Shahid Sadoughi University of Medical Sciences School of Public Health
Social Behavior Research & Health
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Social Determinants of Health Research Center

The Effectiveness of Hope Therapy on Improving the Elderly Quality of Life

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ARTICLEINFO

ORIGINAL ARTICLE

Article History:
Received: 9 Sep 2018
Revised: 5 May 2019
Accepted: 28 May 2019

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Citation:
Zareei Mahmoodabadi H. Nourian M, Javadian SR, Fallah Tafti E. The Effectiveness of Hope Therapy on Improving the Elderly Quality of Life. Social Behavior Research & Health (SBRH). 2019; 3(1): 360-368.

ABSTRACT

Background: Elderly is an era of life, which affects quality of life; aging changes the thinking ways and reduces the self-confidence. The present study was conducted to evaluate the effect of hope therapy on the elderly quality of life in Mehriz, Yazd in 2016 - 2017.
Methods: In this controlled study with pre-test post-test design, the study population consisted of all elderly people who referred to daily care centers of Mehriz. The sample consisted of 24 elderly women in the daily care centers, who were divided into two groups of experimental (n = 12) and awaiting (n = 12).Hope therapy was provided in eight sessions for the experimental group. The instrument used in this research was Quality of Life Scale for the Elderly.
Results: The MANOVA results showed a significant difference between the experimental and awaiting groups. In the experimental group, physical function, depression, anxiety, mental performance, and life satisfaction improved, but education did not affect the sex dimension. Hope therapy, was effective on improving the elderly quality of life.
Conclusion: The studied training can be used as an effective treatment to improve the elderly quality of life.

Keywords: Hope Therapy, Depression, Quality of Life, Elderly

Introduction

The advances of today's societies are indebted to the altruism of the elderly, who spent their entire lives on training the new generation.[1]

Aging is a sensitive period of life, through which the elderly need especial care and attention. Currently, about six percent of the total population of Iran is over 60 years old. This figure is expected to reach 26 percent by 2050.[2]

The world's population growth rate is 1.7 percent; while the growth rate for the population over 65 years of age is 2.5 percent.[1] Aging reduces the quality of life due to the increased incidence of the physical and mental illnesses.

The concept of quality of life dates back to Aristotle in 385 BC. Aristotle defined quality of life as living a happy life, which is different for each individual.[3]

The term quality of life was first used by Pigo in 1920. According to one definition, quality of life refers to each person's perception of his/her health status and degree of satisfaction with this condition.[4]

According to the World Health Organization (WHO), the quality of life refers to people's understanding of their position in life with regard to cultural domains, value systems in which they live, as well as their relationships with their goals, aspirations, and concerns.

The comfort and well-being of individuals are set by their quality of life, which is an important factor with respect to multidimensionality, subjectivity, and dynamicity.

Subjectivity means that life quality is determined by the person individually and dynamicity means that life quality changes over time; therefore, it is necessary to be measured in a certain period of time.[6]

Many scholars are attracted to issues of aging.[7]

Quality of life is one of the most important issues in contemporary health care issues and is one of the biggest health goals for improving the individuals' health. In recent years, quality of life was recognized as one of the most important factors affecting the lives of people, especially the elderly and the disabled.

The elderly's quality of life has been considered progressively due to the increasing population of the elderly in the coming years.[1, 2]

Abedi[8] described the environmental and social conditions as the effective on the elderly's satisfaction and quality of life and considered loneliness as one of the effective factors in its reduction.

Barry found that the elderly living in daily care centers had lower quality of life than those who were living with their families.[9]

In another study, the increase of age increased physical dysfunction, had a great impact on the elderly's autonomy, and increased the elderly's need for help. Thus, the quality of life was decreased. [10]

Research shows that the physical and social context in which elderly people live influences their social experiences, mental health, development, and adaptation.[11]

Many early studies focused on the physical health of the elderly people.[12]

The place where the elderly live is considered as a very important dimension of their quality of life, comfort, and mental health. Many elderly people insist on living in their own homes at the end of their lives and some of them clearly state that they want to die in their own homes.[13]

The elderly's living at their home increases their level of hope and helps them to set a clear goal. The inescapable era of aging and its characteristics, resulted from the physical and psychological decline, make the elderly to be considered as a highly vulnerable age population.

Health is a strong predictor of mental health at the end of adulthood. In addition, physical illness may lead to disability.

With increase of the physical disability and subsequent social isolation, a deep sense of disappointment intensifies.[14]

Hopelessness may be the source of many other psychological problems, including depression. The contemporary science not only pays attention to

prolonging life, but also helps humans to live a calm and healthy life in the final years of their lives.

