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Investigating the effectiveness of cognitive-behavioral education on the spiritual health and resilience of housewives of Buin va Miandasht

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ABSTRACT

This study investigated the effectiveness of cognitive-behavioral education on spiritual health and resilience of housewives of Buin va Miandasht. Due to the practicality of its results, this research is applied research. In terms of research method, it is quasi-experimental and in terms of research design, it is pre-test and post-test with an experimental group and unequal control. The statistical population of this study included all the women who visited Vali-e-Asr Cultural and Educational Center in Buin va Miandasht city. These 30 people were randomly divided into two experimental and control groups of 15 people, the experimental group received group cognitive-behavioral education, and the other group which was the control group was on the waiting list. Also, analysis of covariance was used to analyze the data and SPSS22 software was used to accelerate the results. The results showed that cognitive-behavioral education significantly increases the resilience and spiritual health of housewives. In other words, housewives were able to increase their resilience and spiritual health by participating in cognitive-behavioral education sessions. Therefore, cognitive-behavioral education can be an effective way to reduce women's psychological problems.

Keywords
Cognitive-behavioral education, resilience, spiritual health

Introduction

Despite the advancement of technology in the modern era, there has not been much progress in psychological and mental issues and we see a decrease in peace and vitality and an increase in tensions and psychological problems in people's lives (Haghani Zanjani, 2006). Especially in housewives who face more pressure due to social and cultural conditions, the monotony of life, loneliness, etc. which will make the individual, marital and social life of this group of the society problematic. Several studies have shown that spiritual health plays a significant role in women's marital life and adjustment (Rahimi Shadbad and Alivandi Vafa, 2017).

Tendency and attention to the spiritual issues of life show that the spiritual dimension of the human being is not a new dimension and has always existed, but either it has never been noticed or has been satisfied in other ways through history (Etemadi, 2016).

Also, researches show that there is a positive correlation between spirituality and physical and mental health (Rahimi Shadbad and Alivandi Vafa, 2017). Spiritual health is a sense of acceptance, positive emotions, morality, and a sense of positive interaction with a sovereign and superior divine power, others, and oneself that results in a dynamic, harmonious process of cognitive, emotional, active, and personal outcome (Aghakhani et al., 2016).

On the other hand, Ranjbar's research (2017) showed that one of the problems of married women is their low level of resilience. Resilience is defined as the ability to resist stress and return to normal balance after experiencing stressful factors (Werner, 2013). Resilience prevents personal and interpersonal psychological problems in injured people and protects them from the psychological effects of problematic events. Also, resilience is related to positive emotions that play a protective role against depression and aggression and is a supportive mechanism that modulates the individual's response to high-risk situations (Fergus and Zimmerman, 2010). The results of Kazemian and Ismaili (2012) and Steinhard and Dolbier's research (2009) showed that teaching resilience may lead to increased personal and interpersonal adaptation and using more effective coping strategies against surrounding pressures.

To increase the resilience and spiritual health of individuals, it is necessary to provide intervention approaches, and using cognitive-behavioral therapy is one of the effective and efficient approaches in decreasing the individuals' psychological problems. Studies show that cognitive-behavioral therapy helps with resilience and spiritual health (Moradi and Fathi, 2016) in women. Theorists like Fox (1999), McMalin (1967), and Michenbam (1987) believe that learning, maintenance, and elimination of behaviors can be done through systems where external events and cognitive processes interact with each other (Seif, 2013). Therefore, just like cognitive therapists, cognitive-behavioral therapists consider irrational thinking and destructive self-talk to be the source of psychological problems, but unlike cognitive

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therapists, they use more organized behavioral techniques to change cognitive processes (Rosenhan and Seligman, 2013).

