightforward way to promote the happiness of postmenopausal women. However, further studies are recommended, due to insufficient evidence.

Keywords: Education, Happiness, Mental Health, Postmenopausal Women, Spirituality.

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Introduction

Women's mental health is one of the main pillars of social development [1]. A group of researchers in mental health has employed a different theoretical approach, called positive psychology. In this approach, mental health is regarded as a positive psychological functioning and well-being. The goal is to generate a platform for happiness and make people's lives better [2, 3]. Happiness is one of the significant components of positive psychology [4]. The concept of happiness is a status of joy or satisfaction (positive emotions), in other words, being satisfied with life and without depression and anxiety (negative emotions) [5]. The happiness of the Iranian people is 3%, and this indicated a low level of happiness in the people. The highest level of happiness throughout the world has been reported in Denmark: 8 out of 10. This high score means so much joy that is accounts for the happiness of the people of this country [6]. Some happiness outcomes include an increase in life satisfaction, a promotion of a positive attitude towards life, a positive self-concept, mental health and emotional balance, better sleep quality, and proper coping against

stress [7, 8]. In recent years, many researchers paid more attention to happiness [9].

Humans have different reactions to the same conditions and evaluate the situations based on their unique beliefs and values. External factors explain a small amount (only 8%) of the variance of happiness [10]. Hence, achieving happiness will be possible through paying attention to internal factors such as spiritual goals and values, basic needs, the meaningfulness of life, and the love of God [11]. Today communities have focused on the beginning of aging and menopause in women [12]. Menopause is a stage in life when women review their beliefs about themselves and the surrounding world. Thus, one of the changes that occur in menopause women is the uncertainty about the meaning of life with some futility and lack of purpose, which emphasizes the concept of meaning for this group of women [13]. There is a significant difference between the happiness of premenopausal and postmenopausal women. This difference necessitates an intervention that will enhance the happiness of this group of women [14].

Educations based on spirituality are different depending on the cultural and spiritual context of each community [15]. Spirituality is an influential factor in people's mental health, and [16] there is a positive relationship between spirituality and mental well-being, such as life satisfaction, which is a determining factors for a happy life [17]. Spirituality has an essential role in increasing the level of happiness [18]. Besides, it promotes coping strategies that decrease stress and depression [19]. With increasing life expectancy, it is expected that women spend one-third of their lives during and after menopause on average, so its problems and complications become more tangible [20]. In a comprehensive review on examining the hundreds of studies on the psychology of spirituality and religion, Zinnbauer and Pargament observed no clear consensus concerning distinguishing spirituality from religion [21]. Despite contradictory results on the separation of spirituality and religion, spirituality and religion overlap in many aspects [22]. Aloustani et al. proposed spiritual therapy as a treatment to improve the psychological status of the elderly [23]. Therefore, it seems necessary to prepare preventive and affordable interventions tailored with the cultural-religious context to improve the health of postmenopausal women in the community. This study aimed to determine the effect of religion-based spirituality education on the happiness of postmenopausal women. Our study results can be employed as a therapeutic strategy for the happiness of these women.

Methods

This study was a randomized intervention with an intervention and a control group. To determine the effect of religion-based spirituality education on the happiness of postmenopausal women, we selected 70 postmenopausal women (50-65 years old) referring to Akbarabad Health Center and bases 1, 2, and 3 of Akbarabad affiliated to Tehran University of Medical Sciences, Tehran, Iran, from 2018 to 2019. The sample size was calculated based on the comparison formula of means, 95% confidence level, and 80% test power. The standard deviation of the happiness score was also estimated to be 10, assuming the effect of education equal to 6 for significance. The sample size was calculated according to the formula for comparing the means with the values of σ_1=10, σ_2=10, $z_{1-\alpha/2}$=1.96, $z_{1-\beta}$=0.84, and d= 7. With this method, at least 32 people should be in each groups. The final sample size in each group was set to be 35 people, i.e., a total of 70 people, taking into account the 10% sample attrition [24].

