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Research Article
Published: 30 Apr, 2018

Journal of Psychiatry and Behavioral Health Forecast

The Effect of Spiritual Care Based on Sound Heart Model on Quality of Life in Hemodialysis Patients

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Abstract

Background and Objective: Depression, anxiety and its consequences: frustration, mitigation of effort, as spiritual distress decreases quality of life in hemodialysis patients that requires spiritual care. The aim of this study was to investigate the effect of spiritual care, "based on the Sound heart model," on the quality of life in hemodialysis patients.

Methods: In a semi-experimental study, 32 outpatients under hemodialysis were selected. In educational support system, spiritual counseling was done based on the model. Intervention with emphasis on improving the four-person relationships with God, self, people and nature was done. The purpose of spiritual counseling was: creating optimism, hope and courage to face the crisis of disease, spiritual self-awareness, development of social communication with love and forgiveness, enjoyment of nature. Training spiritual skills in eight individual sessions was conducted by presenting a booklet. The SF36 quality of life questionnaire was completed before the intervention, after completing the consultation and three months later by the patients. The trend analysis was done by repeated measures analysis of variance.

Results: The mean (SD) age of the participants was 57.75 (12.56) and 62.5% of the samples were male. The quality of life score before intervention was 46.36 (14.98) and three months after the intervention, increased to 61.36 (13.16), there was a significant difference between the repeated (001/0 p<) measures using ANOVA

Conclusion: Spiritual counseling was able to provide self-efficacy, self-control and daily self-calculation in patients. Sound heart model can be used to improve the quality of life in hemodialysis patients.

Keywords: Quality of life; Kidney dialysis; Spiritual care

Knowledge Translation (KT)

“What is already known in this topic?” Existing studies have not used a care model. Researchers only have used a few religious concepts or Richard Bergin's interventions based on the Christianity beliefs by trying to adapt to the culture of Iranian Muslim patients.

"This article adds to the previously known knowledge" This study, while presenting a systematic method of care based on the spiritual care model of Sound heart in Islamic paradigm and with harmony with the beliefs of Muslim patients, teaches community-based care using an implementation algorithm.

Introduction

Hemodialysis is one of the most successful and commonly used methods for kidney replacement

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Received Date: *29 Mar 2018*
Accepted Date: *27 Apr 2018*
Published Date: *30 Apr 2018*

Citation: *Mazandarani HK, Asadzandi M, Saffari M, Khaghanizadeh M. The Effect of Spiritual Care Based on Sound Heart Model on Quality of Life in Hemodialysis Patients. J Psychiatry Behav Health Forecast. 2018; 1(1): 1006.*

ISSN 2643-802X

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in controlling chronic renal failure in the world and in Iran, which is essential for the continuation of life with this life-threatening illness [1]. Studies in 2014 showed that approximately 89% of the 662.2 million world's dialysis patients and 94% of the 27,457 Iranian dialysis patients, were hemodialysis patients [2]. This treatment is still the most important treatment for chronic renal failure, which results in more patients surviving, but is considered as a source of stress [3]. Hemodialysis results in: a feeling of dependence on the device, a change in lifestyle, a reduction in the ability to play social roles, an increase in the cost of health services, and a decrease in the quality of life of patients [4,5]. Hemodialysis also causes problems for patients such as: digestive complications, reproductive problems, skin problems, lack of focus, Irritability, boredom, sleep disorders, restless leg syndrome [6-8] and psychiatric disorders such as: depression and anxiety [9,10]. In the last decade, a 46% prevalence of depression has been reported in hemodialysis patients [11,12], which has led to: an increase in fatigue, decreased physical activity and patients' quality of life [13-15].

