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Journal of Caring Sciences, 2014, *3(2), 131-140*
doi:*10.5681/jcs.2014.014*
http:// journals.tbzmed.ac.ir/ JCS

The Effect of Spiritual and Religious Group Psychotherapy on Suicidal Ideation in Depressed Patients: A Randomized Clinical Trial

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ARTICLE INFO

Article Type:
Original Article

Article History:
Received: 6 Feb. 2014
Accepted: 7 April. 2014
ePublished: 1 Jun. 2014

Keywords:
Depression
Suicidal ideation
Spiritual therapies
Psychotherapy

ABSTRACT

Introduction: Suicide is a great economical, social and public health problem. It is prevalent worldwide and has a lot of negative effects on individuals, families and society. Depression is often prelude to Suicide. An important part of the treatment of the mentally ill patients is spiritual-religious psychotherapy which should be done after physical treatment. The aim of this study was to determine the effect of spiritual and religious group psychotherapy on suicidal ideation in depressed patients.
Methods: 51 depressed patients with suicidal ideation from Razi hospital (Tabriz, Iran) participated in this clinical trial. To collect Data questionnaire was used which included demographic and Beck Suicide Scale Ideation. Experimental group participated in 10 sessions of group psychotherapy. Each section lasted 1 hour. Two weeks after the last section post test was done. Statistical software SPSS ver 13 was used for data analysis.
Results: Results of independent t-test revealed no difference between two groups in terms of suicidal ideation before intervention but after study there is a statistical difference. Also the results of ANCOVA test showed a significant relationship between spiritual group therapy and decrease in suicidal ideation, so that this intervention can make 57% of variance in suicidal ideation of experimental group.
Conclusion: Regarding positive effect of spiritual and religious group psychotherapy on decreasing suicidal ideation of depressed patients, we suggest this intervention to be held in Psychiatric Wards and also more study on depression and other psychiatric patients with greater sample size would be helpful.

Introduction

Suicide is the primary emergency situation for mental health team, a major problem for public health[1] and also economical and social areas.[2] Suicide process ranges from suicide attempt to complete suicide.[3]

Suicide rates have increased by 60% over the last 45 years worldwide.[4] Worldwide every year, one million people die due to suicide, 10 to 20 million people attempt suicide and 50 to 120 million people from close relatives are affected deeply by suicide.[5]

Suicidal death accounts for 16 per 100000 people in the world.[6] In 2010 38364 people died due to suicide in the United States of America which was 105 deaths per day.[7] Asian continent accounted for 60% of the world's suicide rate.[5]

Suicide rate in Iran is lower than western societies but still more than Middle East countries.[8] The latest suicide statistics in Iran are presented in 2001 which was 6 in 100000.[6] The suicide statistics in most countries report lower than the real.[9]

Suicide survivors may suffer severe injuries[10] which cost a lot to individual, family and society. Medical and disability costs are estimated at 41 billion dollars a

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This study was approved and funded by the Tabriz University of Medical Sciences (Project number: 353) and is registered in the Iranian Registry of Clinical Trials with the IRCT201206206834N4 code.

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year.[7] Successful suicide has a negative effect on friends and family[11] and they may suffer grief, shock, distrust, fear, anger, embarrassment and shame, and also feel guilty that they could prevent the death. These feelings are associated with stigma and social isolation.[5]

Moreover, stigma and shame puts a heavy pressure on suicide survivor, changes his/ her communication ability in family and society leading to complete isolation after suicide.[12]

These patients suffer from frustration, anger, shame, fear of being, a sense of humility and ambivalence about their survival.[13] 95% of those who commit suicide has a diagnosable mental disorder mostly (80%) depression.[14] 330 million people suffer from this disease worldwide and annually 800000 suicide takes place due to depression.[15]

Due to lack of knowledge about suicide as a major problem and the stigma associated with it, the suicide is not discussed openly. Suicide prevention is also unnoticed worldwide.[5]

Medication used to prevent suicide in depressed patients, have a lot of complications.[16] Electro convulsive therapy also causes some complication along with treatment and in some patients it cannot be used.[17] Another treatment for these patients is psychotherapy. Religious spiritual psychotherapy is an important treatment after physical therapy in psychiatric patients in which religious and spiritual practices help patients to gain a spiritual perception about self, universe, events and phenomena and through this connection, patients can achieve growth and development.[18]

Spirituality is associated with paranormal issues, human connection with the reality[19] and seeking for the purpose of life.[20] Spirituality is a global concept and common issue in all religions and cultures, including the belief and obedience of a very powerful force called as "God".[21] Religion is consists of organized beliefs, practices, ritual and symbols to facilitate closeness to the sacred or transcendent (God, higher power, ultimate truth).[22]