The convenience sampling method was used to choose the participants. Then the samples were assigned to two groups of intervention (n=35) and control (n=35) using a random number table. First, a code from 01 to 70, was given to all research units. Then, we started with a point from the columns of the random numbers table with a finger, and the last two digits of each column, which included the number 01 to 70, were considered, and the higher numbers were ignored. Next, all relevant numbers were considered as the intervention group, and then the remaining 35 samples were considered as the control group. Sampling was continued to achieve the desired number.

Finally, 70 postmenopausal women aged 50-65 years who had a record in the listed health centers and had informed and free consent to enter the study and met the inclusion criteria, were selected.

The inclusion criteria included age (50-65 years), menopause (at least one year after the last menstrual period), literacy for reading and writing, no known mental disorder, no mourning during the previous six months about their first-degree relatives. The exclusion criteria included receiving psychological and psychiatric treatments, not attending training sessions (absence of more than one session), and the death of a first-degree relative during the study. The research instruments consisted of the 29-item Oxford Happiness Questionnaire (OHQ) and the demographic profile questionnaire with which data collection was performed in a self-reporting manner [25]. Demographic variables included age, education level, marital status, employment status, income adequacy, and exercise status. Adequacy of income based on questionnaire options was divided into sufficient or insufficient. Besides, the daily exercise of postmenopausal women was divided into doing exercise or not doing exercise. The OHQ was first developed by Argyle, Martin, and Crossland in 1989. This questionnaire is the opposite of the Beck Depression Inventory (BDI).

Twenty-one questions of this questionnaire were taken from BDI and were scored in reverse, and 11 items were added to it to cover other aspects of mental health. The final form of the questionnaire was prepared with 29-item multiple-choice questions in which, in each question, a person judges himself from feeling unhappy to feeling very happy. The questionnaire is scored on a 4-point Likert-type scale from 0 to 3. The first statement gets a score of 0, and the subsequent statements receive a score of 1 to 3, respectively. Thus, the minimum score for each sample is 0, and the maximum score will be 87. Higher scores represent more happiness [26]. The questions in this questionnaire examine the person's sense of happiness, optimism about the future, satisfaction with aspects of life, sense of personal control over the affairs of life and its satisfaction, power, and energy, passion in life, feeling of health, and well-being, loving others, reminiscence of past good memories, meaningfulness, and purposefulness of life, feeling of commitment and activity and perspective of people at the world with a sense of attractiveness and a feeling of interesting things. The research units chose one of the four options of each question according to their feelings.

In Iran, the OHQ was translated by Alipour and Noorbala, and 8 experts approved the accuracy of its translation. Moreover, the face validity of the questionnaire was confirmed by 10 experts. The validity and reliability of the questionnaire were tested with 110 undergraduate students of Allameh Tabatabaei University and Shahed University of Tehran, that the Cronbach's α of 0.98 and the reliability of 0.92 were achieved. Besides, the test-retest reliability after three weeks was obtained as 0.79 [27]. Abedi et al. reported the reliability of this questionnaire in students by determining the internal consistency of 0.85 and Spearman-Brown correlation coefficient of 0.79 and Guttman method of 0.78. To determine the reliability, we administered the questionnaire to a sample of 50 selected people and did the test-retest method with an interval of two months. Finally, the coefficient value of 0.73 was obtained. To determine the concurrent validity of the questionnaire, we calculated the correlation between this questionnaire and the Fordyce happiness inventory in a sample of 727 people, and the result was 0.73 [28].