If such a context is not available, scientific advances aimed at prolonging life will lead to risky outcomes.

In this regard, hope therapy helps clients to reach certain goals by raising their hope and reviewing the barriers .[15]

In a study, 27% of elderlies' depression was explained by low levels of hope, and hope therapy reduced depression. After depression, anxiety level, low education, and gender were found as predictors of low hope. This study reported that higher levels of income and better social status were associated with high levels of hopes. [16]

According to, hope therapy tries to understand the etiology of the excitements of its clients by determining their unsuccessful problem-causing measures taken to pursue the goals.[17]

In a research, the quality of life and hope therapy was found to affect the physical and social life dimensions of individuals.[18]

The hope therapy theory was effective on the treatment of psychiatric disorders, including depression; its effect on other disorders is still under investigation.[19]

In one research, increasing hope and positive expectations with futuristic treatment could significantly improve the quality of life in patients.[20]

The result of a study showed that hope therapy improved the quality of life better than drug therapy and the effects of treatment persisted three months after the completion of the intervention. [21]

Given the above-mentioned idea on the one hand, the elderly population is rising. On the other hand, the psychological needs of this population were not addressed adequately. This can make the elderly to experience hopelessness in all aspects of life.

Hence, developing a spirit of hope in these people can relieve their pains to some extent. Therefore, given the increasing elderly populations and the community's need, the researcher in this study tried to investigate the effectiveness of hope therapy on improving the quality of life of the elderly.

Methods

In this controlled research with pretest-posttest design, all the elderly women in the daily care centers of Mehriz city in Yazd were studied.

In order to collect data, the semi-structured interviews and convenience sampling method were used among women referring to these centers. Some inclusion criteria were having mental health, being able to read and write, having consent to cooperate voluntarily in the study, and attaining a low score on quality of life. The exclusion criteria included the male gender and being under permanent care in the daily care center.

Accordingly, the samples consisted of 24 elderly women, randomly divided into two groups. Elderly quality of life was assessed at two stages; at the baseline before the intervention and approximately three months after completion of the intervention.

The intervention included eight training sessions of hope therapy (including Snyder's hope therapy, cognitive-behavioral therapy, solution-oriented therapy, narration therapy, etc.), presented only to the experimental group.

All ethical considerations were observed and the ethics code was obtained from the relevant research ethics board.

In order to avoid participants' from contacting each other, effort was made to hold the classes on special days and the same training sessions were held for the awaiting group. The content of the intervention package or techniques provided by the consultant is shown in Table 1.

Lipad Elderly Quality of Life Questionnaire is a 31-item questionnaire developed by Diego et al. (1998) in three cities of Leiden in the Netherlands, Padua in Italy and Helsinki in Finland.

It is an international standard tool for assessing the elderly quality of life based on the needs of this age group. The other objective of this study was to develop a valid and reliable instrument, which is easy to administer and free of cultural load. The

researchers believe that this questionnaire, as an international instrument with no cultural load, can be administered to all age subgroups of the elderly and in different communities.[22]

Seven dimensions of the questionnaire include physical (5 items), self-care (6 items), depression and anxiety (4 items), cognitive (5 items), social (3 items), life satisfaction (6 items), and sexual issues (2 questions).

In this questionnaire, high scores indicate high levels of life quality. This questionnaire was translated and standardized by Davami and Hesamzadeh and its reliability was confirmed (Cronbach's alpha = 0.874).[23] The alpha coefficient in this study was calculated as 0.79.

Results

Statistical indices mean (SD) and MANOVA were used to perform data analysis.

In this study, the participants were 24 elderly women, whose age ranged from 60 to 75 years old and that were at least able to read and write.

Using parametric and nonparametric tests, it was shown that the participants in the experimental group and the control group did not differ significantly in terms of demographic characteristics (P-value > 0.05). The Table 2 shows the mean and standard deviation values of dimensions of quality of life in the experimental and control groups before and after intervention. The significance level (P) was considered to be <0.05.

To assess the equality of variances in dimensions of the quality of life in the studied groups, the Levene's test was used. The results showed that the variances in the dimensions of life quality did not have a significant difference in the two groups. This finding indicates the reliability of the following results.

To investigate the assumption of homogeneity, the variance-covariance matrix of the elderly's quality of life dimensions was applied. The results of BOXS test showed that the homogeneity of the variance-covariance matrix was well observed (P-value > 0.05; MBOXS = 6.89; f = 25.2; and significance level = 0.34) (Table 3).

As Table 3 shows, the results of all tests indicate a significant difference between the experimental and awaiting groups with respect to the dimensions of life quality (P-value > 0.05, F = 0-4).

