

# The Effects of Spiritual Self-Care Training on Caregiving Strain in Mothers of Mentally Retarded Children

MITRA DINDAR<sup>1</sup>, MOZHGAN RAHNAMA<sup>2</sup>, MEHDI AFSHARI<sup>3</sup>, MAHDIEH POODINEH MOGHADAM<sup>4</sup>

## ABSTRACT

**Introduction:** Care for a mentally retarded child induces a lot of problems for the mother and leads her to care giving strain and ignoring her self-care. Spiritual health will co-ordinate all aspects of human life and is necessary for coping with diseases in mother of mentally retarded children.

**Aim:** To evaluate the effects of spiritual self-care training on care giving strain in mothers of mentally retarded children.

**Materials and Methods:** The present study, is a before and after type quasi-experimental research based on which 60 mothers of mentally retarded children who were hospitalized in Elahi Rehabilitation Center in Quchan City, were selected using convenience sampling and were randomly assigned to intervention and control groups. Data was collected by demographic characteristic questionnaire and care giving strain questionnaire that were filled by groups before, immediately and two weeks after spiritual self-care training. Data was analysed using SPSS version 20.

**Results:** According to the results, there was no significant difference between the mean score of care giving strain in intervention and control groups before and immediately after the intervention. However, among the members of the intervention group the score of mother care giving strain decreased an average of 87.21% within two weeks after the intervention, which was statistically significant over time ( $p=0.001$ ). The score of mothers in the control group increased an average of 5% over time which was not statistically significant ( $p=0.4$ ). The observed differences between these groups were also statistically significant even after controlling the effects of such intervening factors as marital status, children age and the years of caring for children ( $p=0.001$ ).

**Conclusion:** Spiritual self-care training can decrease care giving strain in mothers of mentally retarded children. Therefore, strengthening their spiritual beliefs and backgrounds, mothers can greatly reduce the strain caused by care giving problems of mentally retarded children.

**Keywords:** Cognitive delays, Mental disability, Spiritual beliefs

## INTRODUCTION

Mental disability or retardation is a set of disorders characterized by cognitive delays [1]. It is considered as one of the common disorders due to its side effects and prevalence which is about 3% in the overall population. There are approximately 1200000 individuals who are mentally retarded in Iran [2]. Despite its growing incidence, mentally retarded people may have adaptive behaviours. In addition, the prevalence of mental and psychological problems for mentally retarded people is way higher than those in the general population [1]. Children with mental retardation are weak learners in most expected cases and their parent's struggle to teach them new skills and control their inappropriate behaviours is of no avail. Accepting and adapting to such conditions for the parents needs more effort in comparison with normal children [3]. The mother is the first to communicate with her child. The mothers of mentally retarded children may break down following their children problems [4]. As Sadat Hosseini put it, women consist of 75% of the family caregivers. Due to the overlapping of care responsibility with other responsibilities as housewives, mothers overcome with a feeling of exhaustion [5]. In recent years, one of the negative consequences of caring for the mentally retarded child is care giving burden which sometimes referred to as caregiving strain as well [6]. According to Khajavi, increase in the care giving strain has numerous consequences on the caregivers like reducing the amount of time one looks after the patient and finally leaving the patient which would worsen their condition [7]. Thus, caregiving strain is an issue which causes serious problems for the patient and their family, Since it is not regarded as a disease, though it has a hidden nature due to

which both the patient and the caregiver suffers [8]. Developing solutions to deal with caregiving strain is of utmost importance. In this regard, different studies propose the development of psychological training programs and effective coping skills for the adaptation of caregiving strain [9-12]. Of the coping skills that can be taught to reduce caregiving strain is spiritual self-care training. Facing with heavy responsibilities, the caregiver tends to forget their self-care [13] and therefore focusing on the spiritual dimension becomes important. Caregiving strain, as a source of stress, greatly puts health dimensions of caregiver in danger and spirituality as one of the dimensions of human existence which has an influence on stress and crisis situation [6]. According to Reyhani, spiritual care is one of the strategies fulfilling mothers' psychological needs [14]. Spiritual interventions from prayer and invocation to the function of religious texts, are effective interventions leading to the worshiper's intellectual and spiritual experience [15]. According to Mosadegh, mothers of retarded children effectively use spiritual management, successfully adapt to help develop their own mental health and coping with life problems [16]. Despite the fact that numerous studies approved the usefulness of different aspects of spirituality like meaning of life and praying, spiritually often tended to be overlooked by health care providers [17].

