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Group spiritual care impact on resilience of multiple Sclerosis patients in the multiple sclerosis society of Zahedan

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ABSTRACT

Introduction: Multiple sclerosis is one of the most common worldwide chronic diseases of the central nervous system, which causes various mood symptoms, including low resilience in various aspects of the patient's life.

Aim: To determine the group spiritual care impact on resilience of multiple sclerosis patients in the multiple sclerosis society of Zahedan.

Materials and Methods: The present research is a clinical trial study in which 96 multiple sclerosis patients covering by MS Patients Community of Zahedan were selected randomly and organized in two Intervention and control groups according to accessible and reliable conditions. Data were collected using a demographic characteristics questionnaire and Conner Davidson Persistence Scale, which completed before and after the intervention. The intervention group was subjected to 5 sessions of group spiritual care during 3 weeks and for the control group only discussed the daily issues. Data were analyzed by SPSS software version 14.

Results: Results showed that group spiritual care has a significant positive effect on increasing the resiliency of multiple sclerosis patients ($P<0.001$). In all resilience dimensions, including qualification and individual competence, tolerance of negative effects and being strong against stress, positive change acceptance, self-control, spiritual effects, there was a significant increase in scores ($P<0.001$).

Conclusion: Group spiritual care can be effective in increasing the resilience of patients with multiple sclerosis in all dimensions. Thus, the use of this type of care is recommended to improve the resilience of these patients.

Key words: Group spiritual care; Resiliency; Multiple Sclerosis

1. INTRODUCTION

Multiple Sclerosis (MS) is one of the most commonly chronic diseases of the central nervous system in the world (1) that is characterized by demyelination and axonal degeneration (2) and often occurs between the ages of 20 and 40 (3,4). In Iran, there is no exact number of people with this disease. At the 7th Iran MS International Congress, the number of people affected was announced about 40,000 (15 people per 100,000 people) (5). As other chronic diseases, observable psychological responses in these patients include persistent feelings of sadness, frequent perceptions of disability (6) so that these factors contribute to the low quality of life in these patients (7).Resilience of individual's ability to maintain physical health and feel good when faced to problems (8-10).Therefore, in difficult and stressful conditions, it increases the power of coping (11).There is a significant positive relationship between resilience and spirituality (12, 11). Murray and Zenier (1989) consider spirituality as a kind of psychological quality that goes beyond religious beliefs, makes motivation in human beings and creates emotions such as perceiving divine affection and respect for creation (13). Spiritual care in nursing refers to care provided by a nurse and is related to the patients religious and existential needs, such as their questions and experiences regarding the meaning and purpose of religion and spirituality (17), and can is useful for patients in finding the right strategy for compatibility (18). Spiritual care is recognized as the most important contributor to achieving a balance in maintaining health and coping with illness (19).Considering the high prevalence of psychological disorders such as low resiliency among multiple sclerosis patients (6), and the effect spirituality and consequently spiritual care can have on resilience and thereby the quality of life of these patients (16).

2. AIM

The aim of the study was to determine the group spiritual care impact on resilience of multiple sclerosis patients in the multiple sclerosis society of Zahedan.

3. MATERIALS AND METHODS

This study approved by ethics committee of Zabol University of medical science. This research is a clinical trial study that was conducted on M.S patients in two groups of intervention and control, in which the variable independent effect of the group of spiritual care on resiliency of multiple sclerosis patients who are covered by MS Community of Zahedan. The criteria for entering the study included: having MS, having no communication problems, reading and writing literacy, having at least 18 years of age. Exit criteria also consisted of unwillingness to cooperate at each stage of the study, requiring special care. The data collection tools was a two part questioner included demographic questionnaire (age, duration of disease, sex, marital status, number of children, education level, insurance status, employment status, family history of MS) and The Convron Davidson Resiliency Scale (CD-RISC). The Convron

