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Effects of Spiritual Interventions on Happiness Level of the Female Elderly Residing in Nursing Home

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Abstract

Background: Spiritual health is one of the dimensions of health. Currently, studies have identified a link between happiness and spiritual health; however, the effects of spiritual interventions on happiness have not been evaluated among the elderly.

Aim: This study aimed to evaluate the effects of spiritual interventions on the happiness of the female elderly.

Method: A total of 40 subjects were randomly allocated to two intervention and control groups in Madar Nursing Home in Sabzevar, Iran, in 2019. In the intervention group, spiritual interventions were performed as active listening, supporting religious rituals, using supportive systems, and arousing hope for 4 weeks. The happiness level of the participants was assessed before, immediately after, and a month after the intervention using the Oxford Happiness Questionnaire. Data analysis was performed by SPSS software (version 21) using descriptive and inferential statistics.

Results: The mean scores of happiness before the intervention were 45.6 ± 1.2 and 36.5 ± 11.9 in the intervention and control groups, respectively. However, the scores altered to 65.1 ± 9.9 and 35.3 ± 9.4 immediately after the intervention, as well as 64.7 ± 9.7 and 35.1 ± 8.9 a month following the intervention, in the intervention and control groups, respectively. The repeated measures analysis of variance indicated a significant difference among the groups by determining the effect of the happiness score before the intervention ($P < 0.001$).

Implications for Practice: According to the obtained results, spiritual interventions increased the happiness level of the female elderly. Therefore, it is concluded that spiritual interventions can be considered practical approaches to improve the happiness of the elderly.

Keywords: Aging, Happiness, Nurse, Spiritual care

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Introduction

One of the most important mental needs of human beings is happiness. Happiness is considered a positive internal experience and one of the indicators of mental health resulting from the cognitive and emotional evaluation of the elderly (1). In other words, happiness and joy are among the necessary primary and natural requirements of humans and can be considered among the most important factors for family and community health. The spirit of hope, progress, and effort emerges in the light of a happy life (2).

The happiness level of the elderly has been reported low based on the results of studies conducted by Jafari (2017), Ghaderi (2010), and Jamalzadeh (2013) (3-5). According to the evidence, it was shown that the happiness level of the elderly living at home is significantly higher, compared to those residing in nursing homes due to the factors, such as social support, family affection, and respect. Nevertheless, living in nursing homes leads to lowered mood, as well as a lack of satisfaction and happiness (6). The absence of social relationships and decreased physical and mental health of the elderly are indicative of dissatisfaction and unhappiness in this group of society (5).

To date, studies have been performed to improve the happiness of individuals using several techniques, such as undergoing schema therapy and group therapy narration (7), as well as performing cardio exercises (8). The provision of spiritual care is another method to increase happiness and satisfaction with life and raise hope for the future (9). A person can continue to grow during aging while adapting him/herself to the changes and losses and pass the remaining years of life with a feeling of being valuable and effective, in a way that he is satisfied with life. In this context, it seems that spirituality helps individuals better perceive their life by providing a set of words and frameworks (3).

Spiritual care is a unique aspect of nursing and cannot be replaced by social, mental, or religious care. Patient-nurse interaction is facilitated by spiritual care, and nurses can create spiritual power in patients by encouraging them to remember the past and emphasizing the special events, thereby improving their interactions with other family members, environment, nature, and superior power (10, 11). Ellison stated that the daily spiritual experiences of individuals are related to various mental welfare aspects of the elderly (i.e., happiness, satisfaction with life, and hope for the future) (9).

According to the literature, spiritual-social interventions decreased depression symptoms and improved the spiritual welfare of the patients (12). The results of another study showed that the spiritual experiences of patients and reminding their spiritual memories increase hope, satisfaction with life, and spiritual welfare (13). The results of an interventional study in which used hope inducing intervention and active listening (as spiritual care) were indicative of the improved spiritual health of the elderly (1).