Quality of life is person's perception, from feeling of hope, life satisfaction, physical, mental, social, and family health [16], which is directly affected by stress and mental health status [17]. The neglect of quality of life leads to frustration, lack of motivation for efforts and reduction of economic, cultural and health activities of an individual [18]. Over time, with a significant change, hemodialysis patients develop a decline in quality of life [19]. There is a positive relationship between depression and pain with a decrease in quality of life [14,20] and a significant relationship between symptoms of insomnia and the psychological dimension of quality of life [21]. Depression requires care because it reduces adherence to treatment and increases clinical mortality [22,23]. Spiritual care, is an essential component of nursing practice, which determines how people respond to their illness, it is the most important contributor to achieving a balance in maintaining health and coping with illness [24]. Using religion for communication with God [25] and spiritual interventions while helping patients to cope with the biological challenges of disease [26]. It has a positive effect on patients' longevity [27] and improve hemodialysis patients' health [28,29]. Spiritual care by decreasing depression and anxiety of patients improves their quality of life [30,31].

In educational and support system, one of the most important psychological interventions in hemodialysis patients is psychosocial spiritual support and counseling [32]. Spiritual counseling is a treatment and intervention based on the potential power of faith and spirituality, in the direction of healing and recovery [33] which as a complementary method, improves the quality of life of patients [34]. The "Spiritual Care Model of Sound Heart", based on the religious spirituality of the Abrahamic religions, emphasizes self-care and home care in educational and support system. The goal of spiritual care in model is to achieve a healthy spirit or Sound heart (a calm and safe soul, full of trust, love, hope, joy, security, satisfaction of fate, pleasure, patience, happiness, optimism, without fear and future anxiety, as well as regret and sorrow) by development and correction of the four dimensions of human communication (with God, others, Self and nature). The model uses the assistance and participation of the patient and his family in care [35]. Regarding the necessity of community-based care, it acts in harmony with the values and beliefs the followers of the Abrahamic religions, including Muslim patients. For outpatients, provides counseling and spiritual skills training in an educational support system. It considers the values and interests of patients to choose the method of spiritual care and supports the patient and his family with a family-centered approach [36]. The model provides the possibility of establishing meaningful relationship with God by faith. With creating self-awareness (understanding the person's thoughts, intentions and emotional states), benefiting from nature and communicating effectively with family and friends [37] and creating a social-spiritual support network, for emotionally adaptation to illness [38]. So the aim of this study was to investigate" the effect of spiritual care based on the Sound Heart model on the quality of life of hemodialysis patients".

Materials and Methods

This study was conducted in a semi-experimental study, one group, before and after, at Baqiyatallah Hospital in Tehran in 1395. The sample size was calculated 32, using standard deviation and mean value obtained from Rahimi's study [39], with a 20% drop, the probability of the first type error is 0.05 and the test power equal to 80%. At first 38 patients were selected according to Inclusion criteria. (Adult patients, over 18 years, were able to complete questionnaires, Persian language, having a history of six months of dialysis, at least twice a week for dialysis). During the study, 6 patients were excluded according to exclusion criteria (illness leads to hospitalization, loss of self-care capacity, death, and transfer to another center for dialysis or kidney transplantation). Eventually, 32 patients formed the study volume. After receiving the Code of Ethics Committee and Clinical Practice Code, the researcher referred to the hemodialysis department of Baqiyatallah Hospital. According to patients' demographic data and inclusion criteria, samples were selected as available. After explaining the method of research and obtaining informed written consent, the questionnaires were completed before the intervention by the patients.

The demographic questionnaire (12 questions) included: gender, age, marital status, occupation, education, history of kidney transplantation, history of surgery and disease, vascular access, history of dialysis, number of dialysis, and duration of dialysis. The SF-36 quality of life questionnaire assesses the quality of life in eight areas: Physical function (10 questions) and body pain (2 questions) and general health (5 questions) physical activity limitations (4 questions) psychological limitations (3 questions) social functions (2 questions) energy domains (4 questions) and having a good feeling (5 questions). These eight domains form two physical and mental components. The physical component includes: physical activity areas, functional limitations due to physical problems, body pain. The mental component includes: having a good feeling, limiting emotional and social performance. Energy and public health are common in both areas. Questions are rated Likert (1 to 5). Each of these dimensions has 100 points. A high score reflects a better quality of life. The validity and reliability of SF36 quality of life questionnaire have been confirmed in studies both inside and outside Iran. The validity and reliability of the Persian translation of this questionnaire were approved by Mont Azeri et al. In 2005 and Cronbach's alpha was reported 0.65 [40].

