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Comparing the Effectiveness of Spirituality Therapy and Acceptance and Commitment Therapy on Sleep Quality, Resilience, and Death Anxiety in the Elderly

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Quantitative Study

Abstract

Background: Due to the various challenges that elderly individuals experience, their mental health requires greater attention, particularly in respect to resilience and aging-related death anxiety. This study compared the effects of acceptance and commitment therapy (ACT) and spirituality therapy on elderly participants' resilience, sleep quality, and death anxiety.

Methods: The present study was an applied and semi-experimental research with a pretest-posttest design, follow-up, and control group. The statistical population of the study included all elderly residents of nursing facilities in Shiraz, Iran, in 2019. The sample consisted of 45 individuals from the aforementioned community who participated voluntarily. They were randomly divided into the spirituality treatment (n = 15), ACT (n = 15), and control groups (n = 15). Data were gathered using the Connor-Davidson Resilience Scale (CD-RISC), Collett-Lester Fear of Death Scale (CL-FODS), and the Pittsburgh Sleep Quality Index (PSQI). MANCOVA and repeated measures ANOVA were used to examine the data in SPSS software.

Results: According to the findings, ACT and spiritual treatment had a positive impact on sleep quality, resilience, and fear of dying ($P < 0.001$). However, resilience and sleep quality were improved more by ACT. Spirituality treatment was more effective on death anxiety.

Conclusion: It can be concluded that ACT was more successful in improving resilience and sleep quality and spiritual counseling had a greater impact on death anxiety.

Keywords: Spirituality; Acceptance and commitment therapy; Sleep quality; Resilience; Anxiety; Elderly

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Introduction

Presently, the elderly make up a sizable portion of the population. A population is termed elderly if more than 12% of the total population are 60 years or older or more than 10% of the total population are 65 years and older. In 2002, 10% of the world population (629 million people) were 60 or older; by 2050, this number will rise to 2 billion (20% of the total population). The phenomenon of an explosion in the elderly population will occur in Iran if this population aging continues to follow its current path around 2030, and between 25 and 30% of the population will be above the age of 50 (Doumas, Esp, Flay, & Bond, 2017). Therefore, it is essential to focus on the many facets of this issue. One of the worries of aging is the fear of death. An uncommon and intense fear of dying is known as death anxiety, and it is characterized by feelings of dread and trepidation when one considers how one will die or what will happen when one passes away (MacLeod, Crandall, Wilson, & Austin, 2016). According to Sharif et al. (2017), another definition of death anxiety is "anxiety that people experience in anticipating a condition in which they do not exist."

The numerous and diverse challenges that seniors experience have drawn attention to their mental health, particularly aging resilience and need. Resilience is a quality that makes it easier for people to handle challenging and stressful situations in life and lessens despair (Lu, Yuan, Lin, Zhou, & Pan, 2017). The quality of life (QOL) is also improved by the capacity to cope with suffering. Resilience is the ability of people to maintain their health and resist risky and tough situations that lead them to not only overcome those conditions, but also become stronger during and despite them. This may be because of hope for a brighter future (Sriwantha, Jullamate, & Piphatvanitcha, 2018). Results from earlier studies on resilience demonstrate that raising resilience increases one's capacity for problem-solving. Belsky's observations (2002) show that individuals with high resilience view stressful situations as less dangerous and are more likely to seek assistance rather than repress their feelings.

The amount and quality of sleep a person gets has an impact on his or her health. The findings suggested that sleeplessness at night could have an impact on one's QOL. As a result, there is a higher risk of developing depression and anxiety, as well as a lower capacity to handle common stresses (Tsapanou et al., 2017). More than 57% of elderly people report having sleep issues, and only 12% of those with sleep issues do not complain, according to epidemiological studies. Poor sleep quality affects more than 40% of persons over the age of 60 (Bonardi et al., 2016). One of the most prevalent sleep disorders in the elderly is insomnia. There are two types of insomnia associated in the elderly. A primary insomnia disorder is one that is not brought on by any other mental, physical, or substance use disorders. A key issue is having trouble falling asleep, staying asleep for at least a month (Kang et al., 2017). Sleep issues in the elderly can cause sadness, falls, memory issues, concentration issues, irritation, a low QOL, dementia, and, uncaring moods (Astorino et al., 2015).

