

The Effect of Group Spiritual Care on Hope in Patients with Multiple Sclerosis referred to the MS Society of Zahedan, Iran

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Abstract

Background and Aim: Multiple sclerosis (MS) is known as an autoimmune disease and a chronic inflammatory condition, inducing a wide variety of mood affective disorders, including depression and feelings of hopelessness in many aspects of patients' quality of life (QoL). In view of the positive side effects of spirituality and spiritual care on finding appropriate strategies for further adaptation, this study aimed to determine the impact of group spiritual care (GSC) on levels of hope in patients suffering from MS.

Materials and Methods: This clinical trial was conducted on a total number of 96 patients with MS, referring to the National Multiple Sclerosis Society (NMSS) in the city of Zahedan, Iran. Following sample selection via the convenience sampling technique, the patients meeting the inclusion criteria were randomized into two groups, i.e., intervention and control. The data collection tools for this purpose included a demographic information form and the Adult Hope Scale (AHS, Snyder et al. 1991), completed by the subjects at the pre- and post-intervention stages. As well, the intervention group received five sessions of GSC during three weeks but the control group members only talked over daily issues along with their mental health problems. The data were also analyzed using the SPSS Statistics software (ver. 14).

Results: The Kruskal-Wallis test results revealed that the GSC intervention could have a significant positive effect on raising hope in the patients with MS ($p < 0.001$). Moreover, a significant growth was observed in the scores of hope dimensions including agency and pathway ($p < 0.001$).

Conclusion: GSC can effectively boost levels of hope in patients suffering from MS in all dimensions. Therefore, it is recommended to utilize this type of care in order to nurture hope in such individuals.

Keywords: Group Spiritual Care, Hope, Multiple Sclerosis, Iran

Introduction

Multiple sclerosis (MS) is known as a progressive and degenerative disease of the myelin sheath of the nerve cells in the central nervous system (CNS) (Givi & Hosseini Kiasari, 2014), whose complications typically occur in individuals aged between 20 and 40 (Hosseini, Habibi, & Basharpour, 2013). Women also suffer from this condition two to three times more than men (Borghi et al., 2013). According to the statistics, approximately 2.5 million people are live through MS all over the world (Damal, Stoker, & Foley, 2013); however, there is no accurate statistics on the number of infected cases in Iran. As reported at the Seventh International MS Congress in Iran, the number of patients with this condition had been by 40 thousand cases (namely, 15 cases per 100 thousand people) (AshkTorab et al., 2011).

With reference to various studies in this field, the prevalence rate of cognitive and mental health disorders in patients with MS has been estimated at 30 to 70%. In this sense, depression and feelings of hopelessness are among common problems of chronic diseases inflammatory including MS (Givi & Hosseini Kiasari, 2014). From this perspective, hopelessness accompanied by depression, death drive, and suicide attempts, has been defined as tolerance of insuperable conditions and situations, wherein it is not expected to achieve some goals (Baljani et al., 2011). On the contrary, hope has been depicted as the process of thinking about personal goals as well as motivation and ways to accomplish them (Poorgholami et al., 2016). According to Snyder's Hope Theory and its related therapies, hope has been described as a construct consisting of two concepts, including "agency", meaning the capacity to identify routes to personal goals and to start moving towards them, and "pathway", which refers to one's problem-solving ability to overcome existing obstacles in the routes to meet goals (Hirsch & Sirois, 2014). For that reason, there is a significant positive relationship between hope and spirituality (Fallah et al., 2011). In this respect, spirituality and spiritual beliefs empower individuals to manage daily life stressors and aid them feel peace, hope, and comfort and find faith (Frouzandeh, Aein, & Noorian, 2015). Connecting to the omnipotence also assures these individuals that a strong power will always care for them. These people feel more comfortable at events due to their faith and beliefs, they get less stressed and anxious, and as a result, their expectations for the future are much more optimistic (Salimi et al., 2017). In the course of crises and illnesses, spirituality similarly turns out to be of utmost importance. In fact, spiritual needs become more obvious, providing an opportunity for the delivery of spiritual care by nurses (Pahlevanzade et al., 2016).

