Vol. 4, No. 3, (2023), 92-102
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***Published online* September, 2023**

Journal of Preventive Counseling (JPC)

The Effect of Spiritual Therapy on Psychological Resilience and the Spiritual Well-being of Caring for Patients During the COVID-19 Pandemic

DOI: 10.22098/JPC.2022.10510.1089

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Abstract

Aim: This study aimed to assess the effect of spiritual therapy on psychological resilience and the spiritual well-being of caring for patients during the COVID-19 pandemic. **Method:** This study was a quasi-experimental study with a pre-test post-test design with control and intervention groups. The statistical population of the study included all caregivers of patients, who were referred to Tehran's hospitals during the COVID-19 pandemic, for treatment between June and September 2021. Thirty caregivers who were willing to participate in the research were selected as the sample using voluntary sampling and randomly divided into experimental and control groups. Each group of caregivers consisted of 15 individuals. Both experimental and control groups achieved a pretest on Conner & Davidson's (CD-RISC) Resiliency questionnaire and Spiritual Well-being Scale (SWBS). The experimental group received fourteen sessions of spiritual therapy (90-minute sessions twice a week), but the control group did not receive any spiritual therapy. In addition to descriptive statistics, Analysis of covariance (ANCOVA) was used to analyze the results, and all analyses were carried out using SPSS-18 software. Findings indicated that spiritual therapy showed a significant difference in the results among the two groups. **Finding:** Results showed significantly increased psychological resilience and spiritual well-being mean scores of the caregivers in the experimental group compared to the control group after the intervention**. Conclusions:** Consequently, it is beneficial to implement practices to promote the psychological resilience and spiritual well-being of caregivers. This study provides important implications for clinical practice.

Keywords: Spiritual therapy, psychological resilience, spiritual well-being, caring for patients, the COVID-19 pandemic.

Introduction

There has been a global tragedy caused by Covid-19, including in Iran. As a result of SARS-CoV-2 infection, more than 47 million people have died (Prazeres et al., 2021). It has affected all aspects of human life, including both physical and mental health (Lee & Morling, 2020; C. Liu et al., 2020; Pfattheicher et al., 2020). Many studies have addressed COVID-19 since it turned into a global (International Alliance of Carer Organizations, 2020). During the COVID-19 pandemic, caregivers have also been at greater risk of poor physical and mental health, such as depression and anxiety (Centers for Disease Control, Mental Health Statistics, 2020). The caregiver burden is multidimensional and encompasses difficulties in assuming and functioning in the caregiver role. Caregiving is also associated with effects on the caregiver's emotional and physical health that can occur when care demands exceed resources. Caregivers must coordinate care between the patient and healthcare professionals, as well as manage the patients' diet, treatment-related symptoms, side effects, and other issues such as stress and anxiety (Koral, & Cirak, 2021). Previous studies have reported the moderating and mediating effects of both psychological resilience (Wang et al., 2019), and spirituality on the relationship between increased stress and negative outcomes such as depression, anxiety, and decreased life satisfaction (Havnen et al., 2020; Liu et al., 2019). Psychological resilience (Wang et al., 2019), as well as spirituality, have both been reported to moderate and mediate the link between increased stress and negative outcomes, such as depression, anxiety, and decreased life satisfaction (Havnen et al., 2020; Liu et al., 2019). The ability to mentally or emotionally deal with an emergency crisis, or to quickly return to the pre-crisis status, is known as psychological resilience. People with high resilience cope with traumatic events more effectively and experience lower levels of psychiatric symptoms than those with low resilience. Accordingly, resilience may help individuals to reduce psychiatric symptoms (Koral, & Cirak, 2021). Researchers have shown the connection between spirituality and resilience and their impact on healing, emotional, and mental well-being, as well as coping and resilience (Sharma et al., 2017; Havnen et al., 2020; Liu et al., 2019; Roberto et al., 2020).

Spirituality can be helpful as a sedative in societies dealing with an epidemic (Fardin, 2020). In today's times of the COVID-19 pandemic, spiritual skills can be a resource to address mental health issues, both among the general population, especially the most vulnerable, including the elderly, sick, marginalized, and those affected by psychiatric conditions, caregivers, and certain categories of workers, including healthcare professionals (Chirico, 2021). Religious and spiritual beliefs during the COVID-19 pandemic have also been associated with higher levels of hopefulness and lower levels of fear, worry, and sadness, which suggests that spiritual and religious coping can be used by individuals in a positive (i.e. finding meaning, spiritual connection, and benevolent religious reappraisals) and not in a negative (i.e. religious struggle, punishment and reappraisal of God's power) way (Lucchetti et al., 2020). Therefore, to address the spiritual needs and religious beliefs of patients and families, public health stakeholders should ensure the continuity of spiritual and religious activities during the pandemic as well as the training of healthcare professionals on this topic (Chirico, 2021). A recent