A study was conducted by Yarmohammadi et al. to assess the relationship of spiritual health with the happiness and occupational satisfaction of elderly caregivers. The obtained results were indicative of increased spiritual health, happiness, and occupational satisfaction in the aforementioned individuals of nursing centers (14). It can be indicated that spirituality is the most important factor for improving the attitude of individuals toward life (15). A person is happy when she/he has a positive attitude toward life, and thinking about life creates positive emotions in him/her (16).

Recently, descriptive studies have evaluated the relationship between spirituality and happiness (2, 17, 18). However, no standard method has been designed to provide spiritual care in nursing. Numerous nursing interventions, which can be implemented individually, as a package of interventions or in the form of a group, have been reported in different resources. One or several spiritual interventions (e.g., active listening, reading the Quran or saying prayers, arousing hope, poetry therapy, meditation, reminiscence therapy, and prayer therapy) can be selected and implemented by nurses based on patients' needs (19).

According to the above-mentioned statements, studies have assessed the relationship between spirituality and components, such as spiritual health, mental health, quality of life, and life satisfaction. However, to date, the effects of spiritual care on the happiness of the elderly have not been directly evaluated. Given the limited number of studies on the provision of spiritual care interventions for the elderly and regarding the important role of nurses in providing care services for patients, this study aimed to evaluate the effect of spiritual care on the happiness of the elderly living in a nursing home.

Methods

This randomized controlled clinical trial with the pretest-posttest design was conducted on two groups of control and intervention. The study population included all the residents of Madar Nursing Home in Sabzevar, Iran. This center has accepted 157 female elderly on a 24-hour basis. It is one of the largest nursing home care centers in the northeast of Iran. However, a total of 40 subjects were selected through convenience sampling and randomly assigned to two control (n=20) and intervention (n=20) groups via the permuted block technique. The sample size was calculated to detect an average difference of 7.16 and a difference of standard deviation of 1 in terms of happiness between the two groups using G*Power software, 3.1 version.

In each group, 20 individuals were calculated with a confidence interval of 95%, effect size of 0.92, and test power of 80%. During the study, two participants were withdrawn from the study, namely one from the intervention group due to hospitalization and one from the control group due to death. Finally, the collected data from 38 participants in the control (n=19) and intervention (n=19) groups were analyzed. The inclusion criteria were willingness to participate in the study, age of over 60 years, ability to speak Farsi, residence in the nursing home for at least one month, belief in Islam, and lack of concomitant participation in other relevant studies.

On the other hand, the exclusion criteria were the presence of visual or hearing impairments, mental disorders based on the medical records of the subjects, and experience of stressful events in the past 3 months (e.g., losing spouse or a loved one). In addition, the withdrawal criteria during the study were the presence of an acute disease and hospitalization during the intervention, missing more than two sessions, and experiencing social and family crises during the study period.

Data collection tools included the demographic characteristics form and Oxford Happiness Questionnaire for assessing the level of participants' happiness. The happiness level of the subjects was assessed before the intervention by a researcher, who was unaware of the groups, via the completion of the happiness questionnaire. Moreover, in this study, the statistics counselor was also blind and not aware of the allocation of the elderly to the intervention and control groups.

The Oxford Happiness Questionnaire (1982) consists of 29 items and is scored based on a Likert scale. The validity of this tool has been reported as 0.91 by Alipour et al. In addition, the scores of 0, 1, 2, and 3 are allocated to the alternatives a, b, c, and d, respectively, and the sum scores of all the items crossed by the subjects in each group were calculated. Therefore, the final score would be within the range of 0-87 based on the number of items (29). In the present study, the reliability of the Oxford Happiness Questionnaire was obtained using Cronbach's alpha of 0.97.

