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ORIGINAL PAPER

The Assessment Effect of Spiritual Care on Hopelessness and Depression in Suicide Attempts

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Abstract The purpose of this study was to assess the effect of spiritual care on hopelessness and depression among suicide attempts. This semi-experimental study that 60 suicide attempts and these samples were divided in to two cases and control groups. For case group, service package of spiritual care was designed and conducted during their visits to psychiatrists' offices. Findings showed that there was a significant difference after performing spiritual care in depression in both groups ($X^2 = 22$, $P = 0.002$) and their hopelessness ($X^2 = 20$, $P = 0.001$). The use of spiritual intervention is suggested in order to implement holistic nursing care during treatment should be considered as a matter of principle.

Keywords Spiritual therapies · Hopelessness · Depression · Suicide attempted

Introduction

An increasing trend is observed in the rates of suicide in recent years among both men and women. According to the first World Health Organization report, suicide happens in all classes of the society and in all populations. While the number of women attempting suicide is larger, more men succeed in committing suicide (Hollingshaus et al. 2016). According to the latest statistics published by the WHO, more than 800 thousand people die due to suicide every day, and one person dies due to suicide every 40 s (Kroning and Kroning 2016). The rate of suicide in Iran is 6.2 per 100 thousand. According to

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statistics, Iran ranks 58th in the world in terms of the rate of suicide (Izadi and Mohammadzadeh 2008). This phenomenon is often attributed to the increased mental pressure caused by stressful life conditions, which is more evident in the younger generation (Kopacz and Pollitt 2015). Certain life events lead to stress and eventually psychological and physical breakdown and in turn, increase the individual's vulnerability (Chang et al. 2013; Heidari and Ghodusi 2015). The issue of suicide has both a psychopathological and a psychosocial aspect (Donaldson et al. 2000). The inability to successfully deal with problems and solve them may lead to coping problems that manifest themselves as emotional turmoil, increased sensitivity to external stimuli, anxiety, desolation, mood changes and depression. This turmoil often results in the misinterpretation of the surrounding and situations and leads to audacious reactions such as suicide (Maršanic et al. 2014). In psychological terms, a suicide attempt may be regarded as a manifestation of a mental disorder (Kim et al. 2011). Most studies conducted on the phenomenon of suicide propose psychiatric diagnoses such as depression disorders, personality disorders and their associated disorders in suicide attempts. Mood disorders are the main group of psychological disorders associated with suicide (Law et al. 2010). Previous findings suggest a greater subjective feeling of depression and hopelessness and more intense suicide ideations among suicide attempts (Nock et al. 2009). Hopelessness has also been proposed as a risk factor for suicide. In other words, hopelessness is an attribute of depression and indeed a link between depression and suicide. Many patients use suicide as a means of dealing with unbearable depression and hopelessness (Sveen and Walby 2008). Spirituality, however, is a factor that helps cope with specific problems and creates psychological well-being and peacefulness. Spiritual health determines the individual's integrity and is a unique force that harmonizes the physical, mental and social dimensions of the individual's life and is necessary for coping with diseases (Wills 2007). When spiritual health is seriously threatened, the individual may experience mental disorders such as feelings of loneliness and depression and the loss of meaning in life. Previous studies have shown that, as coping strategies, religion and faith have positive effects on the process of treatment (Aist 2012). Man is occupied with an arena of problems and uses different means to resolving or reducing them. The need to understand one's origin and the self, to understand the purpose of life and man's role in the universe and to learn how to interact with others and respond to the world of existence are some of the religious needs of humans (Plante 2008). Religious instructions and rituals can be effectively used in the treatment and prevention of mental disorders (Campbell et al. 2010). Spiritual care has been identified as the most important contributor to the achievement of balance in maintaining health and coping with crises and is known to hasten the progress toward recovery. The goal in nursing is to maintain and promote health, prevent disease and alleviate ailment and discomfort in patients, and spiritual care can contribute significantly to the achievement of this goal (Ho et al. 2012). Considering the high risk of suicide in people with mood disorders (53 cases from March 21 to June 21, 2014, and 96 cases from June 21 to September 21, 2014, from those admitted to the emergency department of Borujen Hospital) and since spiritual care is effective in recovery from mental disorders, the present study was conducted to investigate the effect of spiritual care on hopelessness and depression in suicide attempts.

