


Improving quality of family life among Christian parents of children with low vision in Nsukka catholic diocese using rational emotive family health therapy

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Abstract

Background: Most Christian parents living with children with low vision have reported to be experiencing psychological disturbances that are affecting the family health. As a result, the quality of family life is being impaired. The experience of parents catering for children with low vision is mainly influenced by psychosocial factors that could determine the quality of family life of such parents. This present study is to investigate the efficacy of rational emotive family health therapy in reducing poor quality of family life among Christian parents of children with low vision in Nsukka Catholic Dioceses.

Method: This is a randomized pretest and posttest control trial. Participants were 88 parents of children living with low vision in Nsukka Catholic Dioceses, Nigeria. The power of the sample size was determined using Gpower statistical software. The participants in rational emotive family health therapy programme-group were exposed to a 12-session treatment programme whereas their counterparts in waitlisted control group did not receive anything. A family quality of life scale was utilized in assessing the participants. Data analyses were performed using repeated measures ANOVA.

Results: It was found that rational emotive family health therapy had a significant positive effect on increasing quality of family life among the study participants compared to those in the waitlisted control group.

Conclusion: This study contributed and validated the efficacy of rational emotive family health therapy in improving quality of family life among parents of children with low vision.

Abbreviations: FQoLS = family quality of life scale, REBT = rational emotive behaviour therapy.

Keywords: catholic dioceses, Christian parents, low vision, quality of family life, rational emotive family health therapy, rational emotive behavior therapy, school children

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The datasets generated during and/or analyzed during the current study are not publicly available, but are available from the corresponding author on reasonable request.

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1. Introduction

Vision is one of the important factors in the learning process that also serves as a non-oral communication means in social interaction. In children's life, loss of vision does not only affect their academic competencies but also other aspects of life, such as athletics activities, autonomy, and in social relationships.^[1] Rahi^[2] and Resnikoff et al^[3] demonstrated that low vision in children is a low prevalence condition, ranging from 3 per 10,000 in socioeconomically developed countries, to 15 per 10,000 in poorer countries. It has often been said to coexist with other impairments or disabilities.^[4,2,5] The emergence of low vision is marked by emotional grief that could affect children's entire aspects of development, restrains their participation in social activities, and generally worsens their quality of life,^[6] as well as the quality of family life of their parents.^[7] It is disturbing that some Christian families still believe that a newborn baby with disability is a taboo and sometimes mothers should be held responsible as nobody knew what she might have done. Some Christian parents are filled with wrong notion that conception of child with impairment is attributable to demons and their agents.

Internationally, researchers on disability have made significant progress in conceptualizing and measuring the family quality of life disabilities.^[8] Schalock et al^[9] stated that core international group of researchers have synthesized the alternative conceptualization of quality of life outcomes into a consensus working document focusing on conceptualizing, measurement and application. This consensus document contains 8 domains of quality of life for people with disabilities which are as follows: personal development, self-determination, interpersonal relations, social inclusion, rights, emotional well-being, physical well-being, and material well-being. In as much as individual quality of life has produced an accumulated result in an international consensus document, family quality of life is at the very beginning of the conceptualization process.

Quality of family life (QoFL) have been said to be a policy/program, that its outcome is as a result of natural extension from the work on individual quality of life, especially given the strong emphasis in the disability field on a family-centered service delivery model.^[10,11] Bailey and colleagues^[12] have proposed quality of life of families who have a child with disabilities as a "useful indicator of outcomes of policy initiatives" (p. 322). Conceptualization of family quality of life outcomes has been extremely limited to date.