This approach is naturally respectful and participatory and increases the client's self-control and reduces his destructive behaviors (Brabander, Fallon, and Smolar, 2011). In this vies, clients' familiarity with problem-solving skills helps them think about all of the aspects of situations and keep in mind that the steps leading to their response are mostly based on their instincts, feelings, and emotions. Once the clients experience success in problem-solving, their self-control and resilience will increase (Kodayari Fard and Abedini, 2014). Considering the role of resilience and spiritual health in adaptation and reducing psychological problems of individuals and the need for psychological intervention to correct them, the effect of cognitive-behavioral therapy on reducing psychological problems, the fact that there has been no coherent research on the effect of this treatment on resilience and spiritual health in housewives and also how several organizations such as welfare and consulting and family therapy centers need the results of this research, the researcher of this study sought to study the effectiveness of cognitive-behavioral therapy on resilience and spiritual health of housewives of Buin va Miandasht.

Theoretical foundations of the research

Resilience

Resilience is a dynamic process that involves positive adaptation from tragic and awful incidents. Resilience is also defined as the ability to resist stress and return to normal balance after experiencing stressful factors (Conner and Davidson, 2005). Resilience can also be described as the ability to survive difficult situations or modulating them. Resilience indicates the capacity of individuals to stay healthy and resilience and tolerance in difficult and high-risk situations when not only the individual overcomes the difficult situation but also becomes stronger during and because of it. Thus, resilience is being successful, living, and improving in difficult situations (Bonato, 2013). People who have low or poor resilience and go through those situations with denial and avoidance instead of looking for a logical solution are more likely to experience such work, family, economic and personal turmoil. But, those with high resilience, try to use the existing situations efficiently in the direction of their desires by adopting logical solutions, although they consider them as threatening (Duerr, 2015). Banano (2013) lists the characteristics of resilient children as the following: softness, high intelligence, the strong bond between parents and the child, positive attitude of the child towards the parents' health, feeling competent, empathy, and ability to solve social problems.

Bloom (2003, quoted by Jokar, 2007) lists the supportive factors of resilience in three parts of personal, family, and surrounding Characteristics. He considers personal supportive factors of resilience to be the positive perception of self (self-concept), self-confidence, self-efficacy, high self-esteem, the center of internal control, high intelligence, and habituation with others. Family supportive factors of resilience include bond with at least one parent, family cohesion, accurate family structure and intimacy between the siblings, and surrounding supportive factors of resilience are the presence of one compassionate adult at school or society, other than the parents, small number of negative events in life and a large amount of care during childhood.

Spiritual health

Spiritual health is a sense of acceptance, positive emotions, morality, and a sense of positive interaction with a sovereign and superior divine power, others, and oneself that results in a dynamic, harmonious process of cognitive, emotional, active, and personal outcome (Aghakhani et al., 2016). Elkins sees spirituality as a way of being and experiencing that is achieved through an awareness of a transcendent dimension that can be defined by definable and certain values according to oneself, others, nature, life, and whatever someone considers as the ultimate aim and purpose (Mayer, 2009). Fridman and McDonald (2010) consider spirituality as the need to transcend oneself in life and to be integrated with another one, which leads to the experience of transcendence.

According to Moberg and Brusk, spiritual health is made of a multidimensional structure, including a vertical and a horizontal dimension. The vertical dimension refers to the relationship with God and the horizontal dimension refers to the feeling of purposefulness and satisfaction in life without considering a particular religion (Dehshiri, Sohrabi, Jafari and Najafi, 2008).

In Fisher's spiritual health model, the dimensions of spiritual health are presented as individual, social, surrounding, and transcendent dimensions. In this model, the characteristics of spiritual health include belief in a higher power, the need to communicate with others, inner harmony, maintaining one's existential integrity and strong support systems, caring for nature, and a sense of connection with the surrounding world (Fisher, 2010).