Method

Study Setting

The present quasi-experimental cross-sectional study was conducted to examine the effect of spiritual care on hopelessness and depression in suicide attempts. The study population consisted of suicide attempts admitted to Valiasr hospital of Borujen city in November 2014 to January 2016. The study sample size was calculated as 60 overall and 30 per group using Altman's nomogram and allowing for a type I error of 5% and a type II error of 10% and a standardized difference.

Ethical Approval

The ethical approval for the study was obtained from the Deputy of Researches and Technology Shahrekord University of Medical Sciences under the number ethics code 1393-12-15. Written informed consent was also obtained from the participants.

Instruments for the Study

Data were collected using Beck's Depression Inventory II (BDI-II) and Beck's Hopelessness Scale. The first part of the questionnaire inquired about the demographic details.

Beck's Depression Inventory II (BDI-II)

BDI-II is a later version of BDI-I that requires participants to consider their feelings in the past two weeks to respond to the questions. This questionnaire has been developed to measure the severity of depression in adults and adolescents over 13 and consists of 21 items, each comprising of four statements, only one of which should be encircled by the patient to represent his feelings and behaviors. Each item is given a score from zero to 3, and each respondent obtains a total score ranging from zero to 63. The respondent is placed into one of the following four categories based on his score: A score of 0–13 indicates minimal depression; 14–19 indicates mild depression; 20–28 indicates moderate depression; and 29–63 indicates severe depression. The psychometric properties of this questionnaire in Iran consist of an alpha coefficient of 0.87 and a test–retest coefficient of 0.74 (Myrami and Eghbali 2010).

Beck's Hopelessness Scale (BHS)

Beck's Hopelessness Scale (BHS) is a self-reporting scale consisting of 20 items or statements that assess the respondents' negativity and pessimism about the future. Answers to the items in this scale are in the form of true/false and the total score obtained ranges from zero to 20, where higher scores indicate a greater severity of hopelessness. Previous studies have shown that the scores obtained in this scale are associated with the severity and frequency of suicidal ideations and tendencies. In Iran, the internal consistency of the scale was confirmed with a Cronbach's alpha of 0.79; the factor analysis of the scale led to the extraction of five factors, including (1) losing hope in achieving wishes and desires; (2) pessimism about the future; (3) the attitude toward the future; (4) the outlook on life; and (5) the belief in the future; collectively, these factors explained 48.9% of the total variance

(Khajehmougahi et al. 2009). The validity of the scales was determined using the content validity method, and their reliability was confirmed using Cronbach's alpha coefficient.

Procedure

The questionnaires were completed by eligible participants in their first visit to the hospital. The researcher completed the questionnaires on behalf of those who were unable to fill them out by themselves.

Inclusion Criteria

Having at least 18 years of age, awareness of time and place, absent disorder in individual judgment, do not have psychiatric diagnoses, not having Alzheimer's disease in the medical history, the patient's willingness to participate in the study and to fill in the conscientious consent form, not deaf to communicate effectively, with the criteria for entering the study.

The study samples were randomly divided into a case and a control group. The case group received an educational booklet containing instructions on different spiritual care measures developed by the researcher and colleagues in accordance with Islamic religious texts and approved by a number of experienced professors; the cases reviewed the spiritual care measures and selected eight measures that interested them. The researcher read the booklet out loud to those who were unable to review it by themselves (Table 1).

Over the first eight sessions during which the cases visited the psychiatrist's office, the researcher performed the participant's choice of therapy and spiritual care measures for both the participant and his family (between 3 pm and 9 pm, in the consultation room). For performing the spiritual care program, the researcher first established contact with the patient, introduced himself and tried to gain the patient's trust through his rhetorical abilities. The spiritual care package was then implemented in the case group; for this

Table 1 The content of the spiritual care counseling sessions

Session	Subject of the session
One	Introducing the members to each other and a discussion of spirituality and religion and their effect on life
Two	The effect of faith and trust on reducing psychological problems such as anxiety and depression
Three	Spiritual visualization/progressive muscle relaxation using Johnson's relaxation technique along with listening to calming music (the sound of nature and rain)
Four	The role of patience in bearing hardship and calamities/the role of patience along with a trust in God
Five	Book-therapy and educational pamphlets/reciting the Quran/listening to recitations of the Quran: The patient listened to recitations of Quran and also listened to a recitation of select surahs (Al-Waqi'ah, An-Naba, Ar-Rahman) for 20 min with headphones
Six	Prayer-therapy for reducing psychological problems, increasing hopefulness and reducing depression. The role of prayer in mental health and hope in the future was discussed and the patient was able to recite select prayers with the help of the therapist
Seven	Writing a diary/spiritual self-disclosure: The importance of writing about daily activities performed over the past 24 h and keeping a diary was emphasized and strategies were provided for calming the spirit and maintaining physical health in life
Eight	Compassion and mercy/defining repentance and its conditions