After the completion of the questionnaires in the intervention group, the spiritual health service package was provided by the researcher, including active listening and supportive presence, supporting religious rituals, using supportive systems, and arousing hope. For supportive presence and active listening, the researcher firstly studied the medical files of the subjects and interviewed them to become acquainted with these individuals and visit them daily. The researcher talked and actively listened to the participants' problems and concerns individually, while holding their hands, and answered their questions. In terms of religious rituals, the participants were provided with facilities (e.g., turbah, praying rug, praying chador, Quran, and Mafatih) every day for the acts of worship.

In addition, the subjects were helped in acts, such as tayammum, wudu, and saying prayers. Moreover, the presence of clergies, visitors (i.e., the families of the participants), and benefactors were used as support systems weekly. In order to induce hope, the elderly were motivated to write down the strengths and pleasant memories relevant to the positive and successful events of their life (e.g., career, emotional, or family situations). However, the researcher recorded this information due to the illiteracy of most participants. These reports were reviewed by the subjects the next day or recited by the participants for others in case of the individuals' desire. During the intervention, the participants in the control group were provided with routine care by the nursing home. Immediately after and one month following the intervention, the Oxford Happiness Questionnaire was completed for both groups.

The study protocol was approved by the Ethics Committee of Sabzevar University of Medical Sciences (IR.MEDSAB.REC.1397.051). A clear and simple explanation of the research design, objectives, possible benefits and values, tools and instruments, as well as the withdrawal conditions, were presented to the participants. Furthermore, the researchers ensured the subjects of the confidentiality terms regarding their personal information and obtained informed consent prior to the

study participation.

Data analysis was performed in SPSS software (version 21) using the Shapiro-Wilk test (to evaluate the normal distribution of the quantitative variables), independent t-test, Mann-Whitney U test, and repeated measures analysis (to determine intragroup and intergroup differences regarding the distribution of the measured variables). In addition, the data were analyzed using the Chi-square test (to determine the significance of clinical and demographic variables in the control and intervention groups). Moreover, a p-value less than 0.05 was considered statistically significant.

Results

In this study, no significant difference was observed in terms of the mean age, duration of residency in the nursing home, mean number of visits per month, level of income, level of blood lipid, marital status, previous occupational status, diagnosis of various diseases, depression and addiction, custody status, and movement of the subjects between the intervention and control groups (Table 1).

Table 1. Comparison of demographic variables in control and intervention groups

Demographic variable	Intervention	Control	P-value
Mean age	77.9±7.6	80.9±10.0	*P=0.31
Duration of residency in nursing home (month)	47.9±53.1	47.7±47.7	**P=0.08
Mean number of visits per month	1.8±1.5	1.6±1.4	**P=0.91
Marital status	Single n (%)	1 (5.3%)	***P=0.99
	Married n (%)	1 (5.3%)	
	Divorced n (%)	0 (0%)	
	Deceased spouse n (%)	16 (84.2%)	
Educational level	Illiterate n (%)	16 (84.2%)	***P=0.60
	Elementary n (%)	2 (10.5%)	
	Higher than elementary n (%)	1 (5.3%)	
Previous occupational status	Worker n (%)	3 (15.8%)	****P=0.29
	Unemployed/Housewife n (%)	16 (84.2%)	
Level of income	Low n (%)	8 (42.1%)	***P=0.06
	Sufficient n (%)	7 (36.8%)	
	High n (%)	4 (21.1%)	
Level of participation in religious rituals	Always n (%)	6 (31.6%)	****P=0.69
	Most of the time n (%)	6 (31.6%)	
	Sometimes n (%)	5 (26.3%)	
	Rarely n (%)	2 (10.5%)	
Custody status	No custody n (%)	6 (31.6%)	****P=0.45
	Custody of children n (%)	8 (42.1%)	
	Custody of others n (%)	5 (26.3%)	
History of hypertension	Yes n (%)	13 (68.4%)	****P=0.32
	No n (%)	6 (31.6%)	
History of blood lipid	Yes n (%)	5 (26.3%)	***P=0.06
	No n (%)	14 (73.37%)	
History of diabetes	Yes n (%)	4 (21.1%)	***P=0.34
	No n (%)	15 (78.9%)	
Depression	Yes n (%)	4 (21.1%)	***P=0.99
	No n (%)	15 (78.9%)	
Addiction	Yes n (%)	4 (21.1%)	***P=0.99
	No n (%)	15 (78.9%)	
Ability to move and walk	Without assistance and aids n (%)	7 (36.8%)	***P=0.34
	Without assistance with aids n (%)	6 (31.6%)	
	With others' assistance n (%)	6 (31.6%)	