The intervention included: nine spiritual counseling sessions, 15 to 45 minutes, individually, during dialysis once a week, with emphasis on improving the four-person relationships with God, self, people and nature. The purpose of spiritual counseling was: creating optimism, hope and courage to face the crisis of disease, spiritual self-awareness, development of social communication with love and forgiveness, enjoyment of nature. Training spiritual skills in individual sessions was conducted by presenting a booklet. After completing the training

Table 1: Comparison Quality of life (SF36) questionnaires in participants.

Level / Variable	Pre-test mean (SD)	Posttest 1 mean (SD)	Posttest 2 (Three months later) mean (SD)	Statistical test (RMANOVA)
Physical functioning	51.87(27.52)	59.53(24.96)	62.96(23.48)	F: 7.27 P:0.01
Role limitations – physical	31025(37.52)	38.28 (38.93)	78.12 (36.33)	F:19.00 P<0.001
Pain	44.45(21.42)	45.46 (17.49)	40.07 (15.44)	F:2.04 P:0.16
General health	41.09 (18.21)	43.43 (14.55)	42.34 (13.43)	F:0.26 P:0.60
Emotional well-being	54.50 (26.27)	62.00 (19.30)	67.00 (19.27)	F:13.77 P<0.001
Role limitations - emotional	48.95 (39.98)	61.45 (31.80)	87.50 (27.75)	F:18.36 P<0.001
Social function	55.46 (21.98)	57.81 (16.11)	56.64 (13.46)	F:0.12 P:0.73
Energy/fatigue	43.28 (20.14)	51.87 (15.33)	56.09 (17.02)	F:16.53 P<0.001
Quality of life (SF36)	46.36 (14.98)	52.48 (9.71)	61.34 (13.16)	F:28.33 P<0.001

sessions and three months later, the quality of life questionnaire was completed by the patients. To investigate the normal distribution of quantitative variables, the Kolmogorov-Smirnov test was used. The data obtained from the questionnaires were analyzed using SPSS24 software and repeated measures (RMANOVA) by using ANOVA test. The significance level in this study was less than 0.05.

Findings

The demographic characteristics of the sample, were as follows: 62.5% male, 84.4%, married persons, 50% of retired, 1.3% of illiterate, 81.2% did not have kidney transplants. After spiritual counseling and also three months later, the statistical analysis showed a significant difference (P<0.001). The mean (standard deviation) of the total quality of life questionnaire before the intervention was 46.36 (14.98) and 61.34 (13.16) three months later. Comparison of the domains of the SF36 quality of life questionnaire was found: physical activity, physical activity, feeling good, feeling and fatigue were significantly different. But in other areas, there was no significant statistical difference (Table 1).

Discussion

The findings of this study showed that after spiritual counseling based on Sound heart model, quality of life in hemodialysis patients was increased. Quality of life in hemodialysis patients was reported low in the study of Taheri et al. in Iran in 2010 [41] and Vigan et al. 2012-2013 at the Sylvanus Olympio University Hospital in Lomé, Togo [42] just like patients in this study.