literature review (Ho et al., 2018) identified several benefits associated with meeting the spiritual needs of patients in intensive care units, such as perceived improvement in care quality, enhanced patient satisfaction, and a better perception of care among family members. Similar results are reported in a recent systematic review of spiritual support in terminal illness (Chen et al., 2018), and indicate that spiritual care can improve care quality and patients' wellbeing, as also found in a study focusing on patients' perspectives (Ebenau et al., 2020). Echoing these findings, the third review in palliative care in Europe showed that the effects of spiritual care are positive, particularly in terms of reducing the patient's discomfort (Gijsberts et al., 2019).

Although spirituality is a significant coping mechanism in disease states, spiritual well-being has been neglected in both clinical practice and research. There are very few studies on the relationship between spiritual well-being and care burden in caregivers (Spatuzzi et al., 2019; Rezaei, Fathi, Roshani, & Kalhor, 2019). Interventional studies have shown that the spiritual well-being of caregivers of PWC can be increased, thereby reducing care burden, anxiety, and depression. Lapid et al. (2016) determined that there was an improvement in the spiritual well-being of caregivers after a structured multidisciplinary intervention session. Although both spirituality and psychological resilience are known to play an important role in individuals' attempts to cope with adverse events, there are no studies investigating the effective roles of spiritual therapy on the psychological resilience and spiritual well-being (SWB) of caregivers of patients during the COVID-19 pandemic. Accordingly, this study evaluates whether spiritual therapy affects the psychological resilience and spiritual well-being (SWB) of caring for patients during the COVID-19 pandemic.

Methods

This study was a quasi-experimental study with a pre-test post-test design with control and intervention groups. The statistical population of the study included all caregivers of patients, who were referred to Tehran's hospitals during the COVID-19 pandemic, for treatment between June and September 2021. The inclusion criteria included: age range between 19 and 50 years, literacy, participants in the study were caring for a COVID-19 patient for at least one week, did not suffer from a cognitive disorder or mental illness, and written consent to participate in the intervention program. The exclusion criteria included: the absence of more than two sessions from treatment. Thirty caregivers who were willing to participate in the research were selected as the sample using purposive sampling and randomly divided into experimental and control groups. Each group of caregivers consisted of 15 individuals (ρ=1.7, $1-\beta$=0.95, and α=0.05) (Safinia, Ebrahimi Moghadam, & Abolmaali, 2021). The researcher used a coin-throwing method to assign participants to groups after obtaining their consent. Both experimental and control groups underwent a pretest on Conner & Davidson's (CD-RISC) Resiliency questionnaire and Spiritual well-being scale (SWBS). The experimental group received fourteen sessions of spiritual therapy (90-minute sessions twice a week), but the control group did not receive any spiritual therapy. This study involved the assistance of a clinical therapist for the administration of the protocol mentioned. The training sessions are summarized in Table 1. The post-test was conducted under the same conditions in the experimental and control

groups after the intervention program. The study was conducted online to decrease the risk of COVID-19 transmission. A questionnaire created with Google Forms was shared electronically via Instagram. Before completing the questionnaire, caregivers had to read a fact sheet with information about the study and its objectives. Caregivers who were able to access the online questionnaire and voluntarily participated were included in the study. Once their consent was provided, caregivers could proceed to the questionnaire by ticking the box accompanying the statement, "I agree to participate in the study. The forms were designed in such a way that each participant could complete the survey only once.

Data collection

Data were collected using a sociodemographic information form, Conner & Davidson's (CD-RISC) Resiliency questionnaire, and the Spiritual well-being scale (SWBS).

Sociodemographic information form: A caregiver's information was requested in this form. Caregivers' age, gender, marital status, and length of marriage are also taken into account, in addition to their socioeconomic and employment status, relationship to the patient, the amount of time they spend caring for the patient, and whether they have previous care experience, chronic illnesses.

Conner & Davidson's (CD-RISC) Resiliency questionnaire: Resiliency was measured in this study based on Connor, & Davidson, (2003) resiliency questionnaire. This scale has 25 5-option (never, rarely, sometimes, often, always) items. Thus the total score ranges between 25 and 100. About half of the items are stored in a reverse direction, and the higher scores show greater ability and the lower scores lower strength in resiliency. Confirming the construct validity of the questionnaire, Mohammadi reported its reliability as 0.93 by calculating its Cronbach alpha. Ghiasvand and Ghorbani (2015) reported the questionnaire's reliability as 0.87 and adapted it for use in Iran. Mohammadi obtained the reliability coefficient of the scale as 0.89 and obtained the validity of the scale between 0.41 and 0.64 by correlating each item with the total score of the category. Moreover, the reliability of the resiliency sale was obtained as 0.83 and 0.77 using the Cronbach alpha and the Split-half method, respectively.