purpose, each of the cases received face-to-face instructions by the researcher and his colleagues during the therapy sessions. An educational booklet and pamphlets containing instructions on spiritual care were distributed among the cases and their families to review at home and be encouraged to apply the spiritual advice to their daily life after fully grasping their subject. The researcher gave his phone number to the patients. Over the course of the intervention, the researcher contacted the patients to see how they were proceeding with their tasks and also answered any questions they had and arranged for a face-to-face meeting in the psychiatrist's office to provide better instructions and obviate any ambiguities, if required. It is worth noting that, in the case of any problems or questions, the patients were able to call the researcher on the phone and receive the necessary instructions. Two months later, in the last phone call, both the cases and controls were asked to present to the psychiatrist's office and complete the depression and hopelessness scales in person once again. The data obtained were ultimately analyzed in SPSS/21 using descriptive (mean, standard deviation and frequency) and inferential statistics such as the Chi-square test, the independent and paired t-tests, the one-way ANOVA and Pearson's correlation coefficient.

Results

According to the results obtained, the highest frequency of suicide attempts in the case group (53.33%) was in the 21–24 age group and the lowest (6.6%) were 27 and older. A total of 60% of the cases were single and 33.33% were married, while 23.33% of the controls were married and 66.66% were single. Table 2 presents the other personal details of the study subjects.

The results obtained showed that, before implementing the spiritual care program, the majority of the participants in the case group (46.66%) had severe depression, while in the control group, 36.66% had moderate depression, which suggests the lack of significant differences between the two groups before the intervention ($P = 0.58$, $X^2 = 1.14$). However, after implementing the spiritual care program, all the cases (100%) had minimal depression, and the majority of the controls (60%) had severe depression, suggesting a significant post-intervention difference between the two groups ($P = 0.002$, and $X^2 = 22$; Table 3).

Comparing the two groups in terms of hopelessness before and after the intervention revealed that 60% of the cases and 50% of the controls had severe hopelessness before the spiritual care intervention, suggesting the lack of significant differences between the two groups ($P = 0.63$, $X^2 = 2.13$). After the intervention, however, a significant difference was observed between the two groups in terms of hopelessness, as all the cases (100%) had low hopelessness and the majority of the controls (56.66%) had moderate hopelessness. According to the results, the level of depression differed significantly between the two groups after the spiritual care intervention ($P = 0.001$, $X^2 = 20$; Table 4).

Discussion

Mood disorders are the main group of mental disorders associated with suicide attempt. Various studies, including ones by Maršanić et al. (2014), Yi (2016) and Galfalvy et al. (2006), have emphasized the relationship between mood disorders and suicide attempts. In line with the findings of the cited studies, the present study also found that, before the

Table 2 Demographic data units in case and control groups

Variable groups	Groups	Case *N* %	Control *N* %
Age	18–21	8 (26.66)	14 (46.66)
	21–24	16 (53.33)	2 (4.66)
	24–27	4 (13.33)	8 (26.66)
	27≤	2 (6.6)	6 (20)
Gender	Female	17 (56.66)	20 (66.66)
	Male	13 (43.33)	10 (33.33)
Location	City	27 (90)	30 (100)
	Village	3 (10)	0
Level of education	Illiterate	0	0
	Diploma	19 (63.33)	17 (56.66)
	Bachelor's degree	10 (33.33)	13 (43.33)
	Master's degree and higher	1 (3.33)	0
Marital status	Single	18 (60)	20 (66.66)
	Married	10 (33.33)	7 (23.33)
	Divorced	2 (6.66)	3 (10)
	Widow	0	0
Satisfaction with family	Yes	16 (53.33)	12 (40)
	No	14 (46.66)	18 (60)
Employment status	Student	1(3.33)	2 (6.66)
	College student	8 (26.66)	1 (3.33)
	Unemployed	20 (66.66)	23 (76.66)
	Housewife	2 (6.66)	3 (10)
	Other employee	0	1 (3.33)
History of drug abuse	Yes	6 (20)	3 (10)
	No	24 (80)	27 (90)
History of suicide	Yes	12 (40)	5 (16.66)
	No	18 (60)	25 (83.33)

Table 3 Comparison of depression in the case and control groups before and after the implementation of spiritual care