In general, high incidence of mental retardation [2] and its side effects on the child creates a lot of problems for the family especially for the mother [18-21] and causes the family to experience the caregiving strain and reduces the amount of time they give to look after the patient [6,7]. It is essential to use solutions like training programs in coping with caregiving strain [8,9,11]. Therefore, coping with heavy

responsibilities, on one hand, leads to forgetting self-care especially spiritual self-care and, on the other hand, threatens all dimensions of health including spiritual dimension [6]. This study investigates the effective role of spiritual care and management in fulfilling mother's psychological needs and adapting with the condition of the retarded child [14,16]. This study aims to determine the effects of spiritual self-care training on caregiving strain in mothers of mentally retarded children.

## MATERIALS AND METHODS

The present study was quasi-experimental research conducted before and after, in control and intervention groups. It evaluates the effect of spiritual self-care training independent variable on the amount of care giving strain in mothers of mentally retarded children, who went to Elahi Mentally Retarded Rehabilitation Center in Quchan City between August 2015 and April 2016. This study was conducted after it received the ethical approval from Zabol University of Medical Science and got the agreement from the head of Rehabilitation Center. The population under study consists of all the mothers of mentally retarded children hospitalized in Elahi Rehabilitation Center in Quchan who had the inclusion criteria for this research. Mothers who met the following criteria were included in the study: having a mentally retarded child, being Muslim, primary school education (minimum), having filial and parental relationship, lack of definite depression diagnosis, and non-use of antidepressants and narcotics. The exclusion criteria were as illiteracy, having half-mother-child relationship, definite depression diagnosis, using antidepressants and narcotics, and rejecting to participate in the study. The sample size was calculated based on the results of pilot study [22] to determine approximately 32% of the difference in the difference of caregiving strain score variation percentage in the two groups with and without intervention. Considering 10 percent sample dropping, the study evaluated 0.05 % type one error and 90% statistical power of 30 people in the intervention group and 30 people in the control group. The samples were selected using convenience sampling and after the subjects were qualified and the informed consent from the research community was obtained, they were randomly assigned to the intervention and control. For blinding (single blind) of the study, two groups were separately invited to explain the aims and methods of the research.

### The data collection tools in this study were as follows:

Demographic characteristic questionnaire conducted after studying books and articles and consulting with 10 teachers of the Zabol Medical Science University. Test-retest method was used in order to assess the repeatability and reliability of the questionnaire. The questionnaire included 13 questions related to mother's personal information, namely, age, residence, marital status, number of children, number of mentally retarded children, education, insurance, occupation, income, having occupational disease, years of caring for the child, and child personal information, namely, age, sex and having occupational disease.

Multidimensional Caregiver Burden Inventory which has 24 points and was invented by Novak and Guest in 1989 [23] is a questionnaire which has 5 sub-scales including: a) time-based caregiving strain (choices 1 to 5) which is indicative of the time a caregiver spends looking after their patient; b) Evolutionary caregiving strain (choices 6 to 10) which indicates the amount of pressure put on the caregiver during their different life cycles (like maturity) due to caring for the patient; c) Physical care giving strain (choices 11 to 14) which reveals the physical strain and exhaustion caused during the time the care giver spends looking after their patient; d) Social care giving strain (choices 15 to 19) that represents social life aspects caused during the time the caregiver spends looking after their patient; e) Emotional caregiving strain (choices 20 to 24) that represents the caregiver's emotions and feelings caused during the time the caregiver spends looking after their patient. This questionnaire