The discipline of enhancing the psychological well-being of the elderly has adopted a number of treatments, such as reality therapy, logotherapy, and cognitive behavioral therapy (CBT). Another therapy method that has the potential to enhance the lives of elderly people and improve mental health is acceptance and commitment therapy (ACT). The underlying principles of ACT include (1) acceptance or willingness to experience pain or other upsetting events without attempting to contain it, and (2) value-based action or commitment combined with a willingness to act based on meaningful personal goals more than eliminating unwanted experiences that interact with other experiences.

Dependencies on nonverbal communication promote good functioning. This approach makes use of linguistic metaphors, exposure-based activities, experimental experiences, and mental health training (Zhang, Mellsop, Brink, & Wang, 2015). In this treatment, it is first attempted to lessen exertive control and raise the patient's psychological acceptance of their mental experiences. In other words, the person is taught that no external or internal reaction can remove unwanted mental experiences and that any action done to avoid or regulate them is ineffective or has an adverse consequence. The individual becomes conscious of their mental awareness of the present moment in the second phase. The third phase involves teaching the individual how to detach himself from his mental experiences in a way that he can do on his own (Movahedrad, Seyed Alitabar, Mohammadi, & Hoseinifard, 2023). In the fourth stage, experiences help to lessen the excessive concentration on the visual self or the narrative of the person in mind. The fifth stage assists a person in determining their fundamental principles and translating them into clear goals and ideals while also accepting their subjective experiences (Twohig & Levin, 2017). Studies on ACT demonstrate its impact on mental health issues and disorders. For instance, given the growing elderly population and their significant issues with sleep, resilience, and death dread, it appears that many elderly individuals lack the knowledge and abilities necessary to effectively manage such issues. Such issues can be minimized through training in spiritual therapy and ACT for the elderly. This study compared the effects of ACT and spirituality therapy on elderly participants' resilience, sleep quality, and death anxiety.

Methods

The current study was an applied and semi-experimental research with a pretest-posttest design, a control group, and follow-up. The statistical population of this study consisted of all elderly inhabitants of nursing homes in Shiraz, Iran, in 2019. There were 146 elderly individuals in total. The 45 patients were chosen at random using the convenience sampling approach and randomly assigned to one of three groups: spirituality therapy (n = 15), ACT (n = 15), and control group (n = 15). For each group, the necessary sample size was estimated at 0.40, 0.95, and 0.80 test power, and 10% loss (13). The following criteria were required for inclusion: a minimum age of 60 years, not receiving psychological treatment since diagnosis, absence of acute or chronic medical conditions that would interfere with blood sampling, such as epilepsy, skeletal conditions, heart and respiratory failures, and tolerance for long sessions, absence of severe mental illnesses, such as psychotic disorders, and lack of psychotropic medications use and substance abuse. The exclusion criteria included not attending more than 2 sessions of therapy and experiencing significant stress as a result of unanticipated accidents.

The ethical principles taken into considerations were as follows: All participants received written information related to the research and participated in it if they wished. The participants were assured that all information would remain confidential and used for research purposes only. the names and surnames of the participants were not registered to protect their privacy. This research was approved by the ethics committee of Hormozgan University of Medical Sciences, Iran, with the code IR.HUMS.REC.1398.339 and received the clinical trial code IRCT20200210046450N1.

The data collection tools used in the study included the Connor-Davidson

Resilience Scale (CD-RISC), Collett-Lester Fear of Death Scale (CL-FODS), and the Pittsburgh Sleep Quality Index (PSQI).