Bormann [43] Kim and Spillers [44] used the Richards & Bergin spiritual interventions, include: praying for patients, encouraging patients to pray, discussing divine issues, using the Bible in the treatment, using techniques of relaxation and imaging, persuading the patient for forgiveness and sacrifice, helping the patient to be in harmony with spiritual values, self-disclosure of ideas, expression of spiritual experience, consultation with Priest. In Iran Mahdavi [45] Rehāni [46] used group spiritual care with the Richards & Bergin spiritual education package, which was co-sponsored by religious experts and professors, with Iran's culture and Islam. They provided spiritual care with emphasizes on trust, resort, patience, charity, mention, prayer. That is consistent with this research in the areas of: prayer and mention, pardon and forgiveness and speaking about divine destiny and self-disclosure of ideas. Spiritual interventions in this study include: strengthening and correction of the four dimensions of human communication (with God, others, self, and creation) by applying the skills of faith therapy (prayer, remembrance of God, healing touch with healing worship, trust, tolerance, and resort) to create the courage to face disease crisis, future optimism and hope. The skill of daily checking and recording of emotional states (self-calculation) for creating self-spiritual awareness. Recommending forgiveness, charity, goodness to develop relationships with people. And use of the blessings of the creation world (looking at the water and trees, listening to the song of birds, using bright and joyous colors, Kindness to animals, growing plants, Perfume use) to develop a relationship with nature [47].

The use of Richard Bergin's spiritual interventions, without any change, in the study of Ghahari et al. in Iran, had no significant effect on the stress, anxiety and depression of women with cancer [48]. The sound heart model Emphasizes community-based care and is in harmony with the religious culture of the Muslim people of the world and followers of the Abrahamic religions.

Spiritual Care and Strengthening Family Relationships in Kim's Study, increased Coping and Welfare among family caregivers of Alzheimer's Patients [49]. The sound heart model also looks at the home as a place to create a sense of security and relaxation in the patient. Emphasizes the strengthening of family relationships, the participation and support of family members in patient care and is consistent with this study. Momeni performed spiritual care program for three days based on the needs of the patient with the help of a clergyman and a family member and reduced the anxiety of patients with ischemic heart disease [50]. Sound heart model emphasizes on teamwork with the help of doctor, nurse, cleric, psychologist and family member for spiritual counseling. But in this study, the investigator performed all stages of spiritual care alone.

The frequency of anxiety and depression in hemodialysis patients in the study of El Filali et al. in the Northeast of Morocco Dialysis Center in 2015 revealed the importance of psychiatric care [51]. Aqajani used religious concepts such as: patience and amnesty to conduct spiritual counseling and could reduce the anxiety and depression of hemodialysis patients [52]. Morasaie in counseling with spiritual approach, succeeded in promoting hope in hemodialysis patients [53]. Bam dad had a significant effect on improving the spiritual health of patients by listening and instilling hope during hospitalization [54]. In these studies, a model of spiritual care was not used while this study was conducted based on a care model and

the interventions were planned and implemented in the form of executive steps and scheduling algorithm.

Application of the Sound Heart Model reduced anxiety in patients undergoing CABG, (36) and improved sleep quality in patients with coronary disease [55]. In these studies, spiritual care was performed by a nurse for hospitalized patients in the acute phase and in a semi-compensatory system. However, in this study, hemodialysis patients were considered as outpatients with self-care ability and therefore, in the educational system, spiritual counseling was conducted to give chronic patients an effective way of self-care.

The limitations of this study were: Lack of time for the student to measure the quality of life in six months to one year, the reluctance of patients family in counseling sessions, the lack of a place for spiritual counseling, the unwillingness of patients to attend hours for counseling other than dialysis time, and patients' unwillingness for home visits and lack of control group in the study. Therefore, it is suggested that spiritual counseling be performed, in a suitable place (like the counseling room), with the presence of the patient and one of his family members, in a teamwork form.

Conclusion

Using a community- based spiritual care model is an appropriate method to meet the spiritual needs of patients and improve their quality of life. Considering the importance of improving the quality of life in patients and the findings of this study, it is recommended to use this model for chronic patients.

Acknowledgments

We would like to sincerely thank and appreciates the dialysis staff of Baqiyatallah hospital and all patients who collaborated in conducting this study.

Conflicting of Interest

This article is extracted from a master thesis in nursing IRCT2016120431233N1 and ethics committee code number: IR.BMSU.REC.1395.180 at Baqiyatallah University of Medical Sciences, Tehran, Iran.

Financial Disclosure

Study was done with financial assistance of: spiritual health group, Academy of Medical Sciences and Quran, Hadith and Medicine research center of Baqiyatallah University of Medical Sciences.