All in all, there is high proportion of parents of children with low vision experiencing severe depression and anxiety,^[13] fatigue,^[14] amplified physical illness,^[15] and poorer general well-being.^[16] Given these health and psychological problems stemming from the challenges associated with vision loss among children, practicing health counselors, health service providers, psychologists and psychiatrists working in schools, community settings, and hospitals should make available their professional skills in assisting the parents of children with low vision, incorporating cognitive, emotive and behavioral techniques of Rational emotive behavior therapy (REBT). By applying the rational-emotive family health therapy, the psychological health of affected Christian parents might improve significantly with regard to reducing the erroneous beliefs and boosting the QoFL. Thus, it becomes necessary that parents of such children with low vision receive sufficient support and psychotherapeutic interventions to ensure they acquire adaptive skills for better QoFL. Towards this end, psychological support and services

could greatly change the way in which parents of children with low vision think, feel and behave in their respective communities.^[17] It is possible that if the irrational beliefs of those parents are altered, how they perceive and interpret general community actions in reference to their children with low vision would be better and accurate.^[17] However, if such negative thinking and unrealistic feelings among parents of children with low vision are allowed, it could affect other members of families.

1.1. Rational emotive family health therapy

Some scholars suggested employing cognitive behavioral approaches in dealing with such irrational beliefs preoccupying the thoughts of parents of children with visual impairment.^[18] In this study, we adopted a rational emotive family health therapy (REFHT) created by Ede et al^[19] as an extension of REBT approach developed by Ellis^[20] to assist parents of children with low vision in order to enhance their QoFL. The basic philosophy of their model as a psycho-educational approach is targeted at exploring REBT views of life by using it to alter irrational beliefs associated with parents' challenges and improving their healthy living among parents of children living with visual impairments. It was also targeted to change the irrational beliefs that generate interpretations of realities that are false. Ellis and Blau^[21] opined that beliefs are the fundamental sources of human emotional balance or imbalance and its outcome can be rational and irrational behaviors. Ellis^[22] noted that REBT principles states that people possess innate resources to construct and reinforce the beliefs they hold about their negative experiences.

As a therapeutic model, REBT utilization has frequently been scrutinized in relation to its ability to produce cognitive, emotional, and behavioral changes across diverse populations of various abnormalities and disorders. All in all, REBT have been noted to be an effective intervention technique in addressing both adults and children disabilities.^[23] REBT as a therapeutic model encourages a synergy between the therapists and the client in an attempt to reducing the irrational beliefs and thought that triggers undesirable emotions and behaviors which is the activating points of event.^[24] According to Ellis, Gordon, Neenan, and Palmer,^[25] the implication is that the beliefs are determined by how the individual sense organs perceives, interpret and evaluate the events. The present research work about the QoFL of parents of children with low vision has been mainly conducted in countries of the world. There are very few of such studies conducted in Nigeria to the best knowledge of the researchers. Therefore, REBT therapists, psychotherapeutic service providers, and family health professionals are called to work closely in assisting parents of children with disabilities using rational emotive family health therapy. If information about general well-being with regards to parents QoFL and children having low vision are not provided to these Christian parents, they may continue to be vulnerable to poor state of health, anger, and guilt feeling resulting from unresolved solution for a severely helpless child.^[26]

1.2. Study rationale

Although there is substantial research supporting the use of REBT for individuals and cognitive behavioral therapy for families, unfortunately empirical work on the effectiveness of family health model of REBT is still few.^[27] Past study

recommended that family counsellors should test new approaches addressing family health, wellbeing, and conditions of the families.^[28] That is to say that seeking for a new way of helping families with psychological and health problem is essential. To the researchers' knowledge, few studies have investigated the efficacy of a REFHT on quality of life among Christian parents of children with low vision in Nsukka Catholic Dioceses Nigeria. In this study, we hypothesized that quality of life among Christian parents of children with low vision will be significantly improved and maintained at follow-up using REFHT intervention.

2. Methods and materials

2.1. Ethical statement and considerations

The researchers' institutional review board on research ethics committee granted ethical approval for the study. Participation to this study was by voluntary. The research ethical conducts as stated in American Psychological Association was strictly followed. For example, informed consent was obtained from the parents. The day they completed the consent form, they were informed about the purpose of the research, time, processes, right to continue and discontinue from the study. We also highlighted on possible adverse effects and risk associated with the intervention as well as possible benefits. They were given the phone number of the research team leader. The parents that agreed to participate were assured of confidentiality.