*: Independent t-test; **: Mann-Whitney U test; ***: Fisher's exact test; ****: Chi-square test

The results of the Shapiro-Wilk test showed that the data distribution was not normal at all three time points. According to the results of the Mann-Whitney U test, there was a significant difference in the mean scores of happiness at three time points in both control and intervention groups among the participants. The mean scores of happiness before the intervention were 45.6 ± 1.2 and 36.5 ± 11.9 in the intervention and control groups, respectively. However, the scores altered to 45.6 ± 1.2 and 35.3 ± 9.4 immediately after the intervention ($P < 0.001$) and 64.7 ± 9.7 and 35.1 ± 8.9 a month following the intervention in the intervention and control groups, respectively ($P < 0.001$).

The repeated measures analysis of variance (ANOVA) was used to investigate the effects of time and group, as well as the interaction of time and group effect. The results of the repeated measures ANOVA by determining the effect of the happiness score before the intervention showed that time did not have a significant effect on happiness ($P = 0.33$). Furthermore, the repeated measures ANOVA indicated a pattern of changes regarding happiness which was not statistically different between the two groups (i.e., the interaction of time and group) ($P = 0.90$). However, the mean values of happiness scores showed a significant difference between the groups by determining the effect of happiness score before the intervention ($P < 0.001$). This finding revealed that the average score of happiness depends on the type of treatment. Therefore, the effect of the intervention was significant considering the average scores.

The results of the Friedman test revealed a significant difference in the mean happiness scores of the intervention group during 3 months before (45.6 ± 14.1), immediately after the intervention (65.1 ± 9.9), and a month after the intervention (64.7 ± 9.7) ($P < 0.001$). Nevertheless, in this regard, no significant difference was observed in the control group ($P = 0.93$; Table 3).

Table 2. Comparison of mean happiness scores (before, immediately after, and one month following the intervention) between control and intervention groups

Happiness score	Group	Mean \pm standard deviation	P-value
Before intervention	Control	36.5 ± 11.9	*0.02
	Intervention	45.6 ± 1.2	
Immediately after intervention	Control	35.3 ± 9.4	* < 0.001
	Intervention	65.1 ± 9.9	
One month following intervention	Control	35.1 ± 8.9	* < 0.001
	Intervention	64.7 ± 9.7	

*: Mann-Whitney U test

Table 3. Comparison of mean happiness scores at three different time points in each group

Group		Mean \pm standard deviation	P-value
Control	Before intervention	36.47 ± 11.87	* $P = 0.93$
	Immediately after intervention	35.31 ± 9.41	
	One month following intervention	35.11 ± 8.94	
Intervention	Before intervention	45.6 ± 14.1	* $P < 0.001$
	Immediately after intervention	65.1 ± 9.9	
	One month following intervention	64.7 ± 9.7	

*: Friedman test

Discussion

According to the obtained results of the present study, spiritual care increased the happiness level of the elderly in the intervention group, which is in line with the finding of a study by Damirchi et al. In the aforementioned study, it was reported that spiritual group therapy increased the level of happiness and psychological hardness of female elderly. However, the effectiveness of group therapy cannot be neglected in the aforementioned study since participation in group sessions calmed the subjects in performing their tasks. In addition, sharing their issues with others decreased their anxiety and stress and increased their compatibility with various issues (21).