References

1. Hinkle JL, Cheever KH. Brunner & Suddarth's textbook of medical-surgical nursing: Lippincott Williams & Wilkins. 2013.
2. Najafizadeh K. Date of kidney transplantation in Iran. Presented at the First International Congress on Nephrology and Urology 2015. Iranian Society for the Protection of kidney patients. State's kidney transplant. 2015: 2-6.
3. Pron K AZF, Ghouja Zadeh M, Ahangar R. The stressors and adaptability methods for patients undergoing peritoneal dialysis. Nursing & Midwifery Journal of Tabriz. 2010; 5: 34-41.
4. Ramirez SP, Macêdo DS, Sales PMG, Figueiredo SM, Daher EF, Araújo SM, et al. The relationship between religious coping, psychological distress and quality of life in hemodialysis patients. Journal of psychosomatic research. 2012; 72: 129-135.
5. Ouzouni S, Kouidi E, Sioulis A, Grekas D, Deligiannis A. Effects of intradialytic exercise training on health-related quality of life indices in haemodialysis patients. Clinical rehabilitation. 2009; 23: 53-63.
6. Dong R, Guo Z-Y, Ding J-R, Zhou Y-Y, Wu H. Gastrointestinal symptoms: a comparison between patients undergoing peritoneal dialysis and hemodialysis. World Journal of Gastroenterology: WJG. 2014; 20: 11370.
7. Danquah FVN, Zimmerman L, Diamond PM, Meininger J, Bergstrom N. Frequency, severity, and distress of dialysis-related symptoms reported by patients on hemodialysis. Nephrology Nursing Journal. 2010; 37: 627-639.
8. Zamanian H, Kharameh ZT. Translation and psychometric properties of the persian version of the dialysis symptom index in hemodialysis patients. Nephro-urology monthly. 2015; 7.
9. Rioux JP, Narayanan R, Chan CT. Caregiver burden among nocturnal home hemodialysis patients. Hemodialysis International. 2012; 16: 214-219.
10. Mollahadi M, Tayyebi A, Ebadi A, Daneshmandi M. Comparison between anxiety, depression and stress in hemodialysis and kidney transplantation patients. Iranian Journal of Critical Care Nursing. 2010; 2: 153-156.
11. Yucedal C, Olmez N, Gezen G, Celik F, Altindag A, Yilmaz M, et al. Depression in dialysis patients. Journal of Renal Care. 2003; 29: 151-155.
12. Saglimbene V, Palmer S, Scardapane M, Craig JC, Ruospo M, Natale P, et al. Depression and all-cause and cardiovascular mortality in patients on haemodialysis: a multinational cohort study. Nephrology Dialysis Transplantation. 2016; 32: 377-384.
13. Bai YL, Lai LY, Lee BO, Chang YY, Chiou CP. The impact of depression on fatigue in patients with haemodialysis: a correlational study. Journal of clinical nursing. 2015; 24: 2014-2022.
14. Belayev LY, Mor MK, Sevick MA, Shields AM, Rollman BL, Palevsky PM, et al. Longitudinal associations of depressive symptoms and pain with quality of life in patients receiving chronic hemodialysis. Hemodialysis International. 2015; 19: 216-224.
15. Chan L, Tummalapalli SL, Ferrandino R, Poojary P, Saha A, Chauhan K, et al. The Effect of Depression in Chronic Hemodialysis Patients on Inpatient Hospitalization Outcomes. Blood purification. 2017; 43: 226-234.
16. Zeraati AA, Naghibi M, Ojahedi MJ, Ahmad ZS, Hasan ZB. Comparison of Quality of Life between Hemodialysis and Peritoneal Dialysis Patients in Imam Reza and Ghaem Hospital Dialysis Centers in Mashhad. Medical journal of mashhad university of medical sciences. 2010: 169-176.
17. García-Llana H, Remor E, Del Peso G, Selgas R. The role of depression, anxiety, stress and adherence to treatment in dialysis patients' health-related quality of life: a systematic review of the literature. Nefrologia. 2014; 34: 637-657.
18. Heidari M, Alhani F, Kazemnejad A, Moezzi F. The effect of empowerment model on quality of life of Diabetic adolescents. Iranian Journal of Pediatrics. 2007; 17: 87-94.
19. Ferreira RC, Silva FilhoCRd. Quality of life of chronic renal patients on hemodialysis in Marília, SP, Brazil. Jornal Brasileiro de Nefrologia. 2011; 33: 129-135.
20. Santos PR. Depression and quality of life of hemodialysis patients living in a poor region of Brazil. Revista Brasileira de Psiquiatria. 2011; 33: 332-337.
21. Theofilou P. Association of insomnia symptoms with kidney disease quality of life reported by patients on maintenance dialysis. Psychology, health & medicine. 2013; 18: 70-78.
22. Almeida AM, Meleiro A, Alexandrina M. Revisão: Depressão e insuficiência renal crônica: umarevisão. Jornal Brasileiro de Nefrologia. 2000; 22: 192-200.
23. Saeed Z, Ahmad AM, Shakoor A, Ghafoor F, Kanwal S. Depression in patients on hemodialysis and their caregivers. Saudi Journal of Kidney Diseases and Transplantation. 2012; 23: 946.
24. Potter PA, Perry AG, Patricia, Stockert PH. Fundamentals of nursing:

Elsevier Health Sciences. 2016.

25. Tanyi RA, Werner JS. Women's experience of spirituality within end-stage renal disease and hemodialysis. Clinical Nursing Research. 2008; 17: 32-49.

26. Jofre R, López-Gómez JM, Valderrábano F. Quality of life for patient groups. Kidney international. 2000; 57: 121-130.

27. Aghighi M, Heidary Rouchi A, Zamyadi M, Mahdavi-Mazdeh M, Rajolani H, Ahrabi S, et al. Dialysis in iran. Iran J Kidney Dis. 2008; 2: 5-11.

28. Kimmel PL. Psychosocial factors in dialysis patients. Kidney international. 2001; 59: 1599-1613.

29. Oreopoulos D, Ossareh S, Thodis E. Peritoneal dialysis: past, present, and future. Iranian journal of kidney diseases. 2008; 2: 171-182.

30. Koszycki D, Raab K, Aldosary F, Bradwejn J. A multifaith spiritually based intervention for generalized anxiety disorder: A pilot randomized trial. Journal of clinical psychology. 2010; 66: 430-441.

31. Saffari M, Pakpour AH, Naderi MK, Koenig HG, Baldacchino DR, Piper CN. Spiritual coping, religiosity and quality of life: A study on Muslim patients undergoing haemodialysis. Nephrology. 2013; 18: 269-275.

32. Anandarajah G, Hight E. Spirituality and medical practice. American family physician. 2001; 63: 81-88.

33. Moarefzadeh S, Sodani M, Shafi AA. The study of the effect of teaching of contrastive training skills originated of quran on reducing anxiety among high school girl student in Ahvaz. 2010: 19-32.

34. Richards PS, Hardman RK, Berrett ME. Spiritual approaches in the treatment of women with eating disorders: American Psychological Association. 2007: 304.

35. Breiddal SMF. Palliative care: A place for caregivers to thrive. Illness, Crisis & Loss. 2011; 19: 111-124.

36. Asadi M, Asadzandi M, Ebadi A. Effects of spiritual care based on Ghalb Salim nursing model in reducing anxiety of patients undergoing CABG surgery. Iran J Crit Care Nurs. 2014; 7: 142-151.

37. Tanyi RA, Werner JS, Recine ACG, Sperstad RA. Perceptions of incorporating spirituality into their care: A phenomenological study of female patients on hemodialysis. Nephrology Nursing Journal. 2006; 33: 532.

38. Walton J. Finding a balance a grounded theory study of spirituality in Hemodialysis patients. Nephrol Nurs J. 2002; 29: 447-456.