The results of some studies show that the dimensions of spirituality include striving for meaning and purpose, superiority and excellence (for instance, feeling that being human is beyond simple material existence), connection (for instance, connection to others, nature or divinity), and values (Such as love, compassion, and justice), while meaning and purpose in life, self-awareness, connection to oneself, others, and a higher reality are also considered the

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components of spiritual health. On the other hand, the results of researches based on humanism and phenomenology, do not equate spirituality with beliefs, manners, and doing limited tasks (West, 2017).
Confronting serious challenges of families in the modern era, we can look for techniques to repair and strengthen the bonds within the family by building up spirituality in the family. Some of these techniques are:
Strengthening the bond between parents with spirituality: Based on the principle of children's identification with parents and because identification motivates children like an essential spiritual and psychological need, to try to create and shape a character compatible with the adult generation that they accept. If parents can provide a suitable model of spirituality in the family, both in speech and behavior, and if their children trust them, they will try to match their spiritual backgrounds with their parents by imitating them. (Richards et al., 2011)
In this regard, it should also be noted that identification with parents requires building trust. If parents can build the necessary trust in their relationship with their children, they will not face much problem in this regard.
Commitment to knowledge and practice: the concept of doing and adhering to what they advise children to do orally and in words.
Fulfillment of logical promises: Some of the children's wishes and expectations from parents are logical and feasible. This means that these kinds of desires are rational and can be fulfilled by parents. Parents who intelligently fulfill such obligations well by meeting their children's demands promptly.
Increasing realization and mutual understanding: Some parents have a serious desire to understand and know their children and express this desire by developing their world of communication with them.

Cognitive-behavioral therapy

Cognitive-behavioral therapy refers to various methods, all of which rely on both the role of cognitive and behavioral processes in the formation of psychological disorders and the use of cognitive and behavioral experimental measures for modifying inadequate response patterns and achieving self-help (Zarb, 2010). In cognitive-behavioral therapy, they try to improve the client's thoughts and actions by impacting the conscious thinking pattern. Cognitive-behavioral therapy which is derived from behavior therapy focuses on the effect of thinking on emotions, behavior, and one's perception of the world. In this regard, the latest cognitive point of view which is based on information processing patterns about everything happening in the surrounding is philosophically the same type as the school of mental structures. In constructivism, it is believed that a person has an active role in building his reality (Massen et al., 2010). Cognitive-behavioral education is a problem-oriented intervention that addresses cognitive definitions, false attributions, and low self-esteem. The goal of this treatment is to reduce self-defeating attitudes, increase positive attributions and improve confrontation skills. In other words, cognitive-behavioral education is an intervention that creates behavioral and emotional changes in people by teaching them the new ways of confronting and recognizing thoughts in a problem-oriented method. Cognitions are considered as a structure of knowledge or beliefs and a set of strategies for adaptively using this information. In practice, the basic premise of cognitive therapy is that cognitions affect emotions and behaviors. In addition, belief in these cases is important assumptions that determine a cognitive change as a prerequisite for recovery (Seif, 2013).
The results of Bagheri and Doostkam's research (2019) on the effectiveness of cognitive-behavioral group therapy on psychological distress and mental fatigue and spirituality of people with substance use disorders, showed that cognitive-behavioral group therapy significantly reduces psychological distress and mental fatigue of people with substance use disorders. Behzadi and Asgari's research (2018) on the effectiveness of cognitive-behavioral therapy on chronic fatigue and distress in working women, showed that cognitive-behavioral therapy is effective on chronic fatigue and distress. A study by Charmchi et al. (2016) in Health Improvement Management journal on the effectiveness of cognitive-behavioral group therapy on the level of anxiety and psychological resilience in postmenopausal women, showed that the effect of cognitive-behavioral group therapy significantly reduces anxiety and increases psychological resilience of postmenopausal women. Salki's study on the effectiveness of cognitive-behavioral group therapy on anxiety tolerance and optimism in infertile women showed that cognitive-behavioral group therapy positively and significantly increases the ability to tolerate anxiety and increases optimism in infertile women.