measures the caregiver's response using 5-point Likert scales (Strongly Disagree (1), Disagree (2), Undecided (3), Agree (4), and Strongly Agree (5) choices scores between 24 and 56 were judged as poor, 56–88 average, and 88–120 good [22]. Internal and external studies confirmed the validity and reliability of caregiving strain questionnaire. Ali Abasi et al., used content validity in order to determine the validity of the questionnaire with its content validity index based on relevance 91.8%, clarity 90.2%, simplicity 93.6%, and in total is 93.6%. They also showed that reliability analysis using Alpha coefficient internal consistency for full-scales is 0.90% and the Alpha coefficient for the sub-scales is from 0.76 to 0.82 % [8]. Mc Cleery et al., also reported the reliability of the questionnaire using Cronbach's alpha coefficient for each of the following sub-scales, time-based caregiving strain, evolutionary caregiving strain, physical caregiving strain, social caregiving strain, and emotional caregiving strain. They determined Cronbach's alpha coefficient for the whole questionnaire to be 0.80% [24].

Training intervention of this study was performed based on Richards and Bergin's religious-spiritual strategies [25] and conducted in line with Islamic approach in such topics as self-awareness, invocation, reliance and resort, patience, forgiveness and praise after training content was confirmed by religious authority (educator). The educator was studied in seminary and has M.A, covered in Islamic dress and based on the languages spoken in the region was fluent in three languages, namely, Persian, Turkish, and Kurdish. The training was conducted during six 45-minute sessions, for a 2-week period every other day (3 sessions on the even days of the week on morning work shift) [Table/Fig-1].

Treatment Sessions	Session Titles	Training Content
First session	Self-awareness	Communicating with God and listening to inner voice
Second session	Invocation	The word God or any higher power that the mother has faith in it
Third session	Trust and resort	Trust in God and resort to him
Fourth session	Patience	The history of religious figures
Fifth session	Forgiveness	Communicating with sanctities, prayer, sacrifice, penance, and charity
Sixth session	Praise	Gratitude and thanksgiving

[Table/Fig-1]: Study framework.

Mothers were randomly assigned to intervention and control groups for data collection. Mothers of both groups completed demographic characteristic questionnaire and caregiving strain questionnaire. Furthermore, after the completion of all training sessions, mothers, again, filled out caregiving strain questionnaire in both groups.

SPSS Version 20 was used for data analysis. Demographic variable consistency of the groups was examined by Chi-Square test and Independent t-test (Mann-Whitney U test) for comparing the means and impacts of intervention on the mother caregiving strain repeated measure test was employed. Moral considerations such as data confidentiality and patient's right to opt out anytime they want were also taken into account. Moreover, after the completion of the study, the training content was placed on an educational CD and was presented to the control group in a training session.

## RESULTS

The study consists of 60 people, who were divided equally in the intervention group and in the control group. Results of the study showed that the mean age was  $6.815 \pm 39.37$  and  $10.176 \pm 42.6$  in the intervention and control groups, respectively (within the age range of 51-60 (8%), 41-50 (21%), 31-40 (24%) and 21-30 (7%)). The mean SD age of the children was  $7.10 \pm 3.43$  and  $10.43 \pm 3.081$  in the intervention and control groups, respectively [Table/Fig-2]. The mean of years of caring for the child was 8 in both the intervention and control groups. The results of independent t-test (Mann-

Whitney U test) showed that the child age and years of caring for the child in the intervention and control groups were significantly different [Table/Fig-3]. The results of Chi-square test showed that among other pieces of information including child sex, marital status, education, income, occupation, residence, mother physical disease, and child physical disease, only the marital status between the two groups was significantly different [Table/Fig-4].

Based on [Table/Fig-2], in the beginning of the study only the marital status between the intervention and control groups was significantly different.

Based on the results, the total mean±SD of caregiving strain in all the subjects, before the intervention was 78.17±21.36. According to the independent t-test results, comparison of the mean scores of mothers' caregiving strain in the two groups showed no significant differences before the intervention, in fact, the two groups were similar. The results of repeated measure test and comparison of the mean scores of caregiving strain in the intervention and control groups showed no significant differences before and immediately

Characteristics		Intervention	Control	p-value
Marital status	Widow	0(0)	5(100)	0.007
	Married	29 (59.2%)	20 (40.8%)	
	Divorced	1 (16.7%)	5 (83.3%)	
Education	Reading and writing	15 (48.4%)	16 (51.6%)	0.003
	Guidance (secondary school degree)	56 (41.7%)	7 (58.3%)	
	Diploma	7 (63.6%)	4 (36.4%)	
	Higher	3 (75.0%)	1 (25.0%)	
Occupation	Housewife	28 (54.9%)	23 (45.1%)	0.1
	Employee	2 (22.2%)	7 (77.8%)	
Residence	City	28 (54.9%)	23 (45.1%)	0.1
	Village	2 (22.2%)	7 (77.8%)	
Age	Mean±SD	6.815±39.37	10.176±42.6	0.1
Income	Mean±SD	500.000±1943157	163.833±3326737	0.076

[Table/Fig-2]: Personal characteristics in the intervention and control groups.