2.2. Design

This is a randomized pretest and posttest control trial. This design helped the researchers to randomly assign participants into intervention and control groups.

2.3. Intervention

Family health model of REBT^[19] is a family oriented intervention model that aimed at using core principles of rational emotive behavior therapy to assist parents and possibly children on issues related to poor perceptions of personal health, family health, and family wellbeing. It also addresses family members' behavioral and emotional responses on how people perceive the health status of the sick patient (s) in their family. The basic goal is to restructure, modify, and possibly change destructive, unhealthy thoughts, and dysfunctional beliefs attributed to health status of family member. The intervention is a 12-week programme that lasted for 12 sessions. Each session started with an objective and lasted 60 minutes.

2.4. Dependent measure

Family quality of life scale (FQoLS) is a 25-item questionnaire aimed to assess the degree of family quality of life and family wellness.^[29] It measures family members' perceptions about healthy living in their life. FQoLS has 5 subscales and these include family interaction (6 items), parenting (6 items), emotional well-being (4 items), physical/material well-being (5 items) and disability-related support (4 items). The response options range from Very Dissatisfied (1) to Very Satisfied (5). Past studies have validated the reliability of FQoLS in measuring quality of family life.^[30-32] The internal consistency (Cronbach's α) ranges from .88 to .94, supporting the authenticity of FQoLS,

evidence showed that the validity and reliability proof also cut across cultures and countries.^[33]

2.5. Participants and procedure

After the obtaining an approval from relevant bodies like special school headteachers and parents, phone contacts of the parents were collected. The parents that we got their contacts were invited for screening. Each child was assessed by experts to know the children are visually impaired or not before their parents were selected for the study as to ensure that only the Christian parents of children with low vision were selected. Specifically, we concentrated on parents of children with blindness that were residing within Nsukka Catholic Dioceses Nigeria. Some of the parents are not from Enugu state Nigeria but they were residing in the state. The parents were screened using the dependent measure. From the outcome of the screening, 88 parents consisting of male and females were selected. GPower 3.1 software^[34] was used by the researchers to verify if the power of the sample size was enough. Additional information of the recruited participants is included in Table 1. During the recruitment processes, we considered certain criteria before a parent could be included in the study. These include expression of interest, having a child with blindness, having a child that is in government approved schools, must complete the screening tool, must be a Christian parent within the geographical zones under Nsukka Catholic Diocese, and scoring above the cut-off mark as in Beach Center on Disability.^[29] The score helped the researchers to ascertain the baseline data of the problem. On the hand, those parents who scored below and did not meet up with the articulated criteria were excluded from the study. The number of those excluded was not mentioned in the study. Some of them were dismissed because some of them were under the care of family counsellor and social workers, while some just completed medical treatment in 2 to 3 weeks. The eligible parents were divided into 2 different groups-44 participants for treatment group and 44 participants for waitlisted group. See Figure 1 for further information. Doing this, a simple random allocation sequence was employed as recommended by Saghaei.^[35] For sake of quality practice, we concealed the randomization process avoid recruitment bias.

The treatment package given to the participants contained rational emotive family health therapy programme developed by Ede et al.^[19] Participants exposed to rational emotive family health therapy programme were treated, monitored and counselled for 12 weeks. Each week contained a session of treatment lasted for 50 minutes. During the session one the therapist created rapport by asking the participants to introduce themselves as well as self and setting rules and regulations. Thereafter, there was second session where meaning of blindness and quality of family life was discussed. During session 3 the therapist explained the elements of poor quality of family life and what led to it. Sessions 3 to 4 are concerned with identification of irrational thoughts that are associated with poor quality of family life, how irrational beliefs set in, how family health can be affected. Sessions 5 to 6 discussed the relationship between negative perceptions of children with blindness by parents and poor quality family life. During these sessions, participants were taught how dispute irrational beliefs about the presence a child with blindness. In session 7, how to deal with musturbation causing automatic cognitive, emotional, and behavioral reactions. Session 8 and nine dealt with examples

Table 1
Demographic characteristics of the participants based on groups.