Research method

Due to the practicality of its results, this research is applied research. In terms of research method, it is quasi-experimental and in terms of research design, it is pre-test and post-test with an experimental group and unequal control. The statistical population of this study included all the women who visited Vali-e-Asr Cultural and Educational Center in Buin va Miandasht city.
Among the visiting housewives, 30 people were selected as the statistical samples by the available sampling method and based on the score of the relevant questionnaires in the pre-test. These 30 people were randomly divided into two

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experimental and control groups of 15 people, the experimental group received group cognitive-behavioral education, and the other group which was the control group was on the waiting list.
Eligibility conditions were being a housewife between the ages of 20 and 45, having a minimum of middle school degree, no severe mental disorders or any other chronic physical illnesses, achieving a score lower than the cut-off point in resilience (lower than 50) and spiritual health (lower than 42) questionnaires.
A questionnaire was used to collect the data. Connor and Davidson's resilience scale (CD-RISC). This scale consists of 25 items, it has been made to measure the resistance to pressure and threat. Cronbach's alpha coefficient of the scale was 0.87 and the retest reliability coefficient was 0.73. The spiritual health (SWB) questionnaire of Palutzian and Ellison (1982) consisted of 20 questions, 10 religious health and 10 existential health questions. Cognitive-behavioral therapy sessions were conducted in groups as follows:

Table 1: Titles of cognitive-behavioral group therapy based on Zareb's program (2014)

Session 1	Members meeting and greeting, an introduction to the group rules and definition of relevant concepts (resilience and spiritual health), introduction to the variables, definition, and description of cognitive distortions and their effect on moods and feelings.
Session 2	Determination of personal and interpersonal goals focus on interpersonal relationships
Session 3	Facing what other people say, learning peace, teaching relaxation techniques, and practicing it with the group
Session 4	Role of negative thoughts and irrational beliefs in fatigue and mental distress, etc. teaching cognitive formulation of the correlation between thoughts, emotions, and behaviors.
Session 5	Changing negative thoughts and using positive self-talk
Session 6	Teaching boldness and assertiveness, how to express ideas calmly and how to accept negative feedbacks
Session 7	Teaching problem-solving strategies and their applications in daily life
Session 8	Revision of the sessions, summarizing, focus on the future, and setting goals.

Also, analysis of covariance (ANCOVA) was used to analyze the data and SPSS22 software was used to accelerate the results.

Findings

This study investigated the effectiveness of cognitive-behavioral education on spiritual health and resilience of housewives of Buin va Miandasht.

Table 2: Sample descriptive indicators

variable		experimental						control					
		Pre-test			Post-test			Pre-test			Post-test		
		mean	Standard deviation	number	mean	Standard deviation	Number	mean	Standard deviation	number	mean	Standard deviation	number
resilience		42.27	1.715	15	43.47	1.772	15	39.53	1.823	15	39.60	1.831	15
Spiritual health	Total score	49.80	1.280	15	53.73	1.860	15	43.67	1.041	15	43.80	1.024	15
	Religious health	25.40	1.640	15	26.80	1.603	15	22.33	1.021	15	22.47	1.004	15
	Existential health	25.07	1.439	15	26.80	1.302	15	21.33	1.021	15	21.33	1.021	15

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As you can see in the table above, compared to the control group, the mean of the post-test of the experimental group has had a significant increase in both variables of resilience and spiritual health.

Table 3: Levene's test results to assess the homogeneity of the variances

			Levene's statistics	Degree of Freedom 1	Degree of Freedom 2	Significance level
resilience		Pre-test	1.814	1	28	0.202
		Pre-test	2.340	1	28	0.402
Spiritual health	General spiritual health	Pre-test	1.398	1	28	0.247
		Pre-test	0.940	1	28	0.341
	Religious health	Pre-test	1.098	1	28	0.287
		Pre-test	1.604	1	28	0.216
	existential health	Pre-test	0.735	1	28	0.399
		Pre-test	0.249	1	28	0.622

The output of the test shows that the significance level in all variables in the pre-test and post-test stages is greater than the significance level of alpha of 0.05. The null hypothesis in Levene's test is that the variances of the groups are homogeneous. Therefore, because the significance levels obtained are greater than the alpha of 0.05, the null hypothesis which says that the variances are homogeneous, is confirmed.