There are contradictory results about the relationship between spirituality and mental health. Some studies indicate that spirituality is associated with a lower incidence of depression and mental illness, however others have shown that spirituality is associated with an increased incidence of psychological disease or there is no relationship between spirituality and mental health.[20] In a review study koeing and colleagues stated that in 84% of researches it has been shown that suicide less happens in religious societies. According to some investigations, religion is associated with depression and suicide.[23] However pardini et al., showed that religious beliefs is associated with positive mental health outcomes, high level of health, access to social support, stress resistance, psychological relaxation, emotional stability, a sense of inner strength and lower risk of suicide.[24]

In Iran a lot of mental– emotional and interpersonal problems are related to the spiritual– religious issues, spiritual– religious methods can be used as a tool along with the other approaches.[15] Despite the importance of religion and spirituality on mental health in Iran, very little interventional research has been done.

Bahrami et al., studied effectiveness of group spirituality training on decreasing of depress- ion in students and found that spiritual interventions reduced depression. In this study variables such as age, education, and socio-economic status could not be controlled and also volunteered participants (sample size) were low (n=20).[25] Rahmati et al., also showed that spiritual-religious group therapy is effective in improving the mental status of patients with schizophrenia. Using convenient and men sample of patients reduces the generalizability of the results.[18] In another study religious psychotherapy in religious oriented obsessive compulsive disorder and its co-morbidity could

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significantly increase patients' response to treatment.[26]

Despite the importance of religion and spirituality in Iran, interventional studies in the field of spirituality and religion effectiveness in reducing suicidal ideation in depressed patients, has not been found. Since spirituality is an important part of human life and has a significant influence on health, also regarding suicide as a common global problem and depression as a prelude to most suicides the aim of this study is to determine the effect of spiritual- religious group psychotherapy on suicide ideation in depressed patients.

Materials and methods

This is a randomized clinical trial with experimental and control group design. Study approval was received from institutional review board of Tabriz University of Medical Sciences (No: 91121-353).

Participants were recruited from hospitalized men and women with major depression and bipolar disorder (using DSM- IV criterion), who were in depression with suicidal ideation phase and the diagnosis was certified by a psychiatrist from Razi hospital in Tabriz (Iran) in 2013. Study sample was determined according to the study by Rahmati et al., on "the effect of spiritual-religious group therapy on mental status of schizophrenic inpatients".[18] With a standard deviation of 4.26, mean difference of 3.5, at 5% statistical significance level and with a power of 80%, 24 patients were calculated in each group. Regarding the attrition final sample size was estimated 27 patients in experimental and control group.

In order to collect data a 2 part reliable and valid questionnaire was used: first part of the tool was about demographic data and the second part measures patients' suicidal ideation.

Demographic characteristics includes: age, sex, marital status, educational level, occupation, job, income, duration of depression, history of suicide attempt, suicide methods, history of hospitalization and treatment, medications and existence of any other physical illness.

The second part was beck scale for suicide ideation, a 19- item assessment tool to detect and measure the intensity of attitudes, behaviors and plans prepared for suicide.

The first 5 questions measure the desire to live or die and consist of questions about level of interest in life, desire to live or die, saving life in critical conditions and severity of suicidal tendencies. Question 6 to 9 measures passive suicide Including items such as when and how often suicidal thoughts comes to mind, whether one accepts the suicidal thoughts or can control them.

Question 10 to 19 measures active suicide by questions about the main reason for suicide, specific plan for suicide, method or a good opportunity for suicide, the level of confidence and to have the courage or the ability of suicide, the preparation of tools for suicide, writing a suicide note, planning on events and issues after suicide and the informed others of his/her intention to commit suicide. The scale grades from 0 to 2. zero means no score, 1 score means to some extent and 2 means very. Range of scores to die is from 0 to 10, 0 to 8 passive suicides, active suicide from 0 to 20 and the total score is based on the sum of the individual scores from 0 to 38.

Beck suicide scale ideation is significantly correlated with standard clinical tests and suicidal tendencies. Correlation coefficients domain ranges from 0.90 for inpatients and 0.94 for outpatients. Beck scale for suicidal thoughts is highly reliable as cronbach alpha coefficients is 0.87 to 0.97.[27]

However in this study content validity was assessed according to the 10 professor from Tabriz University of Medical Sciences. Reliability was assessed by test-retest method. Scores were assessed at base line and 2 weeks later. Correlation coefficient was 0.89.

