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ORIGINAL PAPER

The Effect of Religion Intervention on Life Satisfaction and Depression in Elderly with Heart Failure

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Abstract

The elderly suffering from heart failure is facing with some problems such as lowering of life satisfaction and depression. Regarding a lack of information in this issue, the current study was conducted to determine the effect of religion intervention on life satisfaction and depression in the elderly with heart failure, in Ilam-Iran. In a clinical trial study conducted on the elderly with heart failure disease in Ilam-Iran, the patients were randomly allocated into two experimental (46) and control (47) groups. The used instruments were a demographic checklist, life satisfaction questionnaire of LSI-Z and Beck depression inventory. The intervention done for test group was a religion-spiritual program designed based on the Richards and Bergin model, and according to Islam and Shia regulations and conducted during six sessions, each 30–45 min. The tools were completed before and after intervention. Gathered data were entered into SPSS software and analyzed by descriptive (mean and standard deviation) and inferential (independent *t* test and ANOVA) statistics. The results showed that there was no significant difference between the mean (SD) of life satisfaction in the experimental group [5.47 (3.37)] and control [5.85 (3.92)] before the intervention ($P = 0.62$) but after the intervention. The mean (SD) of life satisfaction of the test group [8.08 (4.36)] was higher than that of the control group [5.55 (3.96)] ($P = 0.006$). Also, no significant difference between the mean (SD) of depression in the experimental group [47.80 (10.48)] and control [49.87 (11.40)] before the intervention ($P = 0.62$) but after the intervention. The mean (SD) of depression of the test group [28.28 (14.78)] was lower than that of the control group [50.44 (14.02)] ($P = 0.006$). Regarding the positive effect of religion-spiritual program in depression and life satisfaction of the elderly with heart failure, it is suggested this program will be educated to these patients by health-care workers.

Keywords Elderly · Heart failure · Religion intervention

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Background

The rate of the elderly is growing rapidly in Iran (Mirzaie and Darabi 2017; Salehi and Motaghi 2018), besides this, the contagious diseases are getting replaced by non-communicable disorders (NCDs), quickly. So, it is predicted NCDs will be the cause of death of 70% of people in 2020. So for this reason the health policy men are facing with some challenges (Jamison and Mosley 1991; Ebrahimi et al. 2017). The elderly usually are affected with some chronic disease which changes their life pattern reduces self-esteem, disturbs their vulnerability and social activities, and affects the quality of life as well as induces some mental disturbances (Wicke et al. 2014; Khaki et al. 2017).

The prevalence of heart disease is on the rise and has a negative impact on the health status of patients (Mehrpoya et al. 2018; Sepahvand et al. 2015). So many people will die (Goodarzi et al. 2015). Heart failure (HF) is one of the diseases that ruin the life of the elderly people (Bader et al. 2017); HF as a general health problem had a remarkable increase due to growing elderly and raising the age of population (Peters-Klimm et al. 2010). This problem is considered as the final stage of cardiovascular diseases (Navidian et al. 2015) and affects 23 million in the world (Dunlay and Roger 2014). HF also is a complicated clinical syndrome caused by different factors and induces the functional and structural defects on heart which results in dyspnea, fatigue, weakness and other disabilities (Annema et al. 2009). The disease is the main cause of mortality and morbidity whose rate is increased by changing the age pyramid toward the elderly, so demanded more attention (Danielsen et al. 2017). Aging and cardiovascular disease produce various complications (Thanakwang et al. 2012; Mangolian Shahrbabaki et al. 2017; Bahrem et al. 2017), and among them frequent hospitalization (Duque et al. 2011), lack of support by family and health system (Shahrbabaki et al. 2016), trauma (Gioffrè-Florio et al. 2018), misbehavior (Kashfi et al. 2017), reducing physical activity (Koolhaas et al. 2018), reducing life satisfaction and depression are notable (Patra et al. 2017; Tully and Higgins 2014; Huang and Wu 2012).

Despite progressing in health systems, recently, depression is considered as a main psychological problem in aged people that is induced by the crises due to lack of control, disability and sorrow (Khezri Moghadam et al. 2018; Norton et al. 2008). In a meta-analysis study in 2006, the prevalence of HF was 12.5% in the elderly individuals, which needs more consideration (Rutledge et al. 2006). Depressed patients have a sad or moody temper, and thus they do not have any pleasure of life, feeling worthless, and constantly waiting a disaster, hereupon they suppose themselves as unfortunate and helpless (Abbasi et al. 2018). Another issue of the elderly people is related to reducing life satisfaction (Wu and Koo 2016). Life satisfaction represents the viewpoint to world and is associated with the person needs (Matud et al. 2014). In the aged people, life satisfaction is more important and requires carefully interventions (Curi et al. 2018).