Table 4: Bartlett's test

Likelihood ratio	0.684
Chi-square	11.519
Significance level	.000

The second hypothesis of the covariance analysis test is sufficient correlation between dependent variables. Bartlett's test was used to investigate sufficient correlation between dependent variables, which shows sufficient correlation between dependent variables of spiritual health and resilience because the significance level of the test is less than 0.05. The results are as follows:

Table 5: Box's M test for homogeneity of variance-covariance matrices

Box's M	F	Significance level
1.632	.731	.542

This table shows Box's M test. This test assesses the null hypothesis that covariance matrices of the dependent variable are equal in different groups. In the table above, since the value of F (0.731) is not significant at the given degree of error (0.54), the null hypothesis is not rejected. This means that the observed covariance matrices are equal in different groups. According to the results of mentioned assumptions, the assumptions of the analysis of covariance test have been observed. Therefore, this test can be used to assess research questions.

Main hypothesis: cognitive-behavioral education is effective on the spiritual health and resilience of housewives.

Table 6: Results of multivariate analysis of covariance to compare the dependent variables in the two groups

Name of the test	value	Df assumption	Df error	F value	Significance value	Partial eta Squared
Wilks' Lambda test	0.301	4	22	12.802	0.000	0.699

According to table 6, the results of multivariate analysis of covariance show that by controlling the effect of pre-test scores, there is a significant difference between the experimental and control groups in the variability of resilience and

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spiritual health as dependent variables ($p<0.05$). In other words, cognitive-behavioral education has a positive effect on at least one of the dependent variables of resilience and spiritual health (religious and existential) of women. In other words, these results show that there is a significant difference between the studied groups in terms of one of the dependent variables. Also, the eta squared shows that according to the dependent variables, the difference between the two groups is significant in total and the difference is 69%. That is, 69% of the variance related to the difference between the two groups is due to the interaction of dependent variables. To identify which of the observed variables is significant, we analyzed the covariance for the dependent variable.

Table 7: Testing multivariate analysis of covariance of spiritual health and resilience in the experimental and control group

Dependent variable			Total squares	Degree of freedom	Squares mean	F	Significance level	Partial eta Squared
	resilience	groups	9.253	1	9.253	10.724	0.003	0.300
Spiritual health	Total spiritual health	groups	84.374	1	84.374	30.533	0.000	0.550
	Existential health	groups	12.188	1	12.188	8.919	0.006	0.263
	Religious health	groups	29.792	1	29.792	12.444	0.001	0.366

According to the data in the table above, since the value of F is significant in the variables of spiritual health and resilience at the significance level of 0.05, the null hypothesis is rejected and the research hypothesis is confirmed with 9% confidence. In other words, cognitive-behavioral education affects the spiritual health and resilience of housewives, and the eta value indicates that 30% of changes in resilience, 55% of changes in total spiritual health, 26% of changes in existential health, and 36% of Changes in religious health were due to the impact of cognitive-behavioral education.

The first sub-hypothesis: cognitive-behavioral education is effective on the resilience of housewives

Table 8: univariate analysis of covariance

Dependent variable		Sum of squares	Degree of freedom	Mean square	F	Significance level	Partial eta Squared
resilience	groups	8.777	1	8.777	10.146	0.004	0.273

According to table 8, the test results show that due to the significance level (0.004) of the F-test in the post-test, the significance level of resilience is less than 0.05. Therefore, it can be concluded that cognitive-behavioral education affects women's resilience. Thus, the research hypothesis is confirmed with 95% confidence. Based on the effect size values in the table, it can be said that 27% of the changes in the resilience variable were due to the impact of cognitive-behavioral education.

The second sub-hypothesis: cognitive-behavioral education is effective on the spiritual health of housewives

To test this hypothesis, a multivariate analysis of covariance was used. In this analysis, the group (experimental group and control group) was entered into the model as an inter-subject factor, subjects 'scores in spiritual health (religious and existential) in the pre-test stage as control variables, and subjects' scores in these variables in the post-test stage as dependent variables.