According to the findings, the effect size is equal to 0.49. In other words, 49 percent of the individual differences in dimensions of the elderly's quality of life were related to the training of the experimental group. To find out which dimensions of the elderly's quality of life varied between the two groups, one-way analysis of variance was conducted by MANOVA (Table 4).

Table 4 indicates that the differences in dimensions of physical functioning, depression and anxiety, mental functioning, and life satisfaction were significant between the experimental and awaiting groups. Based on the descriptive data (Table 1), the difference in all three dimensions was in favor of the experimental group and they had a higher mean score than the control group.

Table 1. Contents of the training sessions

The process of hope therapy consists of two main steps and each step consists of two stages. The first stage is the hope creation or hope induction, which is achieved by hope seeking and hope consolidation. The second stage includes increasing hope that will be accomplished by increasing and sustaining of hope. This stage briefly contains:

1. Hope seeking: Identifying hope by telling your own story, encouraging the clients to express their concerns, teaching body relaxation and guided meditation, focusing on the problematic field, reviewing it from multiple aspects in life, providing the logic of treatment to the clients, helping the clients to change the events of their stories from the perspective of hope, and showing them the direction when necessary. Reorientation of the clients towards the present time encourages them to have promising writings in the meetings.

2. Consolidation of hope: Therapeutic alliance between the clients and the therapist is the main component of hope among the clients.

3. Raising hope: Having a clearer conceptualization of the reasonable goals, creating many ways to achieve them, reserving energy to track and pursue goals, redefining and overcoming the obstacles to overcome them.
Target extension improvement techniques: The technique of creating a framework for revealing goals, the technique of setting clear and practical goals, the technique of creating an inner video, the technique of searching for creating stories of hope, profiling hope, and the technique of finding silver cover.

4. Maintaining hope: Identifying purposeful thoughts, identifying barriers, goal-oriented thinking, and having proper and active thinking about barriers is another factor in increasing hope.

Table 2. The mean (SD) values of dimensions of elderly quality of life in the experimental and control groups before and after intervention

	Group	Pretest		Post-test	
		Mean	SD	Mean	SD
Physical functioning	Experimental	10.91	2.7	8.16	3.01
	Awaiting	8.8	4.5	8.91	4.16
Self-care	Experimental	6.8	3.35	5.4	3.31
	Awaiting	7.08	4.2	6.91	4.69
Anxiety and depression	Experimental	7.08	3.28	4.83	1.58
	Awaiting	6.75	4.15	6.83	4.01
Mental functioning	Experimental	8.75	2.49	7.41	1.78
	Awaiting	9.16	4.08	9.41	3.44
Social functioning	Experimental	3.00	1.71	2.41	1.37
	Awaiting	3.33	2.29	2.66	1.07
Sexual functioning	Experimental	6.00	1.10	5.83	.87
	Awaiting	5.08	1.56	5.25	1.13
Life satisfaction	Experimental	6.58	3.82	4.16	1.89
	Awaiting	6.00	2.44	6.83	2.28

Table 3. MANOVA results on the mean scores of the elderly quality of life dimensions

Test	Value	F	Hypothesis degree of freedom	Error degree of freedom	Significance level	Eta-square
Pillai's trace	0.04	2.54	7	9	0.01	0.49
Wilks's lambda	0.95	2.54	7	9	0.01	0.49
Hotelling's trace	0.04	2.54	7	9	0.01	0.49
The largest root	0.04	2.54	7	9	0.01	0.49

Table 4. The results of inter-group test regarding the dimensions of quality of life

Source	Dependent variable	Mean square	Df	F	Significance level	Eta-square	Test power
Group	Physical functioning	18.85	1	2.4	0.05	22.2	48.0
	Life satisfaction	12.21	1	88.0	0.36	6.00	14.0
	Depression and anxiety	57.54	1	36.8	0.01	36.00	77.0
	Mental functioning	41.11	1	98.10	0.005	42.00	87.0
	Social Functioning	0.73	1	38.0	0.54	20.00	9.01
	Sexual functioning	2.77	1	1.01	0.93	1.01	0.05
	Life satisfaction	48.95	1	37.9	0.008	39.0	81.0
Error	Physical functioning	62.34	15	2.4			
	Self-care	206.34	15	88.0			
	Depression and anxiety	101.52	15	36.8			
	Mental functioning	56.25	15	98.10			
	Social Functioning	28.26	15	38.0			
	Sexual functioning	5.41	15	1.02			
	Life satisfaction	77.1	15	37.9			
Total	Physical functioning	20.7	24	2.4			
	Self-care	129.1	24	88.0			
	Depression and anxiety	104.6	24	36.8			
	Mental functioning	18.90	24	98.10			
	Social Functioning	189.1	24	38.0			
	Sexual functioning	75.7	24	1.02			
	Life satisfaction	86.6	24	37.9			

Discussion

The results of this research show that hope therapy in the post-test increased the quality of life among the elderly (P-value = 0.01). These results are consistent with the results of other studies.[18, 23, 24]

In one study, the quality of life in the elderly decreased with increase of depression. [23, 24] also found that increased rate of depression reduced the correction factors, benefits of possible preventive measures, motivation for healthy lifestyle, as well as leisure and sports' activities, which are effective in reducing the quality of life.