	Treatment Group n (%)	Control group n (%)	Statistic	Sig
			χ^2	
Gender				
Male	18 (20.5)	22 (25.0)	0.392	0.521
Female	26 (29.5)	22 (25.0)		
Number of children				
Two children	7 (8.0)	2 (2.3)	.293	0.978
Three children	7 (8.0)	9 (10.2)		
Four children	10 (11.4)	14 (15.9)		
Five and Above	20 (22.7)	19 (21.6)		
Educational qualification				
PhD degree	24 (36.4)	12 (18.2)	7.429	0.024
Master's degree	27 (40.9)	27 (40.9)		
Bachelor degree	15 (22.7)	27 (40.9)		
Location of school				
Urban	32 (48.5)	39 (59.1)		
Rural	34 (51.5)	27 (40.9)		

% = percentage, χ^2 = Chi-square, n = number of participant, REFHT = Rationnal emotive family health therapy, sig = associated probability.

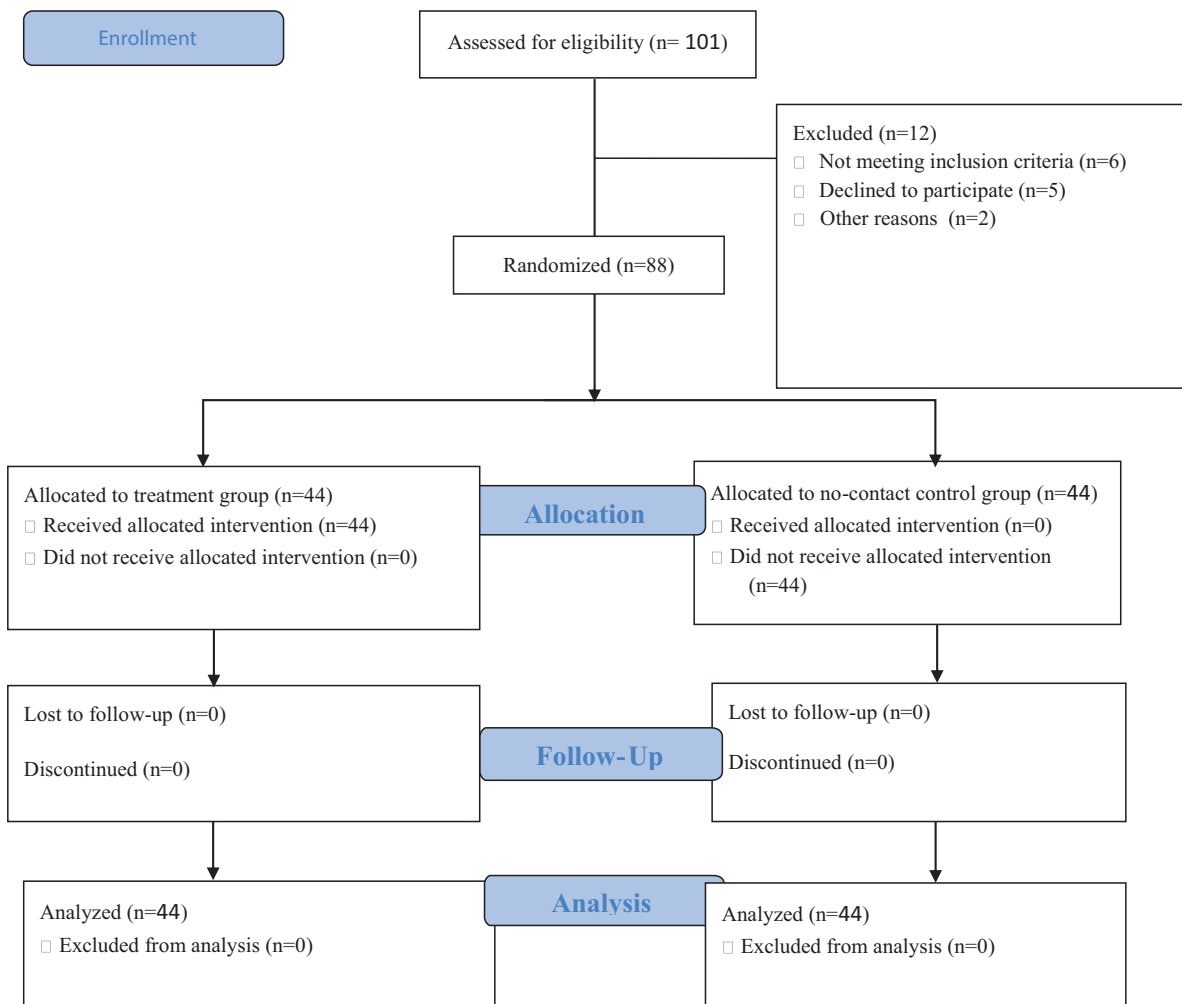


Figure 1. Participants' Eligibility Flow Chart.

of musturbation, classification of example of musturbation according to self, others and world/future, changing family irrational beliefs that affect quality of life to rational beliefs, and exercises. Session 10 to 11 addressed how utilize philosophies rational emotive family health to overcome dysfunctions causing poor quality of family life among parents of children with visual loss. how to reflect on reality, dispute faulty inferences and worthlessness, and how to challenge frustration using rational-emotive techniques. Finally, session 12 focused on review of previous sessions, exercises, and termination.

A family counsellor delivered the treatment from the beginning to the end. The family counsellor had her basic training in guidance and counselling and later specializes in family counselling where she obtained PhD in family counselling. She has been practicing for over 5 to 7 years. Such experiences have exposed her to family interventions such as family health model of REBT. In spite of the fact that she rooted in practice of REBT, 3 external raters