Table 9: multivariate analysis of covariance

Dependent variable			Sum of squares	Degree of freedom	Mean square	F	Significance level	Partial eta Squared
	Total spiritual health	groups	88.120	1	88.120	32.447	0.000	0.555

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Spiritual health	Religious health	groups	13/406	1	13.406	9.731	0.004	0.272
	Existential health	groups	29/501	1	29.501	14.791	0.001	0.363

According to the significance level in the F-test in the post-test, the significance level of the variables of total spiritual health, religious health, and existential health is less than 0.05, so it can be concluded that cognitive-behavioral education affects the relationship between spiritual health and its subscales in women. Therefore, the research hypothesis is confirmed with 95% confidence. On the other hand, based on the effect size values in the table, it can be said that 55% of the changes in the total spiritual health variable; 27% of the changes in the variable of religious health, and 36% of the changes in the variable of existential health were due to the effect of cognitive-behavioral education.

Conclusion

The present study was conducted to investigate the effectiveness of cognitive-behavioral education on the spiritual health and resilience of housewives in Buin va Miandasht.

Main hypothesis: cognitive-behavioral education is effective on resilience and spiritual health of housewives

The results of multivariate analysis of covariance show that by controlling the effect of pre-test scores, there is a significant difference between the experimental and control groups in the variables of resilience and spiritual health as dependent variables ($P<0.05$). In other words, cognitive-behavioral education affects resilience and spiritual health, and the eta value indicates that 69% of the changes were due to the effect of cognitive-behavioral education. This finding is consistent with many similar studies such as the results of Charmchi et al. (2016), Janfza (2015), Kaviani, Hamid, and Enayati (2014), Morin and Avidan (2017).

This study proved that cognitive-behavioral education significantly increases the resilience and spiritual health of housewives. In other words, housewives were able to increase their resilience and spiritual health by participating in cognitive-behavioral training sessions.

Just like other cognitive approaches, in cognitive-behavioral education, irrational thinking and destructive self-talk are considered to be the source of psychological problems. But unlike cognitive approaches, organized behavioral techniques are used to change cognitive processes. In other words, while changing maladaptive behaviors and achieving self-help, this approach not only helps with focusing on cognitive reconstruction such as changing false expectations, dysfunctional schemas, negative spontaneous thoughts, negative self-talk, and wrong and irrational beliefs, but also emphasizes teaching social skills such as assertiveness, problem-solving, muscle relaxation, and interpersonal skills. Therefore, with this method, people learn to be more resilient to the pressures and problems of life and consequently improve their spiritual health.

The first sub-hypothesis: cognitive-behavioral education is effective on the resilience of housewives

The test results show that according to the significance level (0.004) of the F test in the post-test, the significance level of the resilience variable is less than 0.05, so it can be concluded that cognitive-behavioral education affects women's resilience. Therefore, the research hypothesis is confirmed with 95% confidence. Based on the effect size in the table, it can be said that 27% of the changes in resilience variables were due to the effect of cognitive-behavioral education. This finding is consistent with many similar studies, such as the results of Bagheri and Doostkam (2019), Bashogh (2017), Charmchi et al. (2015), Buivin and Andrew (2016), and Muriel et al. (2015).

When a group of people is exposed to stress and threatening situations, they feel anxious, restless, sad, and helpless, so they either show aggressive behaviors or get depressed and lose their appetite and sleep. If there are long-term stressful situations in these people's lives, their physical and mental health will be disrupted. These people have poor resilience to stress and of course, are very vulnerable. In contrast, there is another group of people that face stressful situations and try to use the existing situations as an opportunity for their progress without giving up. In other words, without reacting in a pathological and emotional way, they try not only to control the situation but also to find logical solutions to the conflicts caused by stress. This resistance and effort to find logical solutions in stressful situations is due to the high resilience of these people.

