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Effect of the combination of Benson's relaxation technique and brief psychoeducational intervention on religious coping, sense of coherence, and quality of life of family caregivers

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Abstract:

INTRODUCTION: Chronic diseases leave a huge impact on the life of children and their family caregivers (FCGs). Therefore, the present study was conducted to determine the effect of the combination of Benson's relaxation technique (BRT) and brief psycho-educational intervention (BPI) on religious coping (RCOPE), sense of coherence (SOC), and quality of life (QoL) of FCGs in children with chronic disease.

MATERIALS AND METHODS: The study population, consisted of 100 FCGs whose children were afflicted by chronic diseases, and participated in the current quasi-experimental pretest posttest design. The children were recruited from two state pediatric hospitals in Tehran, Iran. The RCOPE, SOC, and QoL of FCGs were assessed twice, through pretest (T1) and posttest (T2), four weeks after the intervention, by means of RCOPE, SOC and SF-36 questionnaires. The FCGs participated in four training sessions lasting up to 70 min over one week, followed by four more weeks of training. The Chi-square, Fisher's exact tests, independent *t*-test, and paired *t*-test were performed.

RESULTS: Positive RCOPE had a significant rise at T2 ($P = 0.020$) compared with negative RCOPE that did not show significant changes in T2. SOC scores for the intervention group remarkably rose at T2 ($P = 0.022$); but, for the control group, the drop was marginal. The QoL scores of both physical and mental components were statistically significant in the intervention group at T2 ($P < 0.05$).

CONCLUSION: Findings of the present study suggest that BRT and BPI can help significantly improve the RCOPE, SOC, and QoL of families with children suffering from chronic diseases. Measures that could enhance the RCOPE, SOC, and QoL include low-cost interventions, good safety, and decent outcome.

Keywords:

Chronic diseases, coping, family caregivers, quality of life, religious, sense of coherence

Introduction

Seventy of all deaths are due to chronic diseases.^[1] Chronic diseases such as heart conditions, cancer, diabetes, stroke, chronic respiratory disease and mental conditions account for nearly 90% of healthcare expenditures in US.^[2] These conditions require ongoing medical attention or limit

the activities of daily living and last 1 year or more.^[2] The share of mortality from noncommunicable diseases in Iran currently stands at 82%.^[3] The consequences of chronic diseases include a range of physical, mental, and social implications that affect patients and their family members, friends, and caregivers.^[4] Chronic kidney diseases (CKD) and diabetes are two highly prevalent

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chronic conditions in Iran. CKD is accompanied with lifelong disability and enforces high treatment costs on the families. The findings of a study showed that 91% of patients aged 15–75 years old in Kerman in Iran had some degrees of CKD.^[5]

Diabetes currently affects over 425 million people in the world and 4,985,500 cases of diabetes were reported in Iran in 2017.^[6] Despite improvements in treatment and rates of morbidity and mortality, it continues to remain a substantial burden on affected children and their families.^[7] Furthermore, family caregivers (FCGs) are engaged in long-term treatments, health services coordination, delivery, and management of the social, emotional, and financial problems that accompany chronic diseases, in addition to the high psychological impact.^[8,9] Caregivers may also find it difficult to face the overwhelming news of their children's diagnosis, associated medical risks, and in some cases, the possibility of shortened life expectancy.^[10]

Religion seems to be an important coping strategy for those facing life-threatening illnesses as well as their caregivers. Religious coping (RCOPE) is defined as a means of dealing with stress and could include prayers, congregational support, pastoral care, and religious faith. The stress-buffering effects of RCOPE have been evident in various studies.^[11,12] Studies have demonstrated that many people turn to religion as a resource in their efforts to understand and deal with the most difficult times of their lives.^[11,13]

Sense of coherence (SOC) mirrors one's introduction to life and measures the person's ability to utilize existing assets (keeping in mind the end goal) to conquer challenges, survive life stressors, demonstrate healthy behavior, and stay healthy.^[14] Other studies have reported a link between higher SOC and better QoL in parents of children with chronic disease.^[15,16]

WHO defines "Quality of Life (QoL) as an individual's perception of their position in life in the context of the culture and value systems in which they live and in relation to their goals, expectations, standards, and concerns."^[17] The caregivers' QoL scores are related to the information received and the personal resources of the caregivers. FCGs of children with chronic diseases need information about the medical condition and available resources. Nurses have an important role in educating FCGs about the medical condition and coping strategies. In this study, QoL has been used as a health outcome measure.