were assigned to her for monitoring and supervisions. The 3 of them were also part of the present research team. The goal was to ensure that intervention was systematically implemented as the researchers deemed it. Each rater was assigned to cover 3 sessions. They supervised the counsellor’s activities during the treatment, time, participants’ activities, etc.

As the treatment came to an end, the participants in both groups were assessed for the second time. The treatment lasted for 3 months and there was no drop-out. Possibly the participants complied due to transportation fare given to each. No adverse effects of the intervention was observed. Shortly after the execution of the intervention and second assessment, participants were notified to be at treatment venue by fourth month. Before the third meeting, the participants were reminded via phone numbers using messages. After arrival to the treatment venue, the researchers assessed them for the third time to check if there was improvement in their perception about presence of the visual impaired children in their homes.

2.6. Data analysis

SPSS version 18 was used to analyzed the data collected at first, second, and third assessments. Specifically, an analysis of variance (ANOVA) was used for data analysis. During the analysis, the 2 groups were used as the dependent variable while family quality of life data at Time 1, Time 2, and Time 3 were simultaneously analyzed as sub- dependent variables for each measure. Partial Eta Square was used to find out the effect size of the intervention on the family quality of life. The assumption of the sphericity of the test statistic was tested using the Mauchly

test of sphericity which was not significant for family quality of life as measured by FQoL. Chi-square was used to report if the demographics were significant or not.