Connor-Davidson Resilience Scale: The CD-RISC, which comprises 25 questions, was designed to assess resilience in various individuals and was developed after reviewing research materials from the years 1979 to 1991 (Connor & Davidson, 2003). The sum of all the question-by-question scores is used to calculate the questionnaire's overall score on the Likert scale of accountability. The total score of the scale ranges between 0 and 100. Higher scores represent greater resilience. This questionnaire has a cutoff of 50 points. In other words, persons who score above 50 are considered resilient; the higher the score above 50, the greater the intensity of the person's resilience. In the study by Connor and Davidson (2003), the original version of this questionnaire had a validity and reliability score of 0.89. Using the Cronbach's alpha coefficient test, the questionnaire's reliability was evaluated in Iran; the result was 0.84 for this particular questionnaire (Derakhshanrad, Piven, Rassafiani, Hosseini, & Mohammadi Shahboulaghi, 2014). Based on Cronbach's alpha, the questionnaire's reliability in this study was 0.76.

Collett-Lester Fear of Death Scale: The CL-FODS is a tool for measuring one's own level of fear and anxiety about death. In 1969, Collett and Lester created the scale's basic shape. This scale consists of 32 questions in the 4 subscales of fear of one's own death, fear of the process of one's own dying, fear of the death of others, and fear of the process of others dying (Lester, 1990). The items of this scale are scored on a 5-point Likert scale ranging from 1 to 5. The scores of the subscales and the total score are computed for this questionnaire. This test has a maximum score of 160 and a minimum score of 32. The more death anxiety a person feels, the closer their score is to 160. The reliability of the CL-FODS was evaluated using Cronbach's alpha, and since the reliability coefficient was 0.79, the instrument's validity was approved (Lester, 1990). Based on Cronbach's alpha and ballad techniques, this questionnaire's reliability coefficient in Iran was 0.89 and 0.68, and its concurrent validity with the Templer Death Anxiety Scale (1970) was 0.57, demonstrating the acceptable validity of the survey (Dadfar, 2016). In the present study, the questionnaire's reliability was calculated to be 0.83 using Cronbach's alpha.

Pittsburgh Sleep Quality Index: Buysse, Reynolds, Monk, Berman, and Kupfer (1989) created the PSQI in 1989 to evaluate the quality of a person's sleep. The PSQI contains 18 questions in the 7 subscales of self-reported sleep quality, sleep latency, sleep duration, habitual sleep efficiency, sleep disturbances, use of sleeping medication and daytime dysfunction. The quality of sleep, which is assessed by question number 9, is related to the first subscales. The average score of question 2 and the score of part A of question 5 make up the second subscale. Sleep duration is determined by question number 4. The fourth subscale measures the efficiency and effectiveness of sleep. To calculate the score, the total number of hours of sleep is divided by the total number of hours the subject is in bed, and then, the result is multiplied by 100. The fifth subscale, which deals with sleep disorders, is determined by averaging the answers to question 5. The sixth subscale is sleeping medication, which are mentioned in question number 6. The average scores for questions 7 and 8 are used to establish the seventh subscale, which is related to inappropriate performance throughout the day. Each question has a minimum score of 0 and a maximum score of 3. The total score of the instrument, which ranges from 0 to 21, is made up of the sums of the mean scores for its 7 subscales. The quality of sleep declines as the score rises. A score of more than 6 denotes poor sleep. The concurrent

validity and reliability (Cronbach's alpha) of the original version of the questionnaire were 0.89 and 0.88, respectively (Derakhshanrad et al., 2014). The validity and reliability of the Persian version of this questionnaire, which Farrahi, Nakhaee, Sheibani, Garrusi, and Amirkafi modeled, were 0.86 and 0.89, respectively (Farrahi et al., 2009). In the present study, the reliability of the PSQI was calculated to be 0.79 using Cronbach's alpha.

Eight 90-minute sessions of group spiritual therapy (Roshannia, Ghadampour, & Rezaei, 2018) and nine 90-minute sessions of ACT (Hayes, Strosahl, & Wilson, 2009) were held once a week for 2 months. Both groups answered questions about resilience, fear of dying, and sleep quality prior to the sessions beginning and receiving permission. The control group did not receive any instructions, while the experimental group (spiritual treatment) received weekly training in nursing facilities. The follow-up phase was conducted 2 months after the posttest.