Spiritual well-being scale (SWBS) whose reliability and validity were confirmed in a study conducted by Daaleman, & Frey (Cronbach alpha coefficient: 0.82) (Daaleman, & Frey, 2004). The questionnaire includes 20 questions. 10 questions measure religious well-being and the other 10 questions measure existential well-being. The range of religious well-being scores and existential well-being scores is 10 to 60. The higher the score measured, the higher the degree of existential and religious well-being. These two scores together make the spiritual well-being score. Its range is considered between 20 to 120. Answer to questions is classified based on 6-item Likert from completely disagree to agree. Scoring the questions is done in a reverse manner, and finally, the spiritual well-being is divided into three levels: low (20 to 40), moderate (41 to 99), and high (100 to 120) (Seyedfatemi, Rezaie, Givari, & Hosseini, F. (2006).

Table 1. Summary of the content of spiritual therapy(Richards & Bergin, 2005)
First session: Introducing and introducing the participants to each other. Expression of definitions and distribution of questionnaires
second session: Self-awareness and communication with oneself and listening to the inner voice, examining needs and goals
Third session: Awareness raising, meditation, calculation, and follow-up. Examining the past relations and accepting its role in the current behaviors of the authorities and its effect on moods
Fourth session: Meaning to life events according to values. Goals and beliefs, talk about guilt, repentance, forgiveness
Fifth session: Emphasis on accepting personal responsibility. Teaching ways to deal with social tensions
Sixth session: Doing spiritual work in groups, holding congregational prayers, focusing on resources, giving thanks, practicing
Seventh session: Create enlightenment and insight. Self-confidence, self-reliance, and self-esteem
Eight sessions: Learn ways to support others. Physical, mental, social self-care
Ninth session: Mention and feel the presence. How to pray and for whom to pray, the content of the prayer
Tenth sessions: Emphasis on reality, the need for meaning and growth in life to maximize motivation
Eleven sessions: Eleven Spiritual self-control.
Twelve sessions: Talking about death, the cause of fear of death, resurrection, and life after death, gratitude, faith, trust in God
Thirteen sessions: Practice how to live happily and enjoy life in the present, avoid chasing and pursuing happiness
Fourteenth Session: Reviewing and summarizing the contents of previous meetings with an emphasis on looking after what we have and giving thanks and enduring problems with trust and hope in God

Results

In terms of demographic profile, the mean age of the caregivers was 39.21 ± 11.49 years. Most respondents were 48.8% were female, 41.6% had a primary school education, (45.3%), married (48.3%) or single (40.5%), without children (44.81%), employed or self-employed (43.2%).

Table 2. Descriptive indicators of variables in experimental and control groups

Groups	Variables	Pre-test	Post-test
		Mean±SD	Mean±SD
Control	psychological resilience	34.12±16.6	34.23±16.90
	spiritual well-being	38.42±10.43	38.27±10.44
Experimental	psychological resilience	35.33±17.3	59.87±10.45
	spiritual well-being	39.40±7.78	69.90±12.80

A multivariate covariance analysis was used to investigate the effectiveness of spiritual therapy on psychological resilience and the spiritual well-being of caring for patients during the COVID-19 pandemic. To determine the normalization of the distribution of scores, the Kolmogorov–Smirnov test was used, which was confirmed due to the lack of significance obtained from the normal distribution of scores (P>0.05). In this study, the box test for evaluating the equality of covariance matrix variables in the experimental and control groups also showed that the covariance matrix dependent variables in the groups were equal (F=1.87, BOX M=1.438, P>0.05). After evaluating multivariate covariance analysis, the test results showed a significant difference in psychological resilience and the spiritual well-being groups and control groups (Wilks Lambda=0.166, F=52.60, P <0.001).

Table 3: The results of single-variable covariance analysis

Dependent Variable	Source	SS	df	MS	F	p-value	Eta
Psychological resilience	group	3125.33	1	3125.33	73.43	0.001	0.423
Spiritual well-being	group	231.32	1	231.32	134.343	0.001	0.456

According to Table 3 F for psychological resilience (P<0.01, F=73.43) and spiritual well-being (P<0.01, F=134.343) are significant. Based on these findings, these variables differ significantly between groups. Taking these findings into consideration, it is possible to conclude that spirituality therapy intervention training is effective at improving psychological resilience and spiritual well-being. Furthermore, the effect size in Table 3 shows that group membership is responsible for 42.3% of psychological resilience changes and 45.6% of spiritual well-being changes.