Davidson Resiliency Scale (CD-RISC) produced by Conner and Davidson (21). The psychometric properties of this scale approved in another studies (20).This 25-point scale has five components: individual competency and adequacy, negative impact tolerance, positive acceptance of change, self-controling and spiritual effects. The questionnaire is based on a five-point Likert scale, in which answering completely incorrect gets score 0, and gives a perfect answer gets score 4. To get the total score of the questionnaire, the total points of all questions are combined. This score will range from 0 to 100. The higher the score, the greater the resilience of the respondent will be, and vice versa. The cut-off score for this questionnaire is 50. In other words, the score above 50 will be for those who are resilient, and whatever the score be more than 50, the person's resilience also will be higher, and vice versa (22). The reliability and validity of the Persian version of the resiliency scale have been also evaluated in the preliminary studies of normal and patient samples have been reviewed and approved. Including Mashalpour et al., in 2010 by correlating with Ahwaz's Psychological Hardiness Scale by calculating the correlation coefficient (r = 0.64) at a significant level (P <0.001) has shown this structure has a relatively high degree of validity (9). The sample size in this study was based on the results of the study by Taqizadeh et al. (2012) considering 20% of the dropping of specimens about 48 persons needed in intervention group and 48 persons in control group. Convenient sampling method was used. To blind experiment, two groups were invited separately in order to explain the goals and method of doing research. In the first stage, the questionnaires were given on how the questionnaires should be completed. In the second stage, intervention included group spiritual care. The intervention consisted of Spiritual Care Group meetings, with 5 sessions per week for 45 minutes to 60 minutes for 3 weeks and a 3-day session interval with educational content based on some of the parameters of the Strategic Strategy of Richards and Bergen (2005) And was oriented towards the religion of Islam by a qualified religious scholar (dressed in clergy, having underground education, having a teaching background). The topics presented in each session (Table 1) have already been presented in the study of Hosseini et al., 2014 (24). Immediately after the intervention, each patient was requested to complete the Conner Davidson Resuscitation Questionnaire. It should be noted that during the period of providing spiritual care for the intervention group, for 5 sessions of 45-60 minutes in 3 weeks and a 3-day interval the control group mental health problems and daily issues were addressed and discussed, and patients expressed their experiences and memories in these fields. At the end of the sessions, Conner Davidson Persistence Questionnaire was re-completed in this group, they were appreciated for their participation in the study and provided with educational packages. Ethical considerations including the confidentiality of information and the right to withdraw from the patient at each stage of the research are also observed. Data were analyzed by SPSS software version 14. This study approved in ethics committee of Zabol University.

4. RESULTS

Data on demographic characteristics and disease variables are shown in Tables 1, indicating that the two groups were homogeneous in terms of the distribution of these variables. Comparison of the resilience scores of the patients in the two groups before and after the intervention is presented in Tables 3. According to this table, regarding to the probability level obtained by Kruskal-Wallis test, the intervention and control groups did not show a significant difference in the mean score of resiliency before intervention (P> 0.001). However, the results showed that after the spiritual care there was a significant difference between the resiliency scores in both intervention groups and control groups (P <0.001). Also, the resiliency score in the control group did not change significantly at the end of the study (p = 0.839), while in the intervention group it increased from 23 to 51 (124%), which was statistically significant (p <0.001). The changes in the resilience score in the intervention group were significantly more than the control group (p = 0.0001). Analyzing percentage of changes in the resilience score in different dimensions showed that in the intervention group, the resilience level had a significant increase in all dimensions including individual competency and adequacy (p <0.001), negative effects (p <0.001) positive change in acceptance (p <0.001), self-control (p <0.001) and spiritual (p <0.001). Meanwhile, the most significant change was in terms of individual competency and adequacy. But the mean score in the control group did not significantly change in any of the dimensions (Table 2).

Table 1 The comparison of frequency distribution of MS patients according to demographic data in two groups before intervention

Personal properties		Control- group	Intervention- group	P value	Test
Age	Mean±SD	37/89 ± 9/36	38/77 ± 10/35	0/660	Independent - Samples T Test
Gender	Female	43(%89.58)	43(%89.58)	0.990	Chi square

	Male	5(%10.42)	5(%10.42)		
Marital status	single	9(%18.75)	7(%14.58)	0.346	Chi square
	married	37(%77.08)	35(%72.92)		
	Divorced/Widow	2(%4.17)	6(%12.5)		
No. of children	>3 children	26(%54.17)	25(%52.08)	0.838	Chi square
	≤ 3 children	22(%45.83)	23(%47.92)		
Education	College and before	20(%41.67)	23(%47.92)	0.538	Chi square
	After college	28(%58.33)	25(%52.08)		
Occupation	Practitioner	17(%35.42)	14(%29.17)	0.783	Chi square
	Student	3(%6.25)	2(%4.17)		
	Unemployed /Retired	31(%64/58)	29(%60.42)		
Insurance status	Insured	47(%97.92)	48(%100)	0.500	Chi square
	Not insured	1(%2.08)	0(0)		
MS in other members of family	Yes	0(%0)	1(%2.08)	0.990	Chi square
	No	48(%100)	47(%97.92		

Table 2 Total score of resonance and its subscales of MS patients in intervention and control groups at study baseline and after intervention period