3. Results

Table 1 shows that the treatment group comprised 21 males (47.7%) and 23 (52.3%) females; and the waitlisted control group comprised 19 males (43.2%) and 25(56.8%) females. From the analyses of results, it can be seen that no significant gender difference was observed among the study participants ($\chi^2 = 0.183, P = .669$). With reference to number of children, 7 (15.9%) participants in treatment group have 2 children, 11 (25.0%) participants have 3 children, 12 (27.3%) participants in treatment group have 4 children, and 14 (31.8%) participants in treatment group have 5 and above children. For control group, 5 (11.4%) participants have 2 children, 8 (18.2%) participants have 3 children, 10 (22.7%) participants have 4 children, and 21 (47.7%) participants have 5 and above children. Regarding educational qualification, in the treatment group, 8 participants (18.2%) holds WAEC, 10 (22.7%) holds NCE, 11 (25.0%) holds Bachelor degree, 8(18.2%) holds MED/MSc degree, and 7 (15.9%) holds PhD. In the control group, 9 participants (20.5%) holds WAEC, 14 (31.8%) holds NCE, 6 (13.6%) holds Bachelor degree, 8(18.2%) holds MED/MSc degree, and 7 (15.9%) holds PhD. Significant educational qualification difference was observed among the participants ($\chi^2 = 2.196, P = .700$). Concerning location of school, in the treatment group, 28 participants (63.6%) were from schools in rural area, and 16 (36.4%) were from in urban area. In the control group, 25 participants (56.8%) were from schools in rural area, and 19 (43.2%) were from in urban area. No significant location of school difference was observed among the participants ($\chi^2 = 0.427, P = .513$).

Table 2 reveals the study outcomes for the participants in the treatment group (Rational emotive family health therapy-REFHT) compared to the waitlisted control group (CG) over the 3 periods. Before the treatment, the result in Table 2 shows that there was no significant difference among the treatments and waitlisted control groups at initial evaluation (Time 1) family quality of life of participants who had children with low vision as measured by FQoL, $F(1, 87) = 0.055, P = .815, \eta_p^2 = 0.001$. At the post-treatment level (Time 2), intervention had a significant effect on participants’ family quality of life of participants who had children with Low Vision as measured by FQoL, $F(1, 87) = 3.501, P = .065, \eta_p^2 = 0.040$; and after the post-treatment, a follow-up (Time 3) result still shows that intervention had a significant effect on participants’ family

Table 2
Analysis of variance.

Group gender	Pretest					Posttest					Follow-Up				
	Mean	SD	F	P	η_p^2	Mean	SD	F	P	η_p^2	Mean	SD	F	P	η_p^2
Treatment	33.52	4.59	0.055	.815	0.001	74.23	10.91	3.501	.065	0.040	71.09	4.86	3.582	.062	.041
Control	34.07	5.17				71.86	4.43				72.13	4.28			
Treatment male	35.49	3.90				79.26	15.45				79.48	15.26			
Female	32.16	4.60	1.096	.298		70.74	3.38	10.458	.002		71.05	3.40	10.056	.002	
Control male	34.66	5.46				70.68	5.01				71.09	4.86			
Female	33.48	4.91				73.03	3.48				73.17	3.40			

η_p^2 = Partial Eta Square), p = probability value, SD = standard deviation.

quality of life of participants who had children with low vision as measured by FQoL, $F(1, 87) = 3.582$, $P = .062$, $\eta_p^2 = 0.041$. The effect size (0.040 and 0.041) at time 2 and time 3 respectively for the dependent measure (FQoL) indicate that treatment variable accounted for moderate effect in increasing family quality of life scores of parents who had children with low vision.

In terms of interaction effect of group and gender, the analysis indicated that there is no interaction effect of group and gender on participants' family quality of life as measured by FQoL, $F(1, 87) = 10.458$, $P = .002$; $F(1, 87) = 10.056$, $P = .002$ at Time 2, and Time 3 respectively. This result shows that the family health model of REBT is effective in improving quality of family life of Christian parents irrespective of gender.