The central and dispersion indexes mean and standard deviation were utilized in descriptive statistics. Repeated measures ANOVA was used for inferential statistics. It is important to note that Levene's test (to look into the homogeneity of variances), Kolmogorov-Smirnov test (for the normality of data distribution), Box's M test, and Mauchly's sphericity test were employed to look into the inferential test assumptions. In order to compare the two groups' demographic characteristics, the chi-square test was utilized (gender, marital status, age, and education). SPSS software (version 22; IBM Corp., Armonk, NY, USA) was used to carry out the aforementioned statistical analyses. The tests had a 0.05 level of significance.

Results

The descriptive findings of this study are presented in table 1 together with frequency and percentage tables, as well as statistical indicators like mean, standard deviation, and the number of sample individuals.

The spiritual treatment theory training, ACT, and control groups were examined to determine whether there was a significant change in the sleep quality, resilience, and death anxiety scores. Prior to performing a multivariate analysis of covariance (MANCOVA), the Box's M and Levene's test results were examined to verify the assumptions. The homogeneity of variance-covariance matrices was appropriately noted because the Box's M test did not show any significance for any of the research variables (Box's M = 21.47; df = 12; P = 0.05). Levene's test also revealed that there were no significant differences in any of the variables, indicating that all groups' dependent variable error variances were equal and the parity of intergroup variances was present.

Table 1. Frequency distribution and comparison of demographic characteristics

Demographic variables		Spirituality therapy	ACT	Control	P
Gender	Female	6 (40)	11 (73.3)	4 (26.7)	0.24
	Male	9 (60)	4 (26.7)	11 (73.3)	
Marriage	Single (divorced or widowed)	9 (60)	11 (73.3)	13 (86.7)	0.09
	Married	6 (40)	4 (26.7)	2 (13.3)	
Age (year)	60-65	4 (26.7)	6 (40)	5 (33.3)	0.35
	66-70	7 (46.7)	6 (40)	5 (33.3)	
	≥ 75	4 (26.7)	3 (20)	5 (33.3)	

ACT: Acceptance and commitment therapy

Table 2. Mean and standard deviation of scores of the research variables in experimental and control groups

Variable	Group	Pretest	Posttest	Follow-up
		Mean ± SD	Mean ± SD	Mean ± SD
Sleep quality	Spirituality therapy	17.33 ± 1.98	14.60 ± 1.59	14.33 ±1.67
	ACT	17.00 ± 2.44	11.73 ± 2.15	11.60 ±2.16
	Control	16.86 ± 2.35	16.80 ± 2.30	16.80 ±2.30
Death anxiety	Spirituality therapy	115.26 ± 5.24	99.00 ± 7.47	99.46±7.59
	ACT	116.33 ± 7.55	105.46 ± 7.65	106.13±7.77
	Control	119.46 ± 4.88	119.13 ± 4.77	119.26±4.80
Resilience	Spirituality therapy	34.00 ± 4.44	37.80 ± 4.75	37.40±4.74
	ACT	33.73 ± 3.39	42.20 ± 5.74	42.13±5.98
	Control	33.53 ± 2.74	34.20 ± 2.62	34.33±2.74

SD: Standard deviation; ACT: Acceptance and commitment therapy

As can be seen in table 2, there was a significant difference in sleep quality, resilience, and death anxiety between the three groups of spiritual treatment theory, ACT, and control. It should be mentioned that the Wilks' lambda test with a value of 0.02 and the F = 61.00 test revealed a significant difference in sleep quality, resilience, and death anxiety between the spiritual therapy, ACT, and control groups ($P < 0.001$).

According to the findings presented in table 3, sleep quality (239.49) at the 0.0001 level, resilience (230.10) at the 0.0001 level, and death anxiety (43.35) at the 0.0001 level are all significant. The seventh hypothesis is therefore verified. The couples in the groups were compared using the Bonferroni test.

As can be seen in the findings presented in table 4, the ACT group had a greater mean level of resilience than the control and spiritual treatment groups at the end of the posttest ($P < 0.001$). In other words, ACT was most beneficial in improving resilience and sleep quality. However, spirituality treatment had the greatest impact on fear of death ($P < 0.001$).