Since nursing is to maintain and upgrade health, to prevent illnesses, and to relieve patient discomfort, spiritual care can have a big share in attaining this goal (Saeedi Taheri, Asadzandi, & Ebadi, 2013). Nurses' behavioral patterns in the field of spiritual care can be further divided into two categories, including religious and non-religious interventions. In this regard, the religious interventions reflect on treating patients without bias through religious beliefs to endow them with opportunities to communicate with God and to express their values and beliefs and even to help them practice rituals via their referrals to religious leaders. On the

other hand, the non-religious interventions contain the presence of nurses showing love and compassion to patients at the bedside and next to family members, with direct eye contacts and listening to their talks (Zehtab, & Adib Hajbaghery, 2014). Spiritual or religious care, which is assumed ethical, human-oriented, and sensitive to patients is thus a valued part of overall care services (Bolhari, Naziryy, & Zamaniyan, 2012) that can aid patients find strategies for effective adaptation (Rahimi, Nouh, & Nakhaee, 2013) because support for individuals with sufferings and pains is the key aspect of this type of care (McSherry & Jamieson, 2013).

Given the rising prevalence rate of MS in Iran and the little research on the effect of group spiritual care (GSC) on raising hope in patients with this condition, the present study aimed to determine the effect of GSC on levels of hope in the patients with MS, referring to the National Multiple Sclerosis Society (NMSS) in the city of Zahedan, Iran.

Materials and Methods

This clinical trial was conducted on two groups, i.e., intervention and control, wherein the effect of GSC as the independent variable on hope was investigated in the patients with MS, referring to the NMSS in the city of Zahedan, Iran. Upon obtaining the letter of permission from the Ethics Committee of Zabol University of Medical Sciences (ZUMS), Zabol, Iran, and coordinating with the authorities, this study was completed for three weeks. The study population included all of the patients with MS, referring to the NMSS in the city of Zahedan, Iran, meeting the inclusion criteria, i.e., infection with MS, no communication problems (namely, no hearing and vision impairment), reading and writing ability, a minimum age of 18 years, and adhering to Shia Islam. Among the exclusion criteria were the patients' unwillingness to cooperate at any stage of the study, need for intensive care services, immigration, and death. The data collection tools in this study were: (a) a demographic information form, validated by reviewing books and research articles as well as consulting with 10 faculty members at ZUMS, Zabol, Iran, whose reliability was measured using the test-retest method. This questionnaire was comprised of nine items related to demographic characteristics including age, disease duration, gender, marital status, number of children, level of education, insurance status, employment status, and family history of MS, and (b) the 12-item Adult Hope Scale (AHS) developed by Snyder et al. (1991) to assess levels of hope, administered as a self-assessment tool. The given questionnaire contained two dimensions, namely, agency (items no. 2, 9, 10, and 12) and pathway (items no. 4, 1, 6, and 8). As well, the misleading cases were items no. 3, 5, 7, and 11 (19). The scoring procedure in this questionnaire was based on a four-point Likert-type scale (definitely false=1, relatively false=2, relatively true=3, definitely true=4) (Zahed-Babelan, Rezaei Jamaloei, & Herfati Sobhan, 2012) and that was in reverse order for the items no. 3, 5, 7, and 11 (definitely false=4, relatively false=3, relatively true=2, definitely true=1). The scores of the misleading items were not included. The minimum and maximum scores obtained from the questionnaire could be 8 and 32, respectively. Accordingly, lower scores could mean low levels of hope and high scores represented high levels (Nasiri & Jowkar, 2010).