After obtaining written consent and necessary permits, the researcher explained the goals and importance of correctly completing the questionnaire. Also, the participants' information would remain confidential so that research units could ethically participate in a free and informed manner. By referring to Akbarabad Health Center and bases 1, 2, 3, and 4 of Akbarabad, the researcher attempted to identify eligible people by obtaining the contact numbers of people aged 50-65 years and examining the medical records. Then, the researcher invited the qualified individuals to the Beryanak community house on a specified

date by phone call. In the meeting, the objectives, procedures, and ethical considerations, including the freedom to withdraw from the study at any time and the confidentiality of information, were fully elaborated. Then, the consent form was completed by the participants. Next, the demographic profile form and the Oxford happiness questionnaire were provided to the participants. The researcher provided a full explanation of how to respond to the questionnaire. Because six behavioral training sessions were held for the members of the experimental group, the test group was invited to attend on a given date. Besides, 24 hours before each training session, the participants were reminded via telephone to participate in the training class.

Subsequently, the educational sessions were derived from the spirituality training package of Lotfi Kashani et al. in 2012. This package was based on psychological-spiritual interventions proposed by Richard and Bergin. It was developed with an Islamic approach focused on self-awareness, trust and recourse, patience, forgiveness and remembrance, and problem-solving with a spiritual approach [29]. Training sessions were held in Haft Chenar Health House for six sessions of 90 minutes each (the number of sessions per week was set with the participants' agreement). The training included interactive lectures, group discussions by techniques of reminiscence, ideation, and emotional drainage of happiness with the cooperation of older women themselves. All classes were conducted under the supervision of an expert psychologist (Table 1).

All stages of spiritual therapy were conducted with the participation of women in small groups of 4 to 5 by the presentation of proposed solutions via their ideation and giving positive feedback. At the end of each session, we asked them to write their responses to the questions raised for the next session. At the beginning of each session, the review of responses and other group members' ideas were done for all individuals. Moreover, different ideas were summarized and prioritized regarding changes in women's views about happy life and its improvement during menopause. The final discussion and critique took place with the help of the group members' comments for the best approaches to happiness.

Sampling was carried out from December 22, 2018, to March 6, 2019, for two and a half months. Then, the extraction, analysis, and preparation of the final report lasted until July 2019. The total number of women who completed the questionnaires with informed consent was 70 people (35 persons in the control group and 35 persons in the experimental group). At the end of the intervention, the sample attrition in the intervention group was three people, two of whom were excluded from the study due to the absence of more than one session and one due to the death of her first-degree relatives. In the control group, there was one sample attrition who was excluded from the study due to her absence in the test sessions. The final analysis was performed on 66 women (34 in the control group and 32 in the experimental group). Thus, 4 people were excluded from the study (one from the control group and three from the experimental group). There was no possibility of blinding as the researcher was directly responsible for conducting the intervention program. Nevertheless, the extractors of the questionnaires and the analyzer of the data did not know which group was the intervention or the control, and the questionnaires of the two groups were separated by codes 1 and 2 that only the researcher was informed about it. To prevent information sharing between the two study groups, with the previous telephone coordination, we invited the intervention group to Beryanak community house separately from the control group, and the educational-behavioral program was held.

Similar to the process done for the intervention group, completion of the questionnaires was performed for the control group in three time points of before, immediately after, and one month after the intervention. In the control group, routine care was received provided by the health center. Finally, two training sessions similar to the ones of the intervention group were held for the control group after the end of the

Table 1. Spiritual therapy sessions for elderly women in Haft Chenar Health House, Tehran, in 2018