The purpose of this study was to determine the effect of the combination of Benson's relaxation technique (BRT) and Brief Psycho-Educational Intervention on RCOPE,

SOC and QoL of FCGs in Iranian children with chronic diseases.

Materials and Methods

The current quasi-experimental, pretest posttest study was conducted on 100 FCGs of children who were suffering from a chronic disease (50 in each of the control and intervention groups). These children had been admitted to two public and educational pediatric hospitals in Tehran, Iran in 2016. The intervention included four 60–70-min training sessions over the course of a week with a 4-week follow-up. Sample size was determined at a confidence level of 95% and test power of 80%, and the moderate effect reach of 50 FCGs for each group.

The inclusion criteria were for children to be between 1 and 16 years of age, and have FCGs who were blood relatives. The inclusion criteria for the FCGs were being over 18 years old, having knowledge of Persian language, having no history of or current psychiatric or neuropsychological disorders, and having taken care of their children for at least 1 year. The study's exclusion criteria indicated having a deceased child, and having encountered a critical life event irrelevant to their child's condition within the last 30 days. In addition, FCGs who did not participate in all educational sessions in the intervention group were not included in the analysis.

Of the total 143 FCGs who completed the questionnaire at the pretest stage, 43 FCGs did not participate in the second one (T2). The long commute between home and hospital was the most cited cause for missing the sessions. Two more participants were dropped out of the study due to pregnancy and unsuitable physical conditions and the death of the sick child [Figure 1]. The two participants were in the intervention group and were excluded from the study after completion of questionnaires in the first phase and participated in four training sessions before completing the second phase's questionnaire.

The authors ensured that all procedures comply with the ethical standards and relevant national guidelines on human experimentation. This study was approved by the Ethics Committee of Iran University of Medical Sciences (Grant No: 93-D-105-2440) and complied with the Helsinki Declaration. The FCGs of children provided informed verbal and written consent. The information letter explained the purpose of the study and ensured confidentiality of the collected data, the voluntary nature of participation, and the possibility of withdrawal at any point during the trial. The information letter also revealed the location of the research. FCGs of children with chronic diseases in the control group also

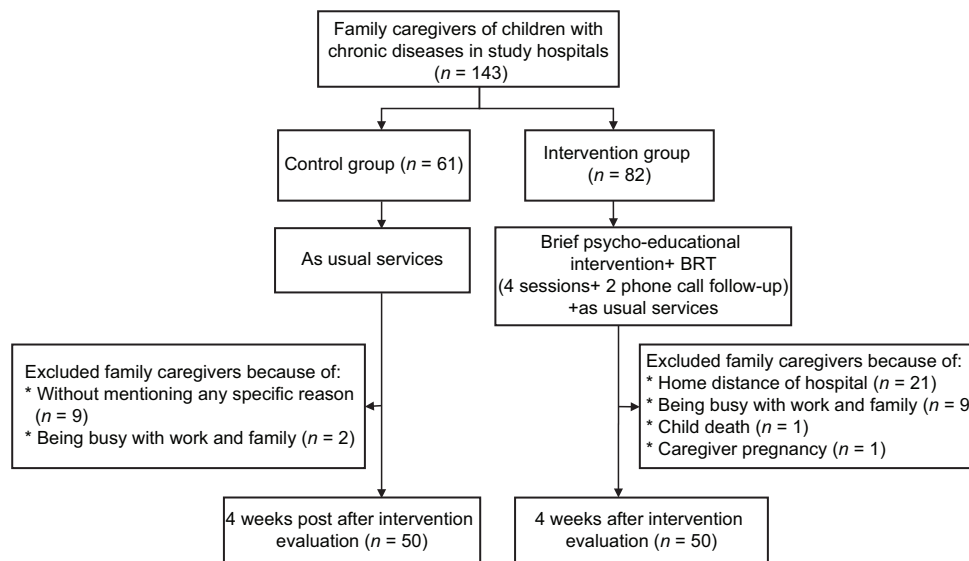


Figure 1: Diagram of the participants enrollment in the study

received the educational package at the end of the final intervention.