Snyder and Lopez in 2007 had also reported the reliability coefficient of this scale by 0.80, using the test-retest method, and its internal consistency through the Cronbach's alpha from 0.74 to 0.84 (Khaledian & sohrabi, 2014). Nasiri and Jowkar in 2011 had similarly calculated the reliability of this scale via the factor analysis and the principal component analysis (PCA) with varimax rotation. The Kaiser-Meyer-Olkin (KMO) measure for this scale was equal to 0.81 and the Bartlett's test of sphericity coefficient was 644.81, which was significant at the level of 0.0001. Besides, the results of the factor analysis showed two main factors on the scale, together explaining the variance by 0.51. The Cronbach's alpha was further employed to assess the reliability of this scale, wherein the coefficients of 0.62 and 0.74 were achieved for the subscales (Nasiri & Jowkar, 2010). Kermani et al. in a study in 2010 on 371 graduate students from six universities based in the city of Tehran, Iran, had also reported the convergent and divergent validity of the AHS compared with the Scale for Suicide Ideation (SSI, Beck et al., 1979: 0.535), the Multidimensional Scale of Perceived Social Support (MSPSS, Zimet et al., 1988: 0.407), and the Meaning in Life Questionnaire (MLQ, Steger et al., 2006: 0.575). The Cronbach's alpha reliability of this scale for agency, pathway, and in total was 0.77, 0.79, and 0.86, respectively (Kermani, Khodapanahi, & Heydari, 2011). In a study by Hamid (2011) recruiting a sample size of 364 students, the Cronbach's alpha for the total scale was 0.89 and that was 0.71 and 0.67 for agency and pathway, respectively. This questionnaire also had internal consistency (Hamid, 2011). The sample size in the present study was determined based on the results reported by Taghi-Zadeh et al. (2013) (Taghizadeh & Mirallai, 2011), for about 22% difference in changes in the resilience scores in two groups with and without interventions, by taking 20% attrition into account, using the Stata software (ver. 11), by about 48 people in each intervention and control group. The study samples, selected through the convenience sampling technique, meeting the inclusion criteria and signing oral and written informed consent forms were accordingly randomized into two groups, i.e., intervention and control. To meet blinding in this study (namely, single-blind), both groups were separately invited and then the research purpose and methodology were explained. In the first phase of the study, the demographic information form and the AHS were distributed and then full explanations were given on how to complete them. In the second phase, the intervention, including GSC was implemented. The intervention involved five group sessions for spiritual care, two times a week, lasting 45-60 minutes for a period of three weeks with three-day intervals between the sessions. The educational content of the intervention was developed based on some parameters within the spiritual strategies proposed by Richards and Bergin (2005) with orientations towards Islam, provided by an eligible religious expert (wearing religious clothes, completing seminary training, and having teaching experience). The topics presented in each session (Table 1) had been already employed in the study by Hosseini et al. (Hosseini et al., 2013). Immediately after the completion of the intervention, each patient was asked to re-complete the AHS.

During the implementation of GSC for the intervention group, five discussion sessions lasting 45-60 minutes were also held for the control group for a period of three weeks with three-day intervals regarding daily issues along with their mental health problems, wherein the patients

could talk about their experiences of life and memories in this respect. As the final session ended, the AHS was also re-completed by the control group. They were ultimately appreciated and presented with educational packages. Furthermore, ethical considerations, including information confidentiality and right to withdraw at any stage of the study, were respected.

The data were then analyzed using the SPSS Statistics software (ver. 14). To investigate the homogeneity of the groups in terms of the demographic characteristics, the Chi-square test was exercised. To compare the group means and the effect of the spiritual care pattern developed by Richards and Bergin on levels of hope in patients with MS, the Wilcoxon signed-rank test and the Kruskal-Wallis test were respectively employed.

Table 1: GSC and topics presented in each session

Sessions	Topics
First	Introduction, briefing, and establishment of group cohesiveness
Second	Role of the Holy Quran recitation in personal relaxation
Third	Role of recommended invocations and their repetitions in personal relaxation
Fourth	Role of daily prayers in personal relaxation
Fifth	Explanations for experiences of spiritual care and its effects as well as preparation of participants to leave groups and to use their achievements

Results

The demographic information and the variables associated with the patients are presented in Tables 2 and 3, indicating that both groups were homogeneous in terms of the distribution of these variables.