Sessions	Content	Presentation Method	Duration of Education
1	Introducing individuals and grouping, discussing the content of self-awareness, its types, and functions, and strategies to strengthen self-awareness	Group discussions and interactive lectures	90 min
2	Addressing the concept of forgiveness, its benefits and consequences, the stages of forgiveness and misconceptions about forgiveness and its outcomes, and members' memories of forgiveness and benevolence	Interactive lectures, ideation, and reminiscence	90 min
3	Discussing people's attitudes and behaviors with a variety of problems, patience, beliefs that debilitate patience, methods of nurturing and strengthening patience with respect to the experiences of women and how to live happily and behavioral outcomes of patient mood in life	Group discussion, reminiscence, and emotional drainage	90 min
4	Remembrance of God, types of remembrance (heart and verbal), consequences of remembrance, opportunities to use remembrance and ways to foster remembrance of God in hardships, ways to avoid sadness and depression in exemplary situations raised by members, and refining the soul and beauty from the perspective of members	Group discussion and reminiscence and expression of experiences	90 min
5	The concept of trust, the underlying beliefs of trust and God-centeredness (i.e., putting God first and allowing all activity in life to flow from the premise that God's priorities are the priorities of the individual), the consequences of trust in life, and common mistakes in trusting in God by reminiscence and expression of experiences	Interactive lectures, reminiscence, and expression of different experiences, and comparison of ideas	90 min
6	Problem-solving, problem-solving steps, religious and spiritual problem-solving skills, and spiritual problem-solving steps with the participation of women and the proposed solutions and summarizing	Ideation, proposing cases and examples, reminiscence, and providing feedback	90 min

course. Besides, both groups had the contact number of the researcher was to ask their questions if necessary. This study was approved by the Ethics Committee of Tehran University of Medical Sciences (No. IR.TUMS.FNM.REC. 1397.033 dated 3/7/2018) and was registered in the clinical trial registration database of the Ministry of Health under the number (IRCT20110425006284N14).

The data of both groups were collected, and analyzed in SPSS version 16. The obtained data were analyzed using descriptive and inferential statistics methods. The independent t -test and Chi-square test were employed to examine and compare the groups in terms of demographic variables. The independent t-test and repeated measures Analysis of Variance (ANOVA) was used to compare the happiness score and the mean difference before, immediately after, and one month after the intervention between both groups. The significance level in the tests was considered 0.05.

Result

The mean±SD age of the participants was 55.84±4.19 years in the intervention group and 54.74±3.8 years in the control group. Most postmenopausal women in both groups were married, homemakers, and were less educated. Only five people in the intervention group and one person in the control group had a high school diploma. Most women were in the age group of 50-54 years. There was no statistically significant difference between the two groups in terms of individual characteristics ($P<0.05$), and they were homogeneous (Table 2).

The repeated measures ANOVA demonstrated the intragroup effects of happiness scores ($P=0.17$, $F=4.344$) in the intervention group and ($P=0.456$, $F=0.794$) in the control group. Comparing three time points of before, immediately after, and one-month after the intervention was performed in the intervention group. The findings of Table 3 indicated a statistically significant difference between them ($P=0.017$). While the observed changes in the happiness scores of the control group in three time points of before, immediately after, and follow-up did not exhibit a statistically significant difference ($P=0.456$). The results of the Least Significant Difference (LSD) test (pairwise comparison of happiness) showed that the happiness of postmenopausal women in the intervention group had a statistically

significant difference immediately after the intervention compared to before the intervention (P=0.024). However, there was no significant difference one month after the intervention and immediately after the intervention based on the test results (P<0.05). Besides, the effect size in the intervention group was (0.123).

Table 2. Demographic characteristics of menopausal women in the intervention and control groups