Instruments

The Brief RCOPE is a 14-item questionnaire that measures RCOPE with major life stressors. As the most commonly used measure of RCOPE in the literature, it has contributed to the growth of knowledge about the roles that religion plays in the process of dealing with crisis, trauma, and transition.^[18] Each of the 14 items vary in intensity on a four-point rating scale from “not at all” to “a great deal”, which distinguishes between positive and negative RCOPE. The positive pattern consists of religious forgiveness, seeking spiritual support, collaborative RCOPE, spiritual connection, religious purification, and benevolent religious reappraisal. The negative pattern is defined by spiritual discontent, punishing God reappraisals, interpersonal religious discontent, demonic reappraisal, and reappraisal of God’s powers. The scores range from 7 to 28 for each single scale with the higher score indicating a stronger positive or negative pattern of RCOPE. The Brief RCOPE and its Iranian version have been evaluated as valid with high Cronbach’s alpha coefficients (>0.70).^[19]

The original SOC scale consists of 29 items (SOC-29), while its shorter variation has 13 items (SOC-13). The SOC scores range from 13 to 91, and the higher score indicates the stronger SOC. The SOC scales have been validated for more than 33 languages in 32 countries.^[20] However, the SOC-13 scale is considered to be applicable cross-culturally. Over the years, the concept of SOC has become well established in public health and health promotion, and thus, has received the attention of healthcare researchers. It has proven to be a valid and reliable scale and has been used in Persian studies.^[19]

The short form health survey (SF-36) was designed and created by Ware and Sherbourne in the US in 1992, and the SF-36 was translated into Persian with approved reliability and validity. The questionnaire assesses eight indicators of general health and both physical and mental components of QoL. This tool is scored on a scale of 0–100 where the score 100 signifies high QoL and the score 0 indicates low QoL.^[21]

The demographic information questionnaire included personal information of FCGs such as age, sex, education level, marital status, insurance and economic status, as well as the child’s information, including age, sex, birth order, type of disease, and the duration of illness.

Intervention

The intervention was comprised of brief psycho-educational intervention (BPI) and BRT programs, intended to help improve the RCOPE, SOC, and QoL of FCGs in children with chronic diseases. The number of participants in each session varied from three to six. Two faculty members, a pediatric nurse, a rehabilitation therapist and an expert pediatric nurse trained the participants in the intervention group. Four sessions of training were held over four consecutive days during a week. The process continued until the size of the intervention group reached 50. Each session was divided almost equally into three parts; lectures, group discussions and relaxation technique. At the end of each session, extra time was allocated to questions and answers. The training sessions were ensured not to exceed 70 min to guarantee the intervention would not be overwhelming for the FCGs and their children. The lecture phase lasted up to 20 min. The lecture covered areas such as information on the children’s disease and caring techniques, what anxiety means

and how to identify its signs, ways of dealing with stress, critical thinking strategies, managing negative thoughts, and how to change ways of life. Five minutes of each following session were reserved for reviewing the previously covered topics. In the group discussion, the participants were asked to discuss and share their experiences on the session’s topic. They shared their points of view and opinions about the experiences of other participants as every participant was offered an opportunity to speak up. At the last 15 min of a 1-h session, the participants received training on BRT and relaxation techniques as follow:

FCGs of children with chronic diseases were instructed to: (1) sit in a relaxed position, (2) close their eyes, (3) relax their muscles from the top of their bodies to their toes while inhaling and exhaling slowly, (4) be mindful of their breathing while focusing on a single phrase being repeated in their thoughts, for instance, inhale... exhale, etc., Then, the participants were asked to practice the techniques daily for 10–20 min at a time. The optimum time for the exercise was at nights when the participants did not have to worry about their children anymore. Those practicing the exercise could keep track of time by looking at the clock, but were not allowed to set an alarm. They were also advised to concentrate on relaxation rather than the technicalities of the exercise in spite of potential disturbance.^[22] Throughout the exercise, the participants were provided with supervision on implementation of the techniques and guidance if necessary, which took about 20 min once the researcher

was assured that all participants had learned the practices and were able to execute them without errors. Each caregiver participating in the sessions was provided with a volunteer to help take care of their child during the practices.

Toward the end of the fourth session, the researcher distributed instructive handouts on the illnesses, side effects, medicines, and the mental issues that she had talked about during the sessions. Four weeks after the last training session, all individuals in the intervention and control groups were asked to complete the questionnaires once again.

During those 4 weeks, the participants were supposed to study the materials and practice BRT on a daily basis. The researcher was available through personal contact information, which she shared with the participants for any further questions or uncertainties. The researcher also contacted all participants to remind them to practice BRT, and to answer any potential questions they might have at the end of the intervention. The intervention’s details are shown in Table 1.