Resiliency Group		control	Intervention	P-value	Test
		median	median		
Resiliency	Before intervention	25(22 , 29.5)	23(19 , 28.5)	0.127	kruskal Wallis
	After intervention	25(23 , 29)	51(50 , 54.5)	0.0001	
Sufficiency	Before intervention	7(5, 9)	6(5 , 8)	0.192	kruskal Wallis
	After intervention	7(5 , 9)	15.5(14 , 17)	0.0001	
Tolerance	Before intervention	8(5 , 10)	7.5(6 , 9)	0.811	kruskal Wallis
	After intervention	8(6 , 10)	15(14 , 16.5)	0.0001	
Acceptance	Before intervention	5(3 , 5.5)	4(3 , 6)	0.528	kruskal Wallis
	After intervention	5(3 , 6)	9(8, 10)	0.0001	
Self-control	Before intervention	3.5(2.5 , 5)	3(2 , 5)	o.577	kruskal Wallis
	After intervention	4(2 , 4.5)	8(7 , 9)	0.0001	
Spiritual effects	Before intervention	8(6 , 10)	2(1 , 3)	0.066	kruskal Wallis
	After intervention	5(3 , 5.5)	4(3 , 6)	0.0001	

5. DISCUSSION

In this study, group spiritual care increased the resilience in patients with multiple sclerosis. This section will discuss the results of this study. It should be noted that due to the limited studies available in this field, the researcher points to studies which differ in some aspects from the present study. In this study it was proved that MS patients had a low level of resilience before the intervention. Possibly, the patient's exposure to the constraints and problems of his illness and his inability to adapt to them has had an impact on the outcome (25) and is considered as the ability to match the level of control in terms of environmental conditions (26-28). In confirming these limitations and problems, Mardani Valendani (2015) writes that the prognosis of this disease is unknown and patients experience varying physical and psychological disorders due to the disease. The present study demonstrates the positive effect of group spiritual care on the resilience of MS patients in all dimensions. It can be deduced that the religious teachings presented during the intervention have a positive effect, and because of the feeling of strength, hope, serenity and confidence, the patient experience a promotion in all aspects of individual competence and adequacy, tolerance of negative effects, positive acceptance of change, self-control and spiritual. Lynn Gall et al. 2009 also suggested that religious / spiritual performance could indirectly affect the matching process through providing stronger and more accessible support and promoting a positive psychological state (29).One of the features of the intervention of the present study was that the group's spiritual care with an orientation toward Islam was presented and its positive effect on the resilience of MS patients was confirmed. Possibly this care has affected the resilience of their patients through strengthening the religious these patients beliefs (30). In confirmation of this article, Ehteshamzade (2011) writes that in a religious person, all events are considered by God as even disaster and blessings. He is obliged to tolerate the difficulties that cannot be justified by the power of reason, tolerate by faith to achieve evolution (31). McNulty (2004) as a result of his study suggested that spiritual health has an impact on the adaptation of MS patients (34). Particularly that these patients may not be of good spiritual health. As Allah Bakhshian et al, as a result of their study, which examined the spiritual health of patients with MS, suggested that the majority of patients (97.9%) were moderate in terms of spiritual health and considering the impact on the various aspects of the lives of these patients, emphasized the need to design programs to improve it (35).

Amir Arjmandi et al. (2015), while confirming the role of religion and spirituality in health, emphasized that there are two types of positive and negative spiritual coping styles, positive spiritual confrontation, characterized by faith in God, and the belief that God cares for his servants, but the negative spiritual confrontation is determined with the feeling that negative events of life and diseases are a sign of God's punishment or grudge in response to a person's guilty or unbeliever. Unlike positive spiritual confrontation this kind of negative coping has opposite effect on the health of the patient (36). With regard to the above, it seems that health care providers, while striving to strengthen the religious and spiritual beliefs of patients, need to be careful not to make negative spiritual responses of patients through the use of these beliefs.

Another feature of the intervention was that the spiritual care was provided in group and its positive effect on the resilience of MS patients was confirmed. Ramezani and Ehzhamami (2015) also presented the efficacy of therapeutic reality on increasing the resilience of MS patients in group and its positive consequences bring up group association, insight and learning resulting from interaction, get to know the meaningfulness of joint pain and ease of emotional drain (37). However, in terms of intervention and the research community, these two studies are different from the present study but are consistent in terms of outcome and are therefore referred to in this section.

6. CONCLUSION

The present study showed that group spiritual therapy with orientation towards Islam in 5 sessions of 45 to 60 minutes in 3 weeks could improve the resilience of MS patients. Therefore, if the beliefs and spiritual backgrounds of these patients are strengthened, they can greatly increase the tolerance of the problems and limitations of the disease in these patients and make them more adopted. Therefore, with regard to the religious background of Iranian society, which provides a suitable platform for the use of this kind of education, on the one hand, and without its complication on the other hand, the use of this type of care is recommended for patients with MS. It is also recommended that a study with high-volume of cases be conducted to identify the factors affecting the degree of resilience of these patients.

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CONFLICT OF INTEREST

None declared.

AUTHOR CONTRIBUTION

Design: MR, MR, Acquisition of data: MR, HS, analysis and interpretation of data: MA, Drafting the article: HS,ASV, final approval of the version to be published : MR,MR, HS, ASV.

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