Spirituality health (SH) measures are the approaches promoting health (Babamohamadi et al. 2017; Ziapour et al. 2017), and it is more effective on general health in the elderly (Goli et al. 2017). SH is defined as the health in beliefs, opinions, moral values and practice, so that the connection between all domains of the health, the health without SH does not have an appropriate function (Goli et al. 2017; Kavoosian et al. 2018; Saydshohadai et al. 2013). In this reason, it is important to find some resolutions to enhance SH (Naghi et al. 2012). The nurses activities are fundamental in the preservation and betterment of SH in the elderly (Coburn et al. 2012), as noted in the literature; nursing spiritual care has the main role for improving health (Elham et al. 2015; Moeini et al. 2016; Hsiao

et al. 2011; Erichsen and Büssing 2013). One of the SH interventions is religion-spiritual programs (Tajbakhsh et al. 2014; Sytsma et al. 2018). Regarding the role of the nurses for improving the psychological symptoms and life satisfaction of the elderly people, through appropriate cares, and a scarcity of the information about spiritual support and health, the current study was conducted for determining the effect of religious intervention on life satisfaction and depression of the elderly.

Methods

This quasi-experimental study was done in Ilam-Iran, in 2017, in aged patients with cardiovascular disease. Herewith, 100 individuals, calculated based on the parameters of Kazemi et al. study (2018), test power of 95% and type-1 error of 0.05, were enrolled into the study, conveniently and allocated into intervention and control groups randomly. The inclusion criteria were having at least 65 years old, suffering from cardiovascular disease by physician order and documents, ability to communicate verbally during interviewing with the researcher, having a religion of Islam-Shia, habitation in Ilam-city, and capability in participation in the sessions. The patients reluctant to continue the program, absent in two sessions, or having a serious disease of crisis were excluded. In this regards, four and three of the patients were excluded in intervention and control groups, respectively.

For data collection, the researcher referred to cardiac care unit (CCU) of Mostafa–Khomini hospital, the single cardiac care center in Ilam with 20 active beds in CCU, and identified the eligible elderly patients in line with the inclusion criteria; hence, the patients consented to the study were recruited conveniently and allocated to intervention and control group randomly (each group 50 individuals). Random allocation was implemented via black and white carts in which the patients who selected black or white carts were considered as intervention or control cases, respectively.

The data collection instruments were a researcher-made demographic checklist (age, gender, hospitalization history, economic status, and family support) including life satisfaction questionnaire of LSI-Z (Wood et al. 1969), and Beck depression inventory (BDI) (Beck et al. 1996). LSI-Z has 13 items with Likert scoring of, do not know = 0, agree = 1, and disagree = 2 about, this would be reverse about negative questions. In this tool, the higher score indicates the greater life satisfaction and categorized in three level of low life satisfaction (0–12 score), moderate (13–21), and high (more than 22) (Wood et al. 1969). BDI also includes 21 items in which their Likert scoring is between zeros to three, with total score range of 0–63, the greater the score, the more depression severity. The level of depression in based on normal and undepressed (equal or less than 9), mild (10–18), moderate (19–29) and severe (30–63) (Beck et al. 1996).

After enrolling the participants, the researcher designed a religion-spiritual program according to Richards and Bergin model (1997), which adapted into Islam-Shia religion by Tajbakhsh et al. (2016, 2018). The program was divided into six educational sessions, each in a week and lasted about 30–45 min (Tajbakhsh et al. 2016, 2018).

The spiritual-religious strategies such as reading verses from the Holy Quran, saying prayers and discussing the psychological effects of praying, narrating religious role models, participating in spiritual-religious programs, repenting and seeking forgiveness, and finally, training and moral analysis of moral values are provided in Table 1, in accordance with the study by Tajbakhsh et al. (2016, 2018). The spiritual caring services provided in this research included: 1. Creating trust, empathy and honesty between nurse and patient in order to establish a proper communication during the sessions; 2. Listening

to their physical and psychological problems, concerns and fears more attentively; 3. Psychological support of patients; 4. Strengthening the internal hope and strength of the subjects; 5. Using positive sentences and strengthening healthy and constructive thoughts; 6. Helping patients to find the meaning of their illness and to realize that no one of the events of life is beyond divine destiny. One who believes in the sovereignty of God over the whole world would consider the system of the world as a wise one and saves himself from the feeling of pessimism, emptiness and disappointment; 7. Providing the necessary facilities for religious ceremonies; 8. Encouraging the patients to say prayers and to read the Quran; 9. Squeezing and touching the hands of patients in order to create the necessary feeling of spiritual support in them; 10. Encouraging the patients to express their religious beliefs; 11. Encouraging the patients to visit religious clergies; 12. Encouraging the patients to accompany those with whom they feel relaxed; 13. Encouraging the patients to visit recreational places and to perform light exercises according to their physician; 14. Assuring the patients that the nurse is always available to them for mental and