Discussion

The goal of the current research was to study the effectiveness of spirituality therapy on the psychological resilience and spiritual well-being (SWB) of caring for patients during the COVID-19 pandemic. The results showed that the spiritual therapy group increased the psychological resilience and spiritual well-being (SWB) of caregivers of the experimental group in comparison with the mean of the control group. Also, the difference between the scores of the experimental group and control group or the effect of the spiritual therapy group difference in post-test psychological resilience and spiritual well-being (SWB) of caregivers scores were related to a spiritual therapy group.

According to the results of the present study, Zadeh, & Nia (2021) have shown that spiritual therapy promotes psychological capital in patients with Covid-19 disease, improving depression, mental health, and mental functioning. The findings of another study suggested that spirituality therapy promoted the hope score in patients with MS. (Afshar et al., 2021). Poorakbaran, Mohammadi GhareGhozlou, & Mosavi, (2019) revealed that the spiritual therapy group increased the resilience of the experimental group in comparison with the mean of the control group.

Also, the difference between the scores of the experimental group and control group or the effect of the spiritual therapy group difference in post-test resiliency scores was related to a spiritual therapy group. Spirituality therapy also had a greater effect on cortisol levels and resilience when compared to other therapies. Moreover, spiritual therapy intervention increased the resiliency of women with breast cancer (Mohamad Karimi, & Shariatnia, 2018). Additionally, Poorakbaran, Mohammadi Ghare Ghozlou, and Mosavi examined the impact of group spirituality therapy on postoperative resilience in breast cancer survivors, finding that 76% of the difference in postoperative resilience scores was related to the group spirituality therapy (Poorakbaran, et al., 2019). An aspect of spirituality is the feeling of connectedness to a transcendent phenomenon, such as the universe, god, or life's purpose. This connectedness, whether related to religion or not, is crucial for societal well-being. As a way to cope with serious and life-threatening adversities, people often turn to a higher power or religion (Koral, & Cirak, 2021).

Studies on caregivers in the pre-COVID-19 period are also limited. Of these, two studies showed that caregivers with high spiritual well-being had a better quality of life and lower care burden scores (Spatuzzi et al., 2019; Vignade Castro, & Fumis, 2020). Vigna et al. (2020) reported that low spirituality increased the emotional burden of caregivers of palliative care patients. Kasapoğlu (2020) also reported a negative correlation between spiritual well-being and fear of COVID-19 in the normal population. One way (if not the only way) to counteract such Coronavirus effects is to strengthen and deepen spirituality. Building a stronger relationship with God the Almighty reduces distress, anxiety, and stress and increases calmness and hope, which in turn improves immunity to disease. By using spirituality to combat uncertainties caused by pandemics, communities could promote health and prevent disease (Heidari, Heidari, & Yoosefee, 2020).

There are several limitations of this study. This study was motivated by the COVID-19 outbreak, however, the outbreak precluded face-to-face data collection, even though a larger number of participants could have been accessed in a regular healthcare setting. Additionally, data collection was conducted online, which has some disadvantages in terms of data reliability. Another limitation of the study was the need for Internet access. The age distribution of the participants suggests a group with a relatively high level of Internet literacy, but the results cannot necessarily be generalized. Moreover, the sample was selected using a non-random sampling method and with a small sample group. Therefore, it cannot be generalized to the whole of Iran. In addition, the sample was limited to those who were able to respond to the online questionnaire and participate in intervention sessions. The study is also limited by a lack of follow-ups. Considering the quasi-experimental study, different implementations of the protocol, sampling method, the type of tools, and how those tools are implemented, the executive and researchers will be advised of the restrictions on the present study. The strength of this study, it is one of the few studies that assessed the effect of spirituality therapy on the psychological resilience and spiritual well-being (SWB) of caregivers of patients during the COVID-19 pandemic.

Conclusion

Since the pandemic has occurred, caregivers' psychological resilience and spiritual well-being needs have changed. Caregivers require assistance with spiritual therapy, receiving

social support, and protecting themselves against psychological effects and infection. The present study is the first to assess the psychological resilience and spiritual well-being of caregivers during the COVID-19 pandemic. Based on our findings, spirituality therapy increased psychological resilience and spiritual well-being in caregivers during COVID-19. Consequently, it is beneficial to implement practices to promote the psychological resilience and spiritual well-being of caregivers. This study provides important implications for clinical practice, as it identifies the spiritual needs of caregivers, as well as guides future studies to determine the spiritual needs of caregivers. Additionally, online applications can be developed to assist caregivers in areas in need during the pandemic.

Disclosure Statements

In this study, the authors declare that they receive no funding from organizations.

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