Data analysis

The statistical analyses were conducted using the Statistical Package for Social Sciences Version 19 (SPSS Inc, Chicago, IL, USA). The normal distribution of quantitative variables was measured using the Kolmogorov–Smirnov test, and the χ^2 test compared independent groups for data normality. In addition,

Table 1: A summary of intervention content and issues

Sessions	Brief description of intervention	Duration
One	The FCGs knowledge of child chronic disease, stage of treatment and strategies to cope with chronic diseases of children were assessed and evaluated Appropriate methods of physical care of children with CKD or diabetes were taught BRT was taught	60-70
Two	Health facts, effects of stress, depression, and caregiving were described Fear management and negative thinking were explained by focusing on positive thinking Aspects of family functions were identified to determine both strengths and weaknesses BRT was practiced	60-70
Three	The importance of coping with crisis and strategies for crisis management were expanded Education on psychosocial issues and coping with problems were provided BRT was practiced	60-70
Four	Effective communication strategies for communicating with children with chronic disease, family and friends, and good listening skills were clarified BRT was practiced	60-70
After intervention called once a week	An instructive booklet was distributed about stress management, BRT, CKD, and diabetes Appropriate methods of physical care for children with CKD or diabetes were reviewed BRT practices were reviewed Questions were answered BRT practices were reviewed	10-15
Four weeks after intervention	Questions were answered SF36, RCOPE, and SOC questionnaires were completed The intervention was closed	15-20

BRT=Benson’s relaxation technique, FCGs=Family caregivers, CKD=Chronic kidney disease, RCOPE=Religious coping, SF=Short form, SOC=Sense of coherence

paired and unpaired *t*-tests were used for continuous data. The differences in the RCOPE, SOC, and SF-36 scores were found significant after calculating the effect size. The effect size was calculated by dividing the difference between pretest and posttest scores using the standard deviation of pretest scores. According to Cohen, an effect size of 0.20 is small, >0.50 is moderate, ≥0.80 is high,^[23] and *P* < 0.05 was considered as statistically significant.

Results

Sample characteristics are summarized in Table 2. All FCGs of children with chronic diseases were mothers with a mean age of 33.78 (±6.7) years in the intervention and 33.46 (±8.1) years in the control group. Most of them were married (95%) and 5% of them were either divorced, widowed, or single. The mean age of children in the intervention and control group was 7.72 (±4.8) years and 7.40 (±5.2) years, respectively. The study findings indicated that the differences between the two groups in terms of socio-demographic characteristics [Table 2] were not significant. The characteristics of the participating group (in the intervention and control groups) did not differ significantly from that of the dropouts (*n* = 43) at T1.

No statistically significant differences were revealed between the participating groups and the dropout group at T1 in terms of RCOPE, SOC, and QoL of intervention and control groups. Positive RCOPE in the intervention group increased significantly at T2 (*P* = 0.020). Negative RCOPE changes were not significant in any of the two groups. Results showed a significant increase in SOC level in the intervention group at T2 (*P* = 0.022), [Table 3]. The improvements in the intervention group over four weeks were statistically significant in terms of the two components of QoL (*P* < 0.001).

Discussion

This study showed that intervention was effective on positive RCOPE. A significant development in positive RCOPE occurred after the intervention, which may be due to the fact that communicating with God was raised as a successful coping mechanism by some caregivers during group discussions.^[11] This breakthrough could be used as a model for other participants. The findings of this study were in line with another study conducted on caregivers of seriously ill patients.^[24]

In this study, negative RCOPE changes were not significant in any of the two groups, although it had a slightly larger drop in the intervention group. There was no professionally skilled person in the research group who could talk about negative RCOPE in an influential

Table 2: Characteristics of children and family caregivers of children with chronic diseases in the intervention (n=50) and control group (n=50)