Groups / Variable		Control	Intervention
		No. (%)	
Education	Elementary	11 (32.4)	7 (21.9)
	Intermediate	17 (50.0)	11 (34.4)
	High school	5 (14.7)	10 (31.3)
	Diploma or Higher	1 (2.9)	4 (12.5)
	Total	34 (100)	32 (100)
	The Chi-square test	X^2=5.580; df=3; P=0.143	
Age (years)	50-54	20 (58.8)	12 (37.5)
	55-59	10 (29.4)	11 (34.4)
	60-65	4 (11.8)	9 (28.1)
	Mean±SD	54.74±3.8	55.84±4.19
	The Independent t test	P=0.26; df=2; t=1.126	
Marital status	Single	۰ (۰)	2 (6.3)
	Married	19 (55.9)	24 (75.0)
	Divorced	5 (14.7)	2 (6.3)
	Widow	10 (29.4)	4 (12.5)
	Total	34 (100)	32 (100)
	The Chi-square test	X^2=6.380; df=3; P=0.078	
Employment Status	Employed	۰ (۰)	2 (6.3)
	Retired	4 (11.8)	7 (21.9)
	Housekeeper	30 (88.2)	23 (71.9)
	Total	34 (100)	32 (100)
	The Chi-square test	X^2=3.685; df=2; P=0.145	
Income	Enough	8 (23.5)	12 (37.5)
	Not enough	26 (76.5)	20 (62.5)
	Total	34 (100)	32 (100)
	The Chi-square test	X^2=1.52; df=1; P=0.282	
Exercise status	Sporty	13 (38.2)	9 (28.1)
	No exercise	21 (61.8)	23 (71.9)
	Total	34 (100)	32 (100)
	The Chi-square test	X^2=0.750; df=1; P=0.443	

Table 3. Comparison of happiness in postmenopausal women before, immediately after, and one month after the intervention in the intervention and control groups

Variable	Intervention			Control		
	Before the Intervention	Immediately After the Intervention	One Month After the Intervention	Before the Intervention	Immediately After the Intervention	One Month After the Intervention
Mean±SD	54.93±7.86	62.81±8.78	59.34±5.96	53.97±5.54	53.79±5.81	54.29±5.17
Effect size		0.123			-	
Repeated measures analysis of variance		P=0.017 F=4.344			P=0.456 F=0.794	
Time effect	F=3.004, P=0.045					
Group effect	F=35.541, P<0.001					
The interaction between time and groups	F=3.735, P=0.035					

Discussion

The analysis of demographic characteristics demonstrated that the intervention and control groups were homogeneous in terms of contextual variables that could somehow influence the study results. Moreover, following the study objective, spiritual therapy in this study could affect the happiness of postmenopausal women because the mean±SD happiness score before the intervention was 56.93±7.86, which increased to 62.81±8.78

immediately after the intervention. According to the results of the independent t-test, the two groups had a statistically significant difference a month later (P=0.001). The mean±SD happiness score of the intervention group a month later was 59.34±5.96, and there was still a significant difference with the mean±SD happiness in the control group equivalent to 55.29±5.17.

The results of the internal studies, including Sadr Damirchi et al. [30], Kamari et al. [31], Khalili Senobari et al. [32] as well as the foreign studies, including Samta P. Pandya [33] in which spirituality training was done as an intervention and the study of Mimi M. Y. Tse et al. [34], were consistent with the present study.

The study of Sadr Damirchi et al. was carried out to determine the effectiveness of group spiritual therapy on the happiness and psychological hardiness of older women. In their study, the mean score of happiness before the intervention was 49.99 in the control group and 49.33 in the intervention group. In this study, the mean±SD ages of the people in the experimental and control groups were 69±5.3 and 68±7.6, respectively [30]. The mean±SD ages in our study were 55.84±4.19 in the intervention group and 54.74±3.8 in the control group; that is, the mean age of women in both groups was lower than in the study of Sadr Damirchi. It seems that although happiness before the study was homogeneous between the two groups in the present study, similar to Sadr Damirchi's survey, as the age of women was lower, happiness scores were, however, higher in both groups before the study. Nevertheless, the results of their study were in line with the present study.

However, it can be stated that the ageing period is an appropriate time to find meaning and personal growth compared to other periods of life. The elderly is relieved of various life' responsibilities during this period, and the experiences and maturity they have gained in their lifetime are valuable assets that can make this period a time of relaxation and self-actualization. Age can be considered as an essential factor in regulating emotions and reducing negative emotions. It seems that the age factor can increase the meaning of life and psychological well-being. Old age can be a period of review and evaluation of oneself, and it can also be regarded as a continuation of the way of life, a time of growth and prosperity, and peace [22, 30, 23].