39. Rahimi A, Ahmadi F, Gholyaf M. Effects of applying continuous care model on quality of life in hemodialysis patients. Razi Journal of Medical Sciences. 2006; 13: 123-134.

40. Montazeri A, Gashtasbi A, Vahdaninya M. Translate and determine the validity and reliability of such questionnaires Persian SF36. Payesh J. 2005; 5: 49-56.

41. Taheri N, Kamangar S, Cheraghian B, Mousavi SZO, Solaimanzadeh M. Life quality of hemodialysis patients. 2013; 8: 119-124.

42. Sabi KA, Noto-Kadou-Kaza B, Amekoudi EY, Vigan J, Ayamekpe K, Amedegnato D. Quality of life of hemodialysis patients in Togo: A single-center study on 64 hemodialysis patients at the Sylvanus Olympio University Hospital in Lomé, Togo. Saudi Journal of Kidney Diseases and Transplantation. 2017; 28: 609.

43. Bormann J, Warren KA, Regalbuto L, Glaser D, Kelly A, Schnack J, et al. A spiritually based caregiver intervention with telephone delivery for family caregivers of veterans with dementia. Alzheimer's Care Today. 2009; 10: 212-220.

44. Kim Y, Spillers RL. Quality of life of family caregivers at 2 years after a relative's cancer diagnosis. Psycho-Oncology. 2010; 19: 431-440.

45. Mahdavi B, Fallahi KM, Mohammadi F, Hosseini M. The effect of group spiritual care on quality of life in family caregivers of elders with Alzheimer's disease. 2015: 34-42.

46. Reihani T, Sekhavat Poor Z, Heidarzadeh M, Mosavi SM, Mazlom SR. The effect of spiritual self-care training on feeling of comfort in mothers of hospitalized preterm infants. Journal of midwifery and reproductive health. 2014; 2: 112-119.

47. Asadzandi M. Sound Heart: Spiritual Nursing Care Model from Religious Viewpoint. Journal of Religion and Health. 2015: 54.

48. Ghahari S, Fallah R, Bolhari J, Moosavi SM, Razaghi Z, Akbari ME. Effectiveness of cognitive-behavioral and spiritual-religious interventions on reducing anxiety and depression of women with breast cancer. Article in Persian] Know Res Appl Psychol. 2012; 13: 33-40.

49. Kim SS, Reed PG, Hayward RD, Kang Y, Koenig HG. Spirituality and psychological well-being: Testing a theory of family interdependence among family caregivers and their elders. Research in nursing & health. 2011; 34: 103-115.

50. Momeni T, Musarezaie A, Moeini M, NajiEsfahani H. The effect of spiritual care program on ischemic heart disease patients, anxiety, hospitalized in CCU: a clinical trial. Journal of Research in Behavioural Sciences. 2013: 554-564.

51. El Filali A, Bentata Y, Ada N, Oneib B. Depression and anxiety disorders in chronic hemodialysis patients and their quality of life: A cross-sectional study about 106 cases in the northeast of morocco. Saudi Journal of Kidney Diseases and Transplantation. 2017; 28: 341.

52. Aghajani M, Afaze MR, Morasai F. The effect of spirituality counseling on anxiety and depression in hemodialysis patients. Evid Based Complement. 2014; 3: 19–28.

53. Morasei F, Aghajani M. The effect of counseling with spirituality approach on hope in patients with chronic renal failure. Complement Med J Fac Nurs Midwifery. 2014; 4: 778–786.

54. Bamdad M, Fallahi Khoshknab M, Dalvandi A, Ardakani K, Reza M. Impact of spiritual care on spiritual health of hospitalized amphetamine dependents. Iran J Psychiatr Nurs. 2013; 1: 10–18.

55. Taheri Z, S AM, Ebadi A. The effect of spiritual care based on Ghalbe Salim Model on the sleep quality of the patients with coronary artery disease. Iran J Crit. Care Nurs. 2014; 7: 92-101.