Comparisons of hope scores among the patients in both study groups at the pre- and post-intervention stages are also provided in Table 4. Accordingly, no significant difference was observed in the median scores of hope in the intervention and control groups before the intervention with respect to the probability value obtained by the Kruskal-Wallis test ($p > 0.001$), but the results demonstrated a significant difference between the median scores of hope in both groups after the GSC intervention ($p < 0.001$). Similarly, the hope score in the control group showed no significant difference at the end of the study. The median score of hope in the control group thus reduced from 15 to 14.5, which was not statistically significant ($p = 0.785$). Nevertheless, the median score augmented from 15 to 22 in the intervention group by 43%, which was statistically significant ($p < 0.001$). The volume of changes in the intervention group was significantly higher than that in the control group ($p = 0.0001$).

Examining the percentage of changes in hope scores in different dimensions indicated a significant increase in all dimensions in the intervention group, including agency ($p < 0.001$) and pathway ($p < 0.001$) (Table 5).

Discussion

In the present study, the GSC intervention advocated hope in patients with MS. The findings also revealed that the patients with MS had low levels of hope before this intervention. Lack of complete recovery and exposure to recurrences may have thus caused them experience feelings of hopelessness. According to Madani (2008), infection with MS undermines a person's self-confidence in the body health and as recurrences are unpredictable, patients are induced that they are unable to plan for their future (Madani et al., 2010). Mardani (2016) also believed that the prognosis of this disease was unknown and patients could be subjected to various types of physical, mental, social, and family-related disorders, severely affecting their independence in performance and planning for the future (Mardanivalendani & Ghafari, 2014).

Moreover, the present study showed the positive effect of the Islam-based GSC on levels of hope in patients with MS. Accordingly, strengthening the spiritual beliefs in these patients during the intervention was possibly effective in achieving these results. As stated by Ghahremani (2012), religious beliefs and faith in God would increase failure tolerance, prevent emergence of physical and mental illnesses, and ultimately raise hope for the future (Ghahremani & Nadi, 2012). Shoa Kasemi (2010), in a research investigating the relationship between religious adaptation strategies and mental health in patients with MS had correspondingly suggested that religiosity and religious practices could be regarded as effective strategies in terms of coping with stress and problems caused by this condition (Shoaa Kazemi, 2010). Additionally, Bussing, et al. (2013) in their study on patients with MS had labeled faith as a factor giving sense to this disease, making patients view it as a chance to grow and gain value in life (Bussing et al., 2013). In support of this, Mac Nolte (2004) had found that spiritual health could shape patient compliance with MS (Mc Nulty, Livneh & Wilson 2004); in particular the appropriate level of mental health may not be evident in patients. According to Alahbakhshian et al. (2010), examining spiritual health in patients with MS, majority of the patients (97.9%) was at the moderate level in terms of spiritual health. So, they had stressed the need to design programs to improve it with regard to the effects of this factor on various aspects of patients' quality of life (QoL) (Allahbakhshian, Jafarpour & Parvizi, 2011).

There were also research studies in which the impact of spirituality and hope had been explored in patients suffering from other diseases, including the correlational study by Ottaviani et al. (2014), in which a direct positive relationship had been uncovered between levels of hope and sense of spirituality in patients with chronic renal failure (CRF) undergoing hemodialysis (Ottaviani et al., 2014). Other studies, namely, the one by Salimi et al. (2017), had reflected on the effect of group spiritual self-care on life expectancy in patients with coronary artery disease (CAD) (Salimi et al., 2017), the survey by Morassaie (2014) on the impact of spiritual-based counseling on life expectancy in patients with CRF (Morassaie & Aghajani, 2014), and the study by Kazemi and Saadati (2011) on the effect of cognitive-behavioral therapy on reducing hopelessness in women with breast cancer confirmed (Shoaa Kazemi & Saadati, 2010). Although these investigations were different in terms of the type of intervention and the sample

size recruited, they were included in this study because they had examined the impact of strengthening spirituality on hope. Abdollahzadeh (2016) also believed that patients whose spiritual aspects of their life had been strengthened could effectively adapt to their disease. Life meaningfulness in stressful conditions was further introduced as the heart of any preventive-educational interventions in this domain (Abdollahzadeh et al., 2017).