Kamari et al. aimed to determine the effectiveness of spirituality therapy training based on positivity on life expectancy and life satisfaction in adolescents. They also reported that the intervention group showed a statistically significant difference in the happiness score compared to the control group (P<0.05). Besides, the post-test scores of happiness in the intervention group increased significantly compared to the pre-test scores [31]. Khalili Sanobari carried out a study to examine the effect of spiritual-religious care on depression in women with multiple sclerosis. In this quasi-experimental study, 60 women with multiple sclerosis aged 20 to 45 years participated. The spiritual therapy intervention was held for 7 sessions of 45 to 60 minutes during 7 weeks with the members' agreement. Spiritual therapy training sessions were conducted in groups for the intervention group with regard to some of the spiritual interventions proposed by Richards and Bergin with the focus on issues such as prayer, self-awareness, forgiveness, patience, trust, recourse, and thanksgiving that a significant reduction in depression was reported after the intervention [32]. These findings suggest that the happiness of postmenopausal women as a result of spiritual therapy can be due to the reduction of depression in them.

Samta P. Pandya investigated the effect of spirituality training on the happiness and psychological well-being of adolescents 13- to 15-year-old. Thays reported that the mean score of satisfaction was 69.07 in the control group and 72.29 in the intervention group [33]. In the study of Samta P. Pandya, similar to the present study, there was no significant difference between the intervention and control groups in happiness scores before the intervention. The mean happiness scores in the Samta P. Pandya study are higher than the happiness scores of postmenopausal women before the intervention in our study. Psychological studies indicate a U-shaped relationship between age and happiness.

This U-shaped relationship is such that happiness is at the lowest in middle age. However, different happiness levels throughout a lifetime may be because of changing priorities of people, e.g. by reducing the importance of career and increasing the importance of health and loneliness or changing their environmental conditions [19, 33]. In any case, the intervention group in this study comprised postmenopausal women, and they are pretty different from other age groups such as adolescents in terms of factors related to happiness.

Mimi M. Y. Tse et al. examined the effect of humor therapy on reducing chronic pain and enhancing happiness and life satisfaction in a quasi-experimental study on 70 older people (36 in the intervention group and 34 in the control group). The samples comprised 38 women and 32 men with the age range between 65 and 95 years. They performed their intervention one hour a week for 8 weeks with joke programs, funny books and pictures, clips, cartoons and comedy videos, news and stories, and various fun tapes, which they shared in folders available to research units. Increasing the level of happiness and life satisfaction in the elderly was also confirmed after this intervention [34]. Therefore, there is a positive correlation between the two variables of happiness and the spiritual experiences of people, and it has been found that more spiritual people will have a happier life [30]. Of course, the relationship between spirituality and religion with mental health has long been of interest to various researchers, but still, further investigations on its dimensions are recommended [21, 35].

Akbari et al. examined the effectiveness of cognitive-behavioral and spiritual-religious interventions in reducing anxiety and depression in women with breast cancer. The results of their survey indicated that although the scores of anxiety and depression declined in the spiritual-religious and cognitive-behavioral groups, there was no significant difference between the groups in depression ($P>0.05$) and anxiety ($P>0.05$) [36]. Thus, the spiritual-religious intervention of this study failed to reduce depression and anxiety in women with breast cancer. The contradictory results can be attributed to differences in the study population because Akbari et al. studied women with breast cancer, while the participants in the present study were postmenopausal women without known underlying disorders. It appears that the physical and psychological consequences of cancer overshadow the effects of spiritual interventions. Among the strengths of this study was applying simple techniques in one of the critical periods of women's lives to promote positive psychological characteristics.

Conclusion

This study supports the positive influence of religious spirituality therapy on postmenopausal women, and the effect of this intervention in this study was determined to be 0.123.