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After obtaining written informed consent, eligible patients completed pre-test. Inclusion criteria were: patients with a diagnosis of major depression and bipolar depression and suicidal ideation using DSM-IV criteria, age 18 to 60 years, ability to listen and sit in group therapy sessions, ability to respond to written questions, patients with non-acute phase of disease according to a psychiatrist (due to impaired thought, speech, concentration, judgment and decision making).

Patients with a score of 6 or higher from beck scale randomly were allocated to experimental or control group (n=27). Two patients due to failing to fill out the questionnaire and one because of discharge excluded from control group. Experimental group received 10 session of group psychotherapy for about 1 hour, 3 days a week. Five separate groups of five and one group of six also separate sessions for men and women were held.

Topics of discussion in the sessions were as first session: introduction, an explanation about goals and provisions of the group, the benefits of group therapy, talking about depression and suicide, explaining the subjects of future sessions and assignments, second session: prayer and third session: reading Quran and its meaning, fourth session: talking about forgiveness and clemency, fifth session: repentance, sixth session: concentration and thinking, seventh session: talking about religious practices, eighth session: talk about helping others and doing voluntary services, ninth session: patience, tenth session: reliance on God. Assistant- Leader method was used in treatment sessions. A clergyman as a professional in religion issues participated in treatment sessions to answer the questions and prevent deviation from religious issues. 2 weeks after intervention post test was taken in both experimental and control group.

The data were analyzed using SPSS software (13 version), descriptive (frequency, percentage, frequency, mean and standard deviation) and inferential statistics. Due to the normal distribution using the Kolmogorov - smirnov, parametric tests were used for data analysis. To compare the two groups in terms of demographic variables chi- square test for qualitative variables and Pearson correlation coefficient for quantitative variables was used.

To compare the two groups in terms of suicidal thoughts at pre and post test, independent t-test was used. Also for detailed analysis and to control the effect of pre-test on post- test, ANCOVA was used. P values less than 0.05 were considered as significant.

Results

Mean and standard deviation for age in experimental group was 33.9(10.4) and in control group 32.7(10.1). The sample had more females than males. The level of education among these patients was more under diploma (59.3%). Most patients in experimental group were unemployed (63%) with no income. Both groups were living in urban society.

Of suicide method, majority of patients (44.4%) used poisoning in experimental group but in control group it was self mutilation and hanging (45.8%). In both experimental and control groups most patients had no physical illness and few patients used anti hypertension, heart disease, and anti diabetic medications other than antipsychotic ones. According to Chi-square test experimental and control groups in terms of gender, marital status, education, job, occupation, income, life adverse events, using other non psychotropic medications, physical illness and suicide methods had no significant differences ($P>0.05$) (Table 1).

Independent t-test shows that experimental and control groups in terms of age, hospitalization history and duration of depression had no significant differences ($P>0.05$). But independent t-test shows that two groups in term of suicide history had significant differences ($P<0.05$) (Table 2).

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According to table3, independent t-test shows that before the intervention, participants in both groups had no significant differences regarding mean of a desire to die, and passive suicidal ideation and total suicidal ideation score (P>0.05), however after intervention the difference in both groups is significant (P<0.05). Also independent t-test shows that before and after intervention participants in the both groups showed no significant difference in mean active suicidal ideation (P>0.05) (Table 3). Also, analysis of covariance, in the preliminary analysis to assess the assumption of homogeneity of slopes showed that the relationship between the variables and the dependent variable as a function of the independent variable is not significant. For a detailed analysis of the effect of pre-test on post-test using ANCOVA results showed that relationship between spiritual group therapy and dependent variable (suicidal thoughts) is Strongly associated. As the independent variable (treatment) caused a 57 percent change in the dependent variable: covariance analysis for the experimental and control groups (Table 4).

Discussion

Intrinsically human being is a religious and spiritual creature and it is an inseparable dimension of humans. As long as the spiritual dimension is not integrated with mental structure, actual treatment does not happen.

Human technology and knowledge is only one way of treating mental health problems and spirituality is another treatment option. Specialist nurses in the spiritual care are able to gain the trust of patients and communicate with empathy.[28]

The aim of this study was to determine the effect of religious spiritual psychotherapy on suicidal thoughts of depressed patients. Unlike the pre-intervention, results of independent t-test revealed that mean score of suicidal thoughts are statistically different in 2 groups after intervention. It means that the intervention had a positive effect in experimental group than in the control group.

According to results relationship between spiritual group therapy and dependent variable (suicidal thoughts) is strongly associated as the independent variable (treatment) caused a 57 percent change in the dependent variable.