Group variable	Intervention mean±SD	Control mean±SD	p-value
Mother age	30.06±9.76	24±10.6	0.1
Child age	7.10±3.43	10.43±3.08	0.0001
Years of caring for the child	7.43±3.22	10.43±3.08	0.001
Number of children	3.20±1.42	2.67±1.27	0.1
Number of mentally retarded children	1.07±0.036	1±0.06	0.4
Income status	1350.03±19.74	1638.33±3.15	0.27

[Table/Fig-3]: Participants characteristics based on group division.

Variable	Intervention					Control					Significance for score percentage difference between the two groups**
	Before intervention	Immediately after intervention	Two weeks after intervention	Variation percentage	Significance in length of time*	Before intervention	Immediately after intervention	Two weeks after intervention	Variation percentage	Significance in length of time*	
Caregiving strain	78.17±21.36	65.30±17.89	57.23±13.74	87.21±30.3	0.0001	75.70±24.21	75.70±19.06	74.23±20.76	41.79±5	0.4	0.001

[Table/Fig-5]: Caregiving strain score variation in the intervention and control groups, before and after intervention.

\*\* Repeated Measurement Test.

after the intervention. However, according to the repeated measure statistical test, the mean scores in the two groups was significantly different two weeks after the intervention. It also determined that after two weeks, the intervention group's scores were slightly decreased to 87.21% which was not statistically significant given the length of time ( $p=0.0001$ ) before the intervention. However, the subject scores in the control group were increased 5% with the length of time which was not statistically significant ( $p=0.4$ ). Also, Mann-Whitney U test results showed that 21% and 5% variation was statistically significant difference in the intervention and control groups, respectively ( $p=0.0001$ ).

Group variables		Intervention N (%)	Control N (%)	p-value
Residence	City	28(54.9)	23 (45.1)	0.1
	Village	2(22.2)	7(77.8)	
Age	21-30	2(6.7)	5(16.7)	0.052
	31-40	15 (50)	9(30)	
	41-50	12(40)	9(30)	
	51-60	1(3.3)	7(23.3)	
Marital status	Married	29 (59.2)	20(40.8)	0.007
	Divorced	1(16.7)	5(83.3)	
	Widow	0(0)	5(100)	
Education	Reading and writing ability	15(48.4)	16(51.6)	0.5
	Sikl	5(41.7)	7(58.3)	
	Diploma	7(63.6)	4(36.4)	
	Higher	3(75)	1(25.0)	
Occupation	Housewife	28(54.9)	23(45.1)	0.1
	Employee	2(22.2)	7(77.8)	
Child sex	Boy	14(46.7)	10(33.3)	0.3
	girl	16(53.3)	20(66.7)	
Mother physical disease	Yes	7(23.3)	5(16.7)	0.5
	No	23(76.7)	25(83.3)	
Child physical disease	Yes	14(46.7)	15(50)	0.8
	No	16(53.3)	15(50)	

[Table/Fig-4]: Participants characteristics based on group division.

It can be concluded that self-care training, significantly reduced mother's caregiving strain score in the intervention group in comparison with control group two weeks after intervention [Table/Fig-5]. The observed differences between the groups were also statistically significant even after controlling the effects of such intervening factors as marital status, children age, and the years of caring for children based on repeated measure test ( $P=0.001$ ).

## DISCUSSION

In the present study, spiritual self-care training showed no effects on caregiving strain in mothers having mentally retarded children immediately after the intervention. However, two weeks after the training, statistically significant difference was observed in the scores of mothers' caregiving strain in the intervention and control groups. This shows the positive effects of spiritual self-care training on the reduction in mother's caregiving strain. Also, the given training provides no immediate effect; rather it needs longer period of time to bring about significant effects. The present study showed the positive effects of spiritual self-training on the follow-up stage.