Variables	Intervention	Control	<i>P</i>
Children characteristics			
Age (year) mean±SD	7.7±4.8	7.4±5.2	0.749
Gender, <i>n</i> (%)			
Male	27 (54)	29 (58)	0.687
Female	23 (46)	21 (42)	
Birth order, <i>n</i> (%)			
1	22 (44)	31 (62)	0.201
2	21 (42)	14 (28)	
≥3	7 (14)	5 (10)	
Type of sickness, <i>n</i> (%)			
Diabetes	18 (36)	20 (40)	0.680
Kidney disease	32 (64)	30 (60)	
Duration of sickness (years), <i>n</i> (%)			
1-2	30 (60)	33 (66)	0.929
3-8	13 (26)	10 (20)	
≥9	7 (14)	7 (14)	
FCGs characteristics			
Age (years), mean±SD	33.8±6.71	33.5±8.10	0.830
Marital status, <i>n</i> (%)			
Married	48 (96)	47 (94)	>0.99
Single	2 (4)	3 (6)	
Occupational status, <i>n</i> (%)			
Housewife	44 (88)	43 (86)	>0.99
Employed	6 (12)	7 (14)	
Level of education, <i>n</i> (%)			
Primary school	7 (14)	9 (18)	0.418
Elementary	15 (30)	3 (6)	
Secondary high school	3 (6)	8 (16)	
Diploma	16 (32)	21 (42)	
University	9 (18)	9 (18)	
Social support, <i>n</i> (%)			
Yes	39 (78)	44 (88)	0.133
No	10 (20)	4 (8)	
Economic status, <i>n</i> (%)			
Bad	11 (22)	19 (38)	0.114
Fair	31 (62)	25 (50)	
Good	8 (16)	6 (12)	

FCGs=Family caregivers, SD=Standard deviation

manner. Using the expertise of a cleric/clergyman to explain this subject to FCGs might have changed the outcome. Steinhauer *et al.* concluded that intervention leads to lower use of negative spiritual coping in HIV/AIDS patients, which goes against the findings of the present study.^[24]

Several studies have confirmed the idea that SOC is a changeable subject. Even though the number of studies that explicitly aimed to increase SOC is limited, the results of the present study showed that changes are possible. Results of this study showed that SOC in the intervention group increased significantly in the second stage of the study (*P* = 0.022). These results are in agreement with a

Table 3: Comparisons of means standard deviations, and effect size of religious coping, sense of coherence, and quality of life, in the family caregivers of children with chronic diseases

Variables	Baseline, mean±SD		Four weeks post intervention, mean±SD		P	Effect size
	Intervention	Control	Intervention	Control		
Positive RCOPE	21.4±4.5	21.4±4.5	23.5±4.2	20.7±3.7	0.020	-0.47
Negative RCOPE	11.7±2.5	11.1±2.7	11.0±1.8	11.2±3.1	0.100	0.28
SOC	53.2±11.0	52.7±11.7	57.2±10.3	51.7±8.4	0.022	-0.36
Physical component of QoL	49.8±17.4	53.6±21.1	58.5±17.8	51.1±15.0	<0.001	-0.49
Mental component of QoL	43.6±16.8	43.8±20.9	56.0±17.8	42.4±18.1	<0.001	-0.74

SD=Standard deviation, QoL=Quality of life, SOC=Sense of coherence, RCOPE=Religious coping

number of previous studies that examined the effect of intervention on SOC in patients.^[25,26]

A significant postintervention improvement was observed in both components of QoL. Although the previous study^[26] has reported that intervention affected the mental domain of caregivers' QoL, it has not affected their physical domain. This difference may result from the present study's relaxation methods as we were teaching the FCGs. Our results are in line with another study done by Ghodsbin *et al.* They found that education can affect both domains of QoL in caregivers of children suffering from leukemia.^[27] However, the present study showed that intervention can positively affect the QoL of FCGs of children with chronic diseases. These results are not consistent with a study conducted on the family members of patients with chronic heart failure.^[28]

There were several limitations of our study; first, the intervention effect was reported among FCGs in one ward; second, the study method did not involve whole randomization. Overall, there were no significant differences between the two intervention and control groups, and it can still not be stated that biases due to differences between the characteristics were completely controlled. Although limited evidence is available, it seems that the FCGs in children with chronic diseases who refused to participate or those who did not complete the questionnaires four weeks after intervention had been more negatively influenced. This strengthens the inference that early identification of FCGs in children with chronic diseases is essential for higher-quality patient care. The researcher might have also been uninformed of potentially influential events in the lives of FCGs throughout the four-week study period. Another limitation was the gender of caregivers (all of them were mothers), which means the results cannot be generalized to the fathers of such children.

Conclusion

We found that the intervention could improve the positive RCOPE, SOC, and QoL of FCGs in children with chronic diseases. The results for the evaluation of RCOPE, SOC, and QoL of FCGs have implications for the planning and implementation of effective interventions

by a multidisciplinary team. This study complements the previous study on the impact of education on QoL.^[29] Further studies on the Iranian population as well as other populations are needed to confirm our results. A longer follow-up period is suggested to assess the long-term effects of BPI and BRT on FCGs of children with chronic diseases as well as the RCOPE, SOC, and QoL.

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Conflicts of interest

There are no conflicts of interest.

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