Although there was no therapeutic group in the present study, the interventions, such as meeting with acquaintances, as well as the presence of clergies and philanthropists, caused the participants to come

out pure introversion and become aware of those around them. Therefore, the findings of the current study are in line with the results of the study carried out by Damirchi et al.

Similarly, Moeini et al. demonstrated that religious programs based on Islam increased spiritual well-being, which is in line with the obtained findings of the present study (22). In the current study, one of the interventions was to support religious ceremonies which provided facilities for the elderly to perform the acts of worship on a daily basis. Since Moeini et al. also implemented the Islamic religious program for the elderly, it can be said that improving the spiritual health of these subjects can enhance their mental and physical conditions.

In another study entitled "The evaluation of the effect of hope inducing program and active listening on the mental health of the elderly", Delavandi et al. showed that the spiritual care program increased the mental health of the elderly residing in Kahrizak Charity Nursing Home Tehran, Iran. It seems that mental health correlates with the happiness level of individuals; accordingly, those who are not happy are pessimistic, sad, and hopeless people and in conflict with their surrounding world (1). On the other hand, happy individuals seek social support in dealing with problems and mostly focus on the positive aspects of an event (23). Based on the evidence, it was shown that the individuals who recount the experiences of spiritual care have better mental health (15).

The results of the present study were compared with the findings of a study conducted by Sankhe et al. Several similarities were observed between the two studies indicating that spiritual care decrease anxiety and depression. Given the relationship of anxiety and depression with happiness (an essential component of happiness is the lack of negative emotions such, as depression and anxiety) (24), it could be concluded that the results of the study carried out by Sankhe et al. are consistent with the findings of the present study.

Another study was performed by Wu LF et al. entitled "The evaluation of the effect of reminiscence therapy on hope, satisfaction with life, and social welfare in Taiwanese elderly with mild-moderate dementia". In the aforementioned study, it was shown that remembering spiritual memories increased hope, satisfaction with life, and mental health of the subjects. In this regard, the findings of the current study are in line with the results of the aforementioned study (25).

In the present study, remembering the positive and successful memories of the elderly were regarded as a part of spiritual care. Accordingly, remembering spiritual memories increased hope, satisfaction with life, and mental health of the elderly. In addition, one of the scored factors extracted from the Oxford Happiness Questionnaire is the level of participants' satisfaction with life. Considering the aforementioned items, a relationship was observed between satisfaction with life and happiness level. Possibly, the purposefulness of life, spiritual goals, as well as love and interest in God, are the main ways to achieve happiness. Accordingly, having a spiritual relationship with God reduces stress and increases coping with stress (15).

There were several limitations in the present study. One of the major limitations was lack of the generalizability of the results to the society's elderly population since there was a difference between the individuals residing in nursing homes with those living in the community in terms of general health. Another limitation was the inclusion of only female subjects. In addition, there was no sufficient space and facilities for the elderly to perform religious rituals.

Implications for Practice

According to the obtained findings of the present study, spiritual care affected the happiness level of the elderly. In the current study, spiritual care was recommended as a nonpharmaceutical therapy to increase happiness and prevent negative emotions. The results of this type of studies help nurses give special attention to the mental status and spiritual dimension of patients in clinics and properly interact with patients, especially the elderly, to improve their spirit and bring them happiness.

Nursing supervisors highlight the attention to the spiritual needs of patients, especially the elderly, with their supervisory functions. By designing supervisory checklists, special attention should be given to the spiritual needs of patients in order to witness the progress of multidimensional (i.e., physical and spiritual) spiritual care in clinics. Considering the results of such studies, it is recommended that medical professors and instructors focus on the role of all aspects of nursing care in educational planning, especially in domains related to the elderly and train students on considering the mental and spiritual requirements of patients in addition to physical needs. Moreover, special attention must be given to the spiritual aspect of subjects in designing curriculums to accelerate the

treatment course.

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Conflicts of Interest

The authors declare that there is no conflict of interest.

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