Table 1 Spiritual-religious strategies for the elderly patients with heart failure (Tajbakhsh et al. 2016, 2018)

Religious strategies		
1	Reading verses from the Holy Quran	Encouraging the elderly to read verses from the Qur'an and its translation; ex. verse 28 of surah Rād: "الَّذِينَ آمَنُوا وَتَطْمَئِنُّ قُلُوبُهُمْ بِذِكْرِ اللَّهِ ۗ أَلَا بِذِكْرِ اللَّهِ تَطْمَئِنُّ الْقُلُوبُ." Those who have believed and whose hearts are assured by the remembrance of Allah. Unquestionably, by the remembrance of Allah hearts are assured. Or the verse 4 of surah Fath: "هُوَ الَّذِي أَنْزَلَ السَّكِينَةَ فِي قُلُوبِ الْمُؤْمِنِينَ لِيَزْدَادُوا إِيمَانًا مَعَ إِيمَانِهِمْ ۗ وَلِلَّهِ جُنُودُ السَّمَاوَاتِ وَالْأَرْضِ ۚ وَكَانَ اللَّهُ عَلِيمًا حَكِيمًا." It is He who sent down tranquillity into the hearts of the believers that they would increase in faith along with their [present] faith. And to Allah belong the soldiers of the heavens and the earth, and ever is Allah Knowing and Wise.
2	Read prayers and discuss the psychological effects of *praying*	Encouraging members to say the Majir prayers in groups and also the prayers in the Maffatih al-Janan along with the translations, relaxation by prayers
3	Narrating the history of *religious* role models	By presenting practical examples such as Prophet Ibrahim (AS), the Prophet Ya'qub (AS), Prophet Yusof, and Prophet Muhammad (PBUH), the Holy Quran wants the believers to follow their lead when encountering problems
4	Participation in *religious* programs	Relationships and social links that resulted from the religious activities reduce anxiety and depression and prevent loneliness. Holy ceremonies such as the holy month of Ramadan, the Hajj, attending the Friday prayer service, pilgrimage of holy places, participation in the charity and support activities, and better social relations between the people and the believers. Frequent attendance in religious services such as mosques leads to a better life and an inner satisfaction and reduction in mental disorders
5	Repent and seeking forgiveness	Some believe that the illness is due to their past immoral behaviors, i.e., a punishment by the God. These people believe that prayer, vow, repentance and charity will increase their tolerance toward the disease and the problems associated with it
6	Training and moral analysis of moral values	Review

psychological support; 15. Repenting and seeking forgiveness from past sins and forsaking anger toward the sinners and perpetrators; 16. Encouraging the patients to listen to music, sing songs, go to theater, cinema, art centers, etc.; 17. Encouraging the patients to establish a friendly connection with others; 18. Encouraging the patients to always smile and to do their favorite hobbies; 19. Encouraging the patients to participate in religious services and social gatherings (Tajbakhsh et al. 2016, 2018).

In order to observe the ethics of research, the research goals were explained to the elderly and they were asked to participate in the study, if they were willing. Also, while assuring them about the confidentiality of information throughout the research, they were assured that the participation or lack of participation in the study had no effect on the process of providing caring services to them. The elderly people were also assured that they could leave the study at any time. After three months of intervention, life satisfaction and depression questionnaire was again completed by the elderly in test and control groups. Gathered data was entered into SPSS software and analyzed by descriptive (mean and standard deviation) and inferential (independent *t* test and ANOVA) statistics.

Results

The findings showed that the mean (SD) age of the patients in the test group was 72.41 (8.26) and in the control group was 75.06 (9.17) ($P < 0.02$). In terms of the hospitalization history, the mean (SD) of the patients admitted to the experimental group during the year was 5.54 (1.36) and in the control group was 6.31 (1.86) ($P = 0.14$). Also, in the control group, 21 (45.7%) of the patients with poor economic status were 20 (43.5%) of the patients with a moderate economic condition and 5 (10.9%) of the patients with a good economic situation, but in the case group 38.3% of patients were with poor economic status, 23 (48.9%) of patients with moderate economic status and 6 (12.8%) of patients with good economic status ($P = 0.51$). In terms of family support, 7 (15.2%) of the patients had low support, 30 (65.2%) had moderate family support, 9 (19.6%) had family support, but in control group 6 (12.8%) had low support, 34 (72.3%) had modest family support, and 7 (14.9%) had high family support.