4. Discussion

This investigated the role of rational emotive family health therapy in improving quality of family life among Christian parents of children with low vision in Nsukka Catholic dioceses. The study suggests that rational emotive family health therapy has a significant benefit in improving quality of family life among Christian parents. It was showed that improvement in quality of family life scores of the Christian parents was attributed to the rational emotive family health therapy. The follow-up assessment revealed that a significant long-range impact of the intervention. Like the finding of this study, past studies have demonstrated that rational-emotive therapies are therapeutic interventions that can improve patients' mental health scores.^[19]

Our finding is in accordance with other past studies that reported promising significant benefit of rational-emotive interventions in improving quality of life among parents of children with visual impairment.^[36,18] In a study carried out by Cobham et al,^[37] the finding showed the impact of REBT-based strategies in decreasing psychological disturbances of parents of children with disability. Utoyo^[38] and Taylor and Renee^[39] also confirmed strengths of rational-behavioral therapies by demonstrating its impact in altering distorted perception related to chronic illness and disability. Given the positive and significant contributions of REBT-based intervention, we suggest family health model of REBT could be used to change the irrationality or dysfunctionality in families leading to poor quality of family life especially those that have children with visual impairment. Otherwise, the poor quality of family life could further lead to stress, anxiety and depression. Like our finding, Anclair et al^[40] showed that REBT is an effective intervention for treatment of health issues related to quality of family life. The present finding validated past empirical study conducted by Ede et al^[19] who proposed usefulness of family health model of REBT in decreasing stress in parents of children with disability. Ede et al strongly recommended family health model of REBT for professionals handling families or parent populations with irrational thought. The essence is to improve their living condition and quality of family life.

Considering the benefits of the family health model of REBT in particular and REBT principle in generally in improving quality of life especially among parents a seen in the current study and other similar studies, we strongly recommend that family counsellors and other related professionals to utilize REBT-principles when dealing with family health related problems. Professionals working in churches such as Catholic church, Anglican church, among others should utilize REBT-philosophies in helping Christian members especially those that have

children with visual impairment. For instance, marriage course instructors, religious leaders and teachers should adopt REBT assumption when they are providing services to new and older couples. The professionals should always make reference to ways of handling disabilities in family and how irrational thinking could affect quality of family life.

The practice implication of the current finding is that pastors, priests, and relevant professionals should change the narrative by condemning discriminatory attitudes and socially ill-constructed narratives of Christian parents of children with visual impairment. Church leaders and counsellors should make Christians believe that people are created in the Image of God (Genesis 1:26). That is to say that God can use anybody to achieve His purposes irrespective of ability, disabilities, and gender (Exodus 4:11). God desires people with disabilities to be in the church (Luke 14:12–14). Christian parents who are affected with depression, trauma, and other psychological disturbances due to irrational beliefs about children with low vision should be made to realize that disability is not caused by sin (John 9:3–4).^[41]

4.1. The strengths and limitations of the study

In part of this world (Nigeria), it appeared that this study is one of earlier studies that investigated the impact of family health model of REBT in reducing negative perception and interpretation of quality of family life. In addition, the inclusion of both parents is strength.

Like other quantitative studies, we would researchers and therapists to interpret with caution based on its limitation. Although the author utilized Gpower to test adequacy of the sample yet the 88 participants are too small when considering generalizability of finding to the larger population of parents of children with low vision in Nigeria and beyond. Therefore, we note it as a limitation and call future researchers to use larger representative of the population. Also, future studies, childhood educators, pastoral counsellors, and other practitioners that may find the current treatment outcome useful should interpret the results with caution. Restricting sample to only those Christian parents residing within Enugu state Nigeria is flaw in this study. We ought to have used a measure of irrational belief to determine if poor quality of family life is associated with negative beliefs or not. It would have given the current study credible look if any scale that measures dysfunctional thoughts of the Christian parents with regards to parenting practice which leads to poor quality of family life. Based on these limitations, we suggest that subsequent studies should improve on that.

5. Conclusion

This study suggested that family health model of REBT accounted for moderate improvement in the quality of family life among Christian parents who had children with visual impairment. The finding also suggested that family health model of REBT is effective in improving quality of family life of Christian parents irrespective of gender. Therefore, we recommended that future can advance this approach in other countries.

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