A cross sectional study on the relationship between saying prayer (namaz) and suicide in 225 of hospitalized suicidal patients by Yaghoubi et al., showed that prayer has an opposite relation with suicide attempt. Then saying prayer as an important rule of Islam is effective in the prevention of suicide and is consistent with the results of present study.[29] In the study by Rahmati et al., the effect of spiritual-religious group therapy on mental status of schizophrenic inpatients was assessed. Results showed that mental status of intervention group significantly differs from pre intervention time while there was no significant difference in the control group before and after the intervention. In general, spiritual- religious group therapy was effective in improving mental status of schizophrenic patients.[18]

Bahrami and colleagues conducted a pilot study on 20 depressed students to verify the effectiveness of group spirituality training on depression. Volunteered students participated in intervention group showed less depression. Intervention consisted of saying prayers, using of Holy Scriptures, meditation, spiritual visualization, forgiveness, worships and rituals, spiritual self disclosure, accompany and serving, writing diaries, concentration and book therapy.[25]

Because depression is strongly associated with suicide, then with less depression suicide thoughts and attempts may decreases which is consistent with our results.

In a study by Molock et al.,[23] relationship between religious coping strategies and suicidal behavior in African- American adolescents was studied. The aim of this study was to assess whether hopelessness

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Table1. Frequency and percentage of socio-demographic characteristics of experimental (n=27) and control groups and comparison between the two groups (n=24)

Variable	Control group N (%)	Experimental group N (%)	Statistical indicators
Sex			
Male	10 (41.7)	10 (37)	X^2= 0.11
Famale	14 (58.3)	17 (63)	P=0.73
Marital status			
Single	12 (50)	14 (51.9)	X^2= 0.01
Married	12 (50)	13 (48.1)	P=0.89
Education			
Under diploma	12 (50)	16 (59.3)	X^2= 0.44
Diploma and above	12 (50)	11 (40.7)	P=0.50
Occupation			
Employee	11 (45.8)	10 (37)	X^2= 0.4
Unemployed	13 (54.2)	17 (63)	P=0.52
Residence			
City	19 (79.2)	21 (77.8)	X^2= 0.01
Village	5 (20.8)	6 (22.2)	P=0.9
Incom			
Have	12 (50)	9 (33.3)	X^2= 1.45
Not have	12 (50)	18 (66.7)	P=0.22
Adverse event			
Have	9 (37.5)	15 (55.6)	X^2= 1.66
Not have	15 (62.5)	12 (44.4)	P=0.19
Non psychotropic Medications			
Have	7 (29.2)	6 (22.2)	X^2= 0.32
Not have	17 (70.8)	11 (77.8)	P=0.57
Physical illness			
Have	5 (20.8)	8 (29.6)	X^2= 0.51
Not have	19 (79.2)	19 (70.4)	P=0.47
Suicide method			
Poisoning	5 (20.8)	12 (44.4)	X^2= 4. 25
Self mutilation and hanging	11 (45.9)	6 (22.3)	P=0.11
Other method	8 (33.3)	9 (33.3)	

Table2. Mean and standard deviation of some socio-demographic characteristics of experimental and control groups and comparison between two groups

Socio- demographic characteristics	Control group Mean(SD)	Experimental group Mean(SD)	95%CI*	Statistical indicators
Age (Year)	32.7 (10.13)	33.9 (10.4)	-4.59, 7.02	t=0.42, df=49 P=0.67
Suicide history**	1.45 (1.06)	2.48 (1.74)	0.19, 1.84	t=2.49, df=49 P=0.01
Depression duration(Year)	7.5 (6.42)	9.55 (7.61)	-1.96, 6.07	t=1.02, df=48 P=0.3
Hospitalization history**	1.95 (3.6)	3.14 (4.11)	-1.01, 3.39	t=1.08, df=49 P=0.28

*Confidence Interval of Mean Difference, **N (%)

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Table3. Mean comparison of suicidal ideation in depressed patients and its dimensions in the two groups before and after intervention