The results of Table 2 showed that there was no significant difference between the mean (SD) of life satisfaction in the experimental group [5.47 (3.37)] and control [5.85 (3.92)] before the intervention ($P = 0.62$) but after the intervention. The mean (SD) of life satisfaction of the test group [8.08 (4.36)] was higher than that of the control group [5.55 (3.96)] ($P = 0.006$).

The results of Table 3 showed that there was no significant difference between the mean (SD) of depression in the experimental group [47.80 (10.48)] and control [49.87 (11.40)] before the intervention ($P = 0.62$) but after the intervention. The mean (SD) of depression

Table 2 Comparison of mean (SD) of life satisfaction score in the intervention and control group

Group	Life satisfaction		*P* value
	Before	After	
Intervention	5.47 (3.37)	8.08 (4.36)	0.006
Control	5.85 (3.92)	5.55 (3.96)	0.70
P value	0.62	0.004	–

of the test group [28.28 (14.78)] was lower than that of the control group [50.44 (14.02)] ($P = 0.006$).

Discussion

The findings of this study showed that after provision of spiritual-religious care, life satisfaction increased in the elderly patients with heart failure and their depression rate decreased. In the study of Tajbakhsh et al. (2014), which aimed at determining the effect of spiritual-religious care on the stress of patients after cardiac surgery, the findings showed that after five 45–60 min sessions/twice a week, the stress of the patients was significantly reduced in the test group, which is consistent with the results of the present study about the positive impact of spiritual-religious care on improving the psychological state of the elderly with HF. Also, in the study of Askari et al. (2018), which aimed at determining the effects of religious spiritual therapies on the quality of life, anxiety and depression in the elderly, the findings showed that after twelve 90-min sessions of spiritual-religious psychotherapy, the quality of life of the elderly increased and their anxiety and depression were reduced, which is consistent with the results of the present study. In fact, religion and spirituality play an effective role in promoting mental health and its application in this area is very important (Weber and Pargament 2014).

According to the findings, the implementation of spiritual-religious intervention has increased the life satisfaction of the elderly patients with heart failure, which is consistent with the results of this study. As illustrated by Wu and Koo (2016), the implementation of a 6-week intervention with the aim of determining the effect of spiritual intervention on hope, life satisfaction and spiritual well-being of the elderly with dementia, significantly increased these factors in the elderly. It was also shown in Kazemi et al. (2018) that spiritual counseling improved the life satisfaction of cancer patients, which is consistent with the results of the present study on the effect of spiritual intervention on improving the life satisfaction of individuals. It seems that due to the relationship between the satisfaction of life, the spiritual well-being and religious (Sharajabad et al. 2017) practice with the spirituality in the elderly, the way has been paved to improve their life satisfaction.

The findings of this study showed that the implementation of spiritual-religious intervention reduced the depression of the elderly patients with heart failure, which was consistent with the results of Elham et al. (2015) in which, the implementation of spiritual intervention reduced the anxiety of the elderly. The meta-analysis study by Kim (2014) showed that the implementation of spiritual intervention reduces depression in the group of cancer patients. In the systematic review and meta-analysis studies (Gonçalves et al. 2015; Oh and Kim 2012), the findings indicated that spiritual interventions reduced the depression of the subjects. In a study by Carneiro et al. (2017) aiming at determining the effect of spiritual healing on the cardiovascular group of patients, the findings showed that the implementation of spiritual healing interventions reduces the depression of the patients

Table 3 Comparison of mean (SD) of depression score in the control and experimental group

Group	Depression		*P* value
	Before	After	
Intervention	47.80 (10.48)	28.28 (14.78)	0.000
Control	49.87 (11.40)	50.44 (14.02)	0.82
P value	0.36	0.000	–

under study. Also, in the study of Iranmehr and Kadkani (2017) among the retired, that was aimed at determination of the effect of cognitive-religious intervention based on the Quranic verses on the anxiety and despair of the retired, the findings showed that the implementation of ten 90-min sessions in the test group reduced the anxiety and despair of the retired which is consistent with the results of the present study on the effect of spiritual-religious intervention on depression in the elderly.

Conclusion

Considering the positive effect of spiritual-religious intervention on life satisfaction and depression reduction in the elderly patients with heart failure, it is recommended that the nurses implement these interventions to improve the health status of the elderly.

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Compliance with Ethical Standards

Conflict of interest The authors declare that they have no conflict of interest.

Research Involving Human Participants and/or Animals Research involves humans.

Informed Consent Assign the patients randomly in the spiritual intervention group and control group. All procedures performed in studies involving human participants were in accordance with the ethical standards of the institutional and/or national research committee and with the 1964 Declaration of Helsinki and its later amendments or comparable ethical standards.

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