The results of Lotfi Kashani et al., study corresponding with this study also showed that spiritual intervention reduces distress in mothers having a child with cancer and this reduction continues up to the follow-up stage [26]. In addition, spiritual intervention in Lotfi Kashani study was 6 sessions of psychotherapy based on spiritual intervention proposed by the Islamic of Richards and Bergins. In it, distress variable had a close relationship with caregiving strain [26]. Andrews suggested that the relationship between symptoms of distress and caregiving strain was statistically significant [27] while for Gratao et al., caregiving strain was a distress risk factor [28]. For Reyhani et al., spiritual self-care training reduces psychological stress and increases distress tolerance in mothers of a premature baby [14]. Although its population and variable, under study, are different with the present study, it is compared with the present study because both studies indicate the positive effects of self-care training. Furthermore, Ahmadi et al., determined that there is a positive significant relationship between secure attachments to God and resiliency and parental mental health of educable mentally retarded children. They concluded that the variation in people's quality of attachments to God can improve their mental health [29]. Moreover, Mosadegh et al., explained spiritual understanding component training as an approach to mental health in mothers with children having mild mental retardation [16]. Despite the differences with the present study, their results are close to this study since they define the role of spiritual dimension strength in improving parental mental health of mentally retarded children. Mosadegh's study, similar to the present study, focused on the positive effects of spiritual understanding component training. This kind of training would strengthen the subjects' spiritual beliefs and help them better cope with impending situations. As the results of Rahnama et al., study showed, communication with God and religious beliefs have a positive effect on the adjustment of the participants in the study and therefore they suggested putting emphasis on these beliefs during religious consulting sessions [30]. Mc Nally et al., in one of their qualitative studies entitled "Taking care of caregivers of retarded children" identified the theme of caregivers' beliefs as an adaptive mechanism [31]. In this regard, Lotfi Kashani et al., quoted that spiritual beliefs can help people prevent distress and anxiety in facing with life uncontrollable events such as death or severe disease [26]. This study identified that mothers of mentally retarded children were under caregiving strain due to caring for their children to the point that more than half of them had a score higher than the mean of caregiving strain. Child's deep attachment to the mother in all matters and all the time possibly affected such results. According to Bartolo et al., there is a significant inverse relationship between caregiver's caring strain and patient autonomy performance [21]. Chang et al., also observed that caregivers who spent more hours during the day caring for their patients experienced more caregiving strain and had lower mental health [32]. Likewise, for Abbasi et al., the more time patients needed to be cared for, the more caregiving strain caregivers endured [32,33]. All these conducted studies correspond to the results of the present study.

## LIMITATION

Sampling time restriction and the long spiritual self-care training process were limitations in the present study which limited the possibility of doing research with bigger sample size.

## CONCLUSION

The present study showed that spiritual self-care training can reduce mother's caregiving strain of mentally retarded children during six 45-minute sessions, for a 2-week period. Thus, strengthening mother's spiritual beliefs and backgrounds can greatly reduce the strain caused by caregiving problems of mentally retarded children as well as reduce their adaptation to the related problems. Iran's religious background provides the ground for conducting such training and parents are advised to use this kind of training in Mental Retardation Rehabilitation Centers.

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#### PARTICULARS OF CONTRIBUTORS:

1. Student Nursing, Zabol University of Medical Science, Zabol, Sistanvbalouchistan, Iran.
2. Assistant Professor, Nursing, Zabol University of Medical Science, Zabol, Sistanvbalouchistan, Iran.
3. PhD, Medical Zabol University of Medical Science, Zabol, Sistanvbalouchistan, Iran.
4. Lecturer Nursing, Zabol University of Medical Science, Zabol, Sistanvbalouchistan, Iran.

#### NAME, ADDRESS, E-MAIL ID OF THE CORRESPONDING AUTHOR:

Dr. Mozghan Rahnama,  
Ferdosi St-nursing and Midwifery School, Zabol, Sistanvbalouchistan, Iran.  
E-mail: morahnama0@gmail.com

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