Because of the positive impact of the religion-based spirituality intervention on the happiness of postmenopausal women, it is suggested that this type of spirituality training be implemented as a routine training in the care package of various groups, especially middle-aged people with techniques of reminiscence, ideation, and emotional drainage of happiness as an available method with the easy and affordable application through cultural centers or neighborhood houses or in health centers. Also, due to the particular position of women's health in the health sector, this should be taken into account by planners, senior managers, and executive managers of healthcare organizations.

However, our study has some limitations. The factors affecting happiness are diverse and vary in different people. Moreover, individual differences in connection with the level of happiness are frequent. To compensate for these limitations, the most common factors referred to in the scientific literature were included as demographic characteristics or the inclusion criteria. On the other hand, religious beliefs will ultimately affect happiness by reducing anxiety and stress [37] and giving hope to life [14]. In the postmenopausal women investigated in this study, a spirituality training package was employed that was adapted to the religious and cultural beliefs of the study population [29]. Furthermore, the social and cultural components of communities, including economic issues and

financial pressures imposed on people, the loneliness of people, poverty, misery [37], and spirituality are among the factors influencing the happiness or sadness of individuals that their control is mainly in the hands of key health policymakers [37, 38].

Ethical Considerations

This study was approved by the Vice-Chancellor for Research, Tehran University of Medical Sciences (No. IR.TUMS.FNM.REC. 1397.033 on 3/7/2018).

Conflict of interest

The authors declared no conflict of interest.

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تأثیر آموزش معنویت با رویکرد مذهبی بر شادکامی زنان یائسه: یک مطالعه کارآزمایی بالینی

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چکیده

سابقه و هدف: با توجه به اهمیت سلامت روان‌شناختی در زنان یائسه به منظور ارتقای حس شادمانی زیستی در آنان، آموزش معنویت مبتنی بر اصول مذهبی به عنوان یک روش برای ایجاد شادکامی مورد سؤال قرار گرفته است. بنابراین مطالعه‌ای با هدف تعیین تأثیر معنویت‌درمانی با رویکرد مذهبی بر شادکامی زنان یائسه انجام گرفت.

روش کار: این مطالعه کارآزمایی بالینی تصادفی در سال ۱۳۹۷، روی ۷۰ زن پس از شروع یائسگی (۳۵ نفر در گروه کنترل و ۳۵ نفر در گروه مداخله) انجام شد. برای تخصیص تصادفی نمونه‌ها به دو گروه کنترل و مداخله از روش جدول اعداد تصادفی استفاده شد. برنامه معنویت‌درمانی در شش جلسه ۹۰دقیقه‌ای و به صورت هفته‌ای یک‌بار به شیوه سخنرانی تعاملی، بحث گروهی، ایده‌پردازی، خاطره‌گویی و ارائه بازخورد، برگزارشد. ابزار گردآوری داده‌ها، پرسش‌نامه اطلاعات جمعیت‌شناختی و پرسش‌نامه شادکامی آکسفورد بود. پرسش‌نامه، قبل، بلافاصله بعد از انجام مداخله و نیز یک ماه بعد از مداخله توسط هر دو گروه به صورت خودگزارش‌دهی و با حضور پژوهشگر برای پاسخ‌دهی به سؤالات احتمالی واحدهای پژوهش تکمیل شد.

یافته‌ها: میانگین نمره شادکامی زنان یائسه در دو گروه، بلافاصله ($P<۰/۰۰۱$) و یک ماه بعد از مداخله ($P=۰/۰۴$) نیز از گروه کنترل بیشتر بود و تفاوت معنی‌داری داشت. میزان اثر مداخله بر شادکامی ۰/۱۲۳ بود.

نتیجه‌گیری: معنویت‌درمانی مبتنی بر اخلاق مذهبی به عنوان روشی ساده، مقرون به صرفه و کاربردی برای ارتقای شادکامی زنان سالمند پیشنهاد می‌شود. با این حال، با توجه به کمبود شواهد، انجام مطالعات بیشتر توصیه می‌شود.

واژگان کلیدی: سلامت روان، شادکامی، معنویت‌درمانی، یائسگی.

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