Discussion

This study compared the effects of ACT and spirituality therapy on resilience, sleep quality, and death anxiety among the elderly. In terms of effectiveness, ACT produced the best results with regard to resilience and sleep quality. However, spirituality treatment had the greatest impact on fear of dying. The results of this research were in line with that by Roshannia et al. (2018), Jennings, Flaxman, Egdell, Pestell, Whipday, and Herbert (2017), Bluett, Homan, Morrison, Levin, and Twohig (2014), and Karekla and Constantinou (2010).

In describing the results, it can be said that acceptance and dedication to spirituality therapy have a greater impact on resilience and sleep quality, even though both treatment modalities have a positive impact on these outcomes.

Table 3. Multivariate analysis of covariance for comparison of pretest and posttest in the experimental and control groups

Variable	SS	df	MS	F	P	Eta
Group						
Sleep Quality	197.63	2	98.81	239.49	0.001	0.92
Resilience	460.21	2	230.10	38.16	0.001	0.66
Death Anxiety	1838.11	2	919.05	43.35	0.001	0.69

SS: Sum of squares; df: degree of reedom; MS: Mean of squares

Table 4. Results of the Bonferroni test in the comparison of research variables

Variable	Group (I)	Group (J)	Mean difference	P
Sleep quality	Spirituality therapy	ACT	2.55	0.001
		Control	-2.73	0.001
	ACT	Control	-5.28	0.001
Resilience	Spirituality therapy	ACT	-4.61	0.001
		Control	3.63	0.003
	ACT	Control	7.97	0.001
Death anxiety	Spirituality therapy	ACT	-5.43	0.008
		Control	-16.37	0.001
	ACT	Control	-10.93	0.001

ACT: Acceptance and commitment therapy

It also teaches the authorities to increase action along worthwhile routes (Karekla & Constantinou, 2010). Enhancing a nonjudgmental and adaptive relationship with experiences as well as expanding internal awareness are both important aspects of changing relationships with internal experiences. In the interim, the therapist encourages clients to fully experience the thoughts and feelings connected to a thought, feeling, relationship, or behavior without repressing or judging them, and experience any subsequent secondary emotions such as shame, guilt, mistrust, reproach, or humiliation. Their sense of internal satisfaction, self-efficacy, and self-confidence increase along with their resilience as individuals exert more control and dominance over their living environment, particularly under stressful circumstances (Twohig & Levin, 2017). The sustainability of ACT depends on the group members' willingness to continue treatment after the values are made clear, which leads to committed action. In addition, two significant ACT processes known as contact with the present moment and self-as-context as the catalyst for raising the clients' awareness of themselves and their current needs, and this awareness aids in the maintenance of self-care behaviors in the elderly.

Moreover, ACT had a greater effect on death anxiety in the elderly than spirituality therapy. Spiritual therapy is known as one of the most important methods in the treatment of disorders, especially anxiety disorders. Spirituality is attributed to beliefs and actions that are based on the assumption that there are transcendental (not physical) dimensions in human life that put him/her in close contact with God and form a range of virtues in him/her. Spirituality creates a kind of meditation and transcendence of existence and causes prosperity. Old age is the stage in which there is an increase in the tendency to spirituality and communication with a transcendent force and the disconnection of relationship with the world; therefore, spiritual therapy reduces the anxiety of death in the elderly. Another reason for the effectiveness of spiritual therapy is helping clients face the reality of death (Karekla & Constantinou, 2010). Awareness of death increases people's sense of responsibility for life. Furthermore, awareness of unavoidable death increases enthusiasm in dealing with risky activities (Kirkland, Fortuna, Kelson, & Phinney, 2014). Spirituality therapy is one of the basic and important treatment methods through which human beings can prevent anxiety disorders and maintain their physical and mental health, and with the help of the infinite source of divine power, gain a sense of hope and peace, and thus, a sense of responsibility and meaning in life.

Conclusion

The following are the primary limitations of this study: This study exclusively

examined the elderly population of Shiraz City; therefore, its findings are limited to the statistical population of the elderly. As a result, care should be exercised when extrapolating the findings to other regions and cities. It is advised that this research be carried out in other communities and a larger sample, and that the findings be compared. It is advised that this study be carried out in other cities, and that the findings be assessed.

Conflict of Interests

Authors have no conflict of interests.

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