Level of depression groups		At least depression *N* %	Minor depression *N* %	Mild depression *N* %	Major depression *N* %	Chi-square test Significance level
Before spiritual care	Case	0	4 (13.33)	12 (40)	14 (46.66)	$X^2 = 1.14$
	Control	0	1 (3.33)	18 (60)	11 (36.66)	$P = 0.58$
After spiritual care	Case	30 (100)	0	0	0	$X^2 = 22$
	Control	0	0	12 (40)	18 (60)	$P = 0.002$

Table 4 Comparison of hopelessness in the case and control groups before and after the implementation of spiritual care

Level of hopelessness groups		Minor hopelessness (0–6) *N* %	Mild hopelessness (7–13) *N* %	Major hopelessness (14–20) *N* %	Chi-square test Significance level
Before spiritual care	Case	3 (10)	9 (30)	18 (60)	$X^2 = 2.13$
	Control	4 (13.33)	11 (36.66)	15 (50)	$P = 0.63$
After spiritual care	Case	30 (100)	0	0	$X^2 = 20$
	Control	0	17 (56.66)	13 (43.33)	$P = 0.001$

spiritual care intervention, the majority of the cases ($n = 14$, 46.66%) had severe depression and the majority of the controls ($n = 18$, 60.18%) had moderate depression, which suggests that the two groups were not significantly different in terms of depression before the spiritual care intervention. McCoubrie and Davies (2006) also found similar results in their study. In the present study, a significant difference was observed between the two groups in terms of depression after the spiritual care intervention. Many studies have demonstrated the relationship of spirituality with health care and clinical outcomes and have found that the lack of attention to the patients' spiritual needs in most healthcare centers leads to poor treatment outcomes and that patients who require prolonged treatment and care for recovery and rehabilitation have special spiritual needs appropriate to their disease (Harvey and Silverman 2007). In another study on the effect of spiritual care on psychological health in schizophrenic patients, Ghanbari and Rahmati (2012) concluded that spirituality improves psychological health and particularly reduces symptoms of depression. In line with these findings, Richards et al. (2007) also assessed the use of complementary therapies in cancer patients and found that spirituality and religion are the most widely used of complementary therapies for reducing depression and creating peacefulness. In their study on prayer as a spiritual approach in psychological interventions, Taheri Kharameh et al. (2013) reported that, as a voluntary spiritual behavior for connecting with God, prayer has a significant effect in preventing threats to mental health, such as anxiety and depression, and leading to recovery. In another study, Koszycki et al. (2010) reported the effectiveness of spiritual activities such as poem-therapy and pilgrimage on the psychological state of patients with anxiety disorders. In another study, Doehring (2014) also proposed spirituality as very essential for changing emotions.

In the present study, the two groups were not significantly different in terms of hopelessness before the spiritual care intervention. Khajeh-Mogehi et al. (2009) and Ramakrishnan et al. (2014) also argued that hopelessness is a major risk factor for suicide in patients with mood disorders. The results obtained in a study conducted by Heidari et al. (2015) also confirmed the role of hope in psychological health. After performing the care intervention, a significant difference was observed in hopelessness between the two groups. In line with the present findings, Delaney et al. (2008) also found that spiritual counseling positively affects psychological factors in cardiac patients and improves their psychological health, especially their hopefulness; their spiritual counseling consisted of music therapy, guided visualization using CDs, prayers and taking walks in the garden. Lichter and MIN (2013) also found that spiritual care is associated with high levels of physical and psychological health in people. Considering the significant effect of spiritual nursing care on mental health in suicide attempts, the researchers recommend that courses be held to

introduce nursing students and nurses to the concepts and components of spiritual care. Future studies are also recommended to further clarify how this intervention affects health and to discuss the barriers to and facilitators of its clinical application for other psychiatric disorders.

Conclusion

Considering the role of spiritual care in increasing hopefulness and reducing depression, a greater attention should be paid in nursing care to the important role of spiritual health in maintaining psychological health in suicide attempts. Increasing the existing knowledge about spiritual needs and encouraging the use of spiritual interventions in nurses are essential steps to the successful implementation of holistic nursing care during medical treatment.

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Compliance with Ethical Standards

Conflict of interest The author declares that she has no conflict of interest.

Ethical Approval All procedures performed in studies involving human participants were in accordance with the ethical standards of the deputy of researches and technology Shahrekord University of Medical Sciences (Ethics code: 1393-12-15) and with the 1964 Helsinki declaration and its later amendments or comparable ethical standards.

Informed Consent Informed consent was obtained from all individual participants included in the study.

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