A study showed that hope therapy significantly improved the quality of life in depressed people by increasing positive attitude towards the future. [18]

Hope therapy helps the individuals to direct more attention to themselves. Therefore, it increases self-care by reducing depression. In addition, improving physical functioning increases the individuals' ability to take care of themselves. Hope therapy leads to self-care by addressing self-oriented goals, reducing depression, and improving quality of life.

In this dimension, hope therapy increased self-care by conceptualizing reasonable goals, creating many ways to achieve them, saving energy to track and pursue them, and redefining indomitable obstacles as challenges.

Use of solution-oriented, cognitive-behavioral, and narrative therapies, as components of the hope therapy has a substantial impact in increasing self-care among the clients.

Hope therapy increases physical functioning by changing the mental dimension, influencing the mind, and providing certain strategies for the clients such as clearer conceptualization of the reasonable goals, creation of many ways to achieve them, and saving energy to track and pursue them as challenges.

The result of research also showed the

importance of positive thinking and hope in physical and psychological well-being.[25] The result of research showed that hope has a significant role in adapting to health-related problems.[26]

In a study, it was shown that hope is related to adaptation to chronic diseases and the process of death.[27] In line with these results, showed that promotion of hope was an effective way to improve the quality of life in chronic patients.[28] The researchers observed an increase in the level of self-care measures and the clients' quality of life following an increase in their hope.

In line with this research, researchers indicated that people who are hopeful in solving problems are creative and effective and have positive perceptions of their own merits in solving problems in different domains. [17]

Hope therapy improves the mental functioning of the clients by improving their mental and physical functioning. As a cognitive therapy, hope therapy increases the mental functioning by strengthening the effective thinking.

Application of solution-oriented cognitive-behavioral therapy and narrative therapy, as components of hope therapy has a significant effect on the clients' mental functioning. Hope therapy improves the clients' social functioning by increasing their psychological, physical, and mental functioning.

The impact of training on sexual functioning was not confirmed, which can be due to the advanced age of our participants or not living with their spouses.

One study also showed that elderly people in Iran avoid answering sexual questions.[23] Additionally, the difference in scores of sexual questions between participants of this study and some other studies[29, 30] can be attributed to the cultural differences between the two communities.

From the researcher's point of view, one of the reasons for rejection of the research hypothesis can be the very poor sexual functioning of the participants caused by the cultural problems.

In this regard, cognitive training can enhance the consolidation of these older people's families and ultimately improve their functioning and quality of life.[31-33]

The samples of this research were selected from a small, dominantly religious population, which can affect the results.

In some studies the level of hope was related to the level of life satisfaction. Among the studied elderly people, those who were divorced as well as the widow/widowers had a lower level of hope. As limitations of this study, this research was conducted on elderly women; so, generalization of the results to other communities and men should be avoided.[1, 34, 35]

Besides, the clients rarely did home assignments due to memory weakness and physical problems. Consequently, future researchers are recommended to conduct the study on men and compare their results with our findings. Furthermore, they can use other educational methods to investigate the issue.

Conclusion

As the findings of this study showed, Hope therapy leads to an increase in social functioning by reducing the level of interpersonal unrealistic expectations, increasing the cooperative approach, and reducing the emotional reactions, enriching the marital relationships, and enriching the relationships through development of the relationship and the level of mutual commitment to the set goals. The impact of training on sexual functioning was not confirmed, which can be due to the advanced age of our participants or not living with their spouses.

Conflicts of Interest

The authors also have no conflicts of interest and have no involvement that might raise the question of bias in the results reported here.

Acknowledgements

Authors hereby appreciate Ms Farzadegan who encouraged the research process. Further, in the current study all ethical issues were observed base on the Helsinki Declaration.

Authors' Contribution

Conceptualization, M.N.; Methodology, H.Z.M.; Investigation, R.J. and H.Z.M.; Review & Editing, H.Z and E.F; Questonnair E.F.
All authors read and approved the final manuscript and are responsible about any question related to article.

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