Conclusion

This study established that GSC with an Islamic approach during five sessions, lasting 45-60 minutes, for three weeks, could raise hope and resilience in patients with MS. Therefore, strengthening beliefs and spirituality in these individuals could make them adopt positive attitudes to the world, help them on how to accept unchangeable conditions and situations like diseases, and give them hope to live a better life. Considering the religiosity in the Iranian society, paving the grounds for uncomplicated GSC interventions, it is recommended to utilize this type of care for patients with MS. Furthermore, it is suggested to carry out studies recruiting a larger sample size aimed to identify factors affecting levels of hope in these individuals.

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Table 2: Comparison of mean and standard deviation of patients with multiple sclerosis in terms of individual characteristics (age, duration of affection) in the two groups before intervention

exam type	P- Value	Control	Intervention	Group Individual characteristic
		Mean (sd)	Mean (sd)	
Independent-Samples T Test	0.660	37.89(9.36)	38.77(10.35)	age

	0.229	12.08(7.80)	14.50(9.18)	The duration of affection

Table 3: Comparison of frequency distribution of patients with multiple sclerosis in terms of demographic information in the two groups before intervention

exam type	P value	Control group		Intervention group		Individual characteristic	
		Percent	Number	Percent	Number		
Chi square	0.99	%89.58	43	%89.58	43	Female	sex
		%10.42	5	%10.42	5	male	
Chi square	0.346	%18.75	9	%14.58	7	Single	marital status
		%77.08	37	%72.92	35	married	
		%4.17	2	%12.5	6	divorced Wife died	
Chi square	0.838	%54.17	26	%52.08	25	Less than 3 children	Number of children
		%45.83	22	%47.92	23	Three children and more	
Chi square	0.538	%41.67	20	%47.92	23	Diploma and lower	Education
		%58.33	28	%52.08	25	Higher than diploma	

Chi square	0.783	%29.17	14	%35.42	17	Employed	Employment status
		%6.25	3	%4.17	2	Student	
		%64.58	31	%60.42	29	Unemployed/retired	
Chi square	0.500	%97.92	47	%100	48	Insured	Insurance status
		%2.08	1	0	0	No insurance	
Chi square	0/99	0	0	%2.08	1	Yes	Infection of other family members with multiple sclerosis
		%100	48	%97.92	47	No	

Table 4: Comparison of patients hope scores with multiple sclerosis in both groups before and after intervention

P-value	Control group	Intervention group	Group
	Middle (distance between the percentiles)	Middle (distance between the percentiles)	
0.124	15(11.5-18.5)	15(14-18)	Before intervention
0.0001	14.5(11-18.5)	22(21-24)	After intervention
0.0001	0(-6.46&8.01)	43.30(29.41&57.74)	Changes percent

Table 5: Comparison of patients hope dimensions with multiple sclerosis in both groups before and after intervention

exam type	P-value	Control group	Intervention group	Group Hope	
		Middle(distance between the percentiles)	Middle(distance between the percentiles)		
kruskal Wallis	0.189	7(6&9.5)	7(6&9)	Before intervention	agent
kruskal Wallis	0.0001	7(6&8.5)	11(10&12)	After intervention	
kruskal Wallis	0.847	8(5&10)	8(7&9)	Before intervention	pathway
kruskal Wallis	0.0001	8(6&10)	11(10&13)	After intervention	

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