In the cognitive-behavioral approach, the common way to begin problem-solving is to identify and change one's irrational thoughts and beliefs, because these thoughts and beliefs have an important impact on four aspects of life experiences. The important thing about cognitive therapy is that cognitive changes are very important for changing human processes. Thus, if the behavioral and emotional improvement is achieved, and if adverse events are dealt with simply, cognition is reconstructed (that is, thoughts and beliefs change). Adaptation between a person's specific vulnerability (for example, he does not value himself unless he is loved) and a specific life event that reflects mediating

beliefs (for example, if a person's partner leaves him, he'll get depressed) was stated by Beck (1987) in the form of a key concept, the stress-readiness model, in which stress refers to adverse life events (accelerating factors) and readiness refers to cognitive vulnerability (predisposing factors). In the framework of a calm and rational mind, the person assess his evaluations and perceptions of an event to obtain correct and clear information. When a person is emotionally disturbed and upset, he often distorts the input information due to the negative biases in his mind and thus, becomes inflexible and also over-generalizes. Therefore, with the help of cognitive and behavioral techniques in this training, people are helped to be able to increase their resilience against traumas and stresses of life by adjusting their thoughts as well as changing their behaviors.

The second sub-hypothesis: cognitive-behavioral education is effective on the spiritual health of housewives

Considering the significance level of the F-test in the post-test, the significance level of the variables of total spiritual health, religious health, and existential health is less than 0.05, so it can be concluded that cognitive-behavioral education is effective on the relationship between spiritual health and its subscales in women. Therefore, the research hypothesis is confirmed with 95% confidence. On the other hand, based on the effect size values in the table, it can be said that 55% of the changes in total spiritual health, 27% of the changes in religious health, and 36% of the changes in existential health were due to the effect of cognitive-behavioral education. This finding is consistent with many similar studies, such as the results of Behzadi and Asgari (2018), Soleimani and Tajodini (2016), Feizabadi and Olamaei Kooyaei (2016), Kolivand, Nazari Mahin and Jafari (2015), Shoram and Slayn (2018) and Morin and Avidan (2017).

Spiritual health is a form of human spiritual experience in two different perspectives: A. Religious health perspective focuses on how people perceive health in their spiritual lives when they are associated with a higher power. B. An existential health perspective that focuses on the social and psychological concerns of individuals. Existential health discusses how people adapt to themselves, society, or their surroundings.

Both aspects of spiritual health play an important role in people's lives and their sense of satisfaction and peace. Many people lose their spiritual health due to psychological problems and life traumas, so it is important to pay attention to this aspect of people's health. Psychological therapies can help people regain their spiritual health, especially existential health.

Cognitive-behavioral education is a problem-oriented intervention that addresses cognitive concepts, misrepresentations, and low self-esteem. The goal of this treatment is to reduce self-defeating attitudes, increase positive attribution, and improve coping skills. In other words, cognitive-behavioral education is an intervention that creates behavioral and emotional changes in a person by teaching new ways of coping and recognizing thoughts in a problem-oriented way. Cognitions are considered as a structure of knowledge or beliefs and a set of strategies for adaptively using this information.

In practice, the basic premise of cognitive therapy is that cognitions affect emotions and behaviors. In addition, believing all of this is an important assumption that determines cognitive change as a prerequisite for recovery. To determine emotional disorders, the cognitive-behavioral approach does not offer a one-dimensional model in which a negative thought or belief about an event leads to a physiological feeling or response and subsequent behavior. Each of these elements can influence the other elements in an interactive cycle. Understanding how these five aspects of a person's life experiences interact with each other will help them better understand an issue. Therefore, by improving their knowledge of the issues ahead, people can maintain their spiritual health by managing their emotions and behaviors.

According to the results of the first sub-hypothesis, it is suggested that cultural and social officials deal with community anxiety through educating housewives and strive to cultivate women's assertiveness and social skills so that housewives show high resilience in society and become flexible in facing changes. According to the results of the second sub-hypothesis, women should ignore their negative inner voice and the destructive and disturbing indoctrination of others and try to do the opposite. They should have faith in the infinite power of God and repeat to themselves: "I deserve the best". Housewives should develop their spiritual relationships. Having happy, healthy, and strong social relationships is a very important factor in the spiritual health of housewives.

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