Suicide dimension	Control group Mean(SD)	Experimental group Mean(SD)	95%CI	Statistical indicators
Desire to death				
Pre	7.7 (1.92)	7.11 (2)	-1.70, 0.51	t=-1.08, df=49 P=0.28
Post	6 (2.10)	2.51 (2.96)	-4.95, -2	t=-4.47, df=49 P=0.00
Passive suicide				
Pre	4.7 (2.05)	4.37 (2.15)	-1.52, 0.48	t=0.54, df=49 P=0.57
Post	4.57 (1.56)	3 (1.89)	-3.13, 0.00	t=-2.07, df=25 P=0.04
Active suicide				
Pre	7.41 (3.70)	8.14 (3.71)	-1.36, 2.82	t=0.7, df=49 P=0.48
Post	8.09 (4.18)	7.5 (3.20)	-4.41, 3.22	t=-0.32, df=25 P=0.75
Total score				
Pre	19.54 (6.47)	19.66 (6.58)	-3.50, 3.80	t=0.06, df=49 P=0.94
Post	17.45 (6.57)	5 (7.20)	-16.35, -8.55	t=-6.42, df=49 P=0.00

*Confidence Interval

Table4. Analysis of covariance of control and experimental groups before and after intervention

Suicide dimension	Mean(SD)	95%CI*	Statistical indicators
Desire to death			
Control group	5.86 (0.51)	4.83, 6.89	F=20.6, df=1, P=0.000
experimental group	2.64 (0.48)	1.67, 3.61	Eta=0.3, Mean square=6.2
Passive suicide			
Control group	4.70 (0.27)	4.14, 5.26	F=13.4, df=1, P=0.00
experimental group	2.53 (0.51)	1.46, 3.60	Eta=035, Mean square=1.55
Active suicide			
Control group		7.57, 10.10	F=7.89, df=1, P=0.01
experimental group	4.82 (1.23)	2.27, 7.37	Eta=0.34, Mean square=7.67
Total suicide score			
Control group	17.49 (1.15)	15.1, 19.80	F=62.2, df=1, P=0.000
experimental group	4.96 (1.09)	2.77, 7.15	Eta=.056, Mean square=32.05

*Confidence Interval

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and depression were primary risk factors for suicide ideation and attempts in African-American adolescents, and whether religious participation and religious coping protect students against suicide. The results showed that hopelessness and depression are risk factors for suicidal thoughts and attempts. Self-directed religious coping was related to increased hopelessness, depression, and suicide attempts and collaborative coping was related to increased reasons for living, and decreased suicide ideation and attempts. These results are in consistent with present study which shows that religion and spirituality can decrease suicide thoughts.

In a study by Dervic et al.,[30] ''entitled moral or religious objections to suicide may protect against suicidal behavior in bipolar disorder'' 149 religious and 51 non religious patient participated in a retrospective case control study. Religiously affiliated patients had fewer past suicide attempts, had fewer suicides in first- degree relatives, and were older at the time of first suicide attempt than unaffiliated patients. Furthermore, patients with religious affiliation had lower aggression, and alcohol and drug abuse and childhood abuse experience which shows a possible protective role of moral or religious objections to suicide which is consistent with present study.

Regarding the issue that intrinsically human being is a religious- spiritual creature, teaching religious and spiritual concepts and reviewing them in life time causes emotional stability, improving mental status and life satisfaction. It also leads to less distressing thoughts, aggression and anxiety associated with suicide and more concentration, Feeling of empowerment and strength due to the bond with ultimate power, trust and giving affairs to God, patience in time of problems, poverty and death of a loved one, believe and hope in God and feeling peace which all result to less negative thoughts and suicide.[28] Group treatments are more effective because people find hope that they are not the only ones who get in trouble and have problems, they less focus on their own problem, by helping each other they feel worthy and self steam increases. People can express their feelings in a group that is causing emotional discharge.[31]

Conclusion

Results of this study revealed no difference between two groups in terms of suicidal ideation before intervention but after study there is a statistical difference. Also the results of ANCOVA test showed a significant relationship between spiritual religious group psychotherapy and decrease in suicidal ideation, so that this intervention can make 57% of variance in suicidal ideation of experimental group.

Among the limitations of this study were small sample size and self report of suicide tendencies. According to these limitations and to find the exact-scientific roots of suicidal tendencies, future investigation with larger sample size and on depressed or other mentally ill patients prone to suicide is suggested. Group spirituality treatment programs is recommended for depressed, schizophrenic, alcohol or drug addicted, anxiety and personality disorder patients who are at risk of suicide.

Because nurses spend a long time with patients, then, spiritual, religious intervention workshops as psychotherapy by psychiatric nurses for patients who are at risk of suicide can probably be effective to prevent this major problem.

Acknowledgments

This research was supported by a grant from the Tabriz University of Medical Sciences. Authors would like to thank all who assisted in this research, especially research deputy of Tabriz University of Medical Sciences, Razi hospital and patients who participated in this study.

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Ethical issues

None to be declared.

Conflict of interest

The authors declare no conflict of interest in this study.

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