



The Effects of Spiritual-Religious Intervention on Anxiety Level of the Family Members of Patients in ICU Ward

Mahmood Rahmati,¹ Behnam Khaledi,² Mahvash Kahrizi,³ Anahita Haydarian,^{4,*} and Mohammad-Rafi Bazrafshan⁵

¹Psychiatric Nursing Department, School of Nursing and Midwifery, Kermanshah University of Medical Sciences (KUMS), Kermanshah, IR Iran

²Psychiatric Nursing Department, School of Nursing and Midwifery, Sleep Disorders Research Centre, Kermanshah University of Medical Sciences (KUMS), Kermanshah, IR Iran

³Department of Theology and Islamic Sciences, School of Medicine, Kermanshah University of Medical Sciences (KUMS), Kermanshah, IR Iran

⁴M.Sc. Student of Critical Care Nursing, School of Nursing and Midwifery, Kermanshah University of Medical Sciences (KUMS), Kermanshah, IR Iran

⁵Department of Nursing, School of Nursing, Larestan University of Medical Sciences, Larestan, IR Iran

*Corresponding author: Anahita Haydarian, M.Sc. Student of Critical Care Nursing, School of Nursing and Midwifery, Kermanshah University of Medical Sciences (KUMS), Kermanshah, IR Iran. Tel: +98-9188392405, Fax: +98-8338279394, E-mail: heydarian.anahita@yahoo.com

Received 2017 April 30; Accepted 2017 May 29.

Abstract

Background: Among the factors effective on the mental health of individuals, family is one of the most important. Hospitalization of a member of the family might cause anxiety and mental problems. Seeking spiritual support, belief in God, and praying are some of the methods that the family members may adopt to deal with the stressors.

Objectives: The present study is an attempt to survey the effects of spiritual-religious intervention on anxiety level in the family members of patients in the ICU ward.

Methods: The study was carried out as a semi-experimental study in which 34 family members of critically ill patients in ICU took part. The subjects were selected through convenient sampling and randomly grouped in intervention (n = 17) and control (n = 17) groups. The subjects in the intervention group received religious-spiritual intervention through a course with eight group meetings (45 - 60 minutes; three times a week). Anxiety of the participants was measured using Spielberger's Test Anxiety Inventory before and after the intervention. The collected data was analyzed in SPSS (V.20).

Results: There was a significant difference in anxiety scores of the intervention group before and after the intervention (P < 0.001). On the other hand, no significant difference was observed in the control group before and after the intervention (P = 0.053).

Conclusions: The findings indicated effectiveness of the spiritual-religious intervention on attenuation of anxiety in the family members of patients in the ICU. Therefore, nurses in ICU can utilize such inexpensive methods to decrease anxiety in the family members of patients.

Keywords: Anxiety, Family, ICU, Spirituality

1. Background

Taking the family into account is one of the main elements of health care (1-4). This means, the key role played by the family members for the patient is as important as the patient. Clearly, the nurses need to adopt different methods to recognize the needs of the patient's family before dealing with anxiety and stress in the family (5-8). Health is one of top concerns and priority for human societies (9). According to statistics published by the Iranian Society of Anesthesiology and Critical Care, every year 1.5 - 2 million individuals are hospitalized due to road accidents, stroke, and the like and 30% of them are hospitalized in an ICU. Finding a loved one in a threatening and stressful environment of ICU and all those complex devices and tech-

nology attached to them cause mental and spiritual pressures in the family members (10-13). The patient is hospitalized in an ICU ward in which most of the patients are critically ill or in their death beds (14-16). Nursing care to prevent anxiety in family members of the patient in an ICU is an important key issue. Given that prevention is always better than treatment, preventing anxiety is highly critical whether from social or health point of view (12, 17-21). Spiritual interventions help individuals adapt directly and facilitates treatment and recovery process indirectly through improving mental peace and providing relief from mental pressures caused by the disease. Human experience in all cultures indicates that man always seeks help from a holy and divine source in the face of critical situations and diseases in particular so that spirituality becomes more im-

portant in hardships (22-27). Spiritual intervention along with other nursing intervention creates a balance among the body, psyche, and spirituality, which leads to complete health from different aspects (28-32).

2. Objectives

Nurses need to examine spiritual needs as a part of the community-based care. Given the key role and importance of the family for patients, the family must be as imports as the patient in the care intervention. In light of this, the present study is an attempt to survey the effect of spiritual-religious aspect on anxiety of family members of the patients in ICU.

3. Methods

The study was carried out as a semi-experimental work and the effects of spiritual-religious intervention on anxiety level of the family members of the patients in ICU in 2015 were examined.

Sample size was obtained based on the formula for comparing mean score of a quantitative trait between 2 groups with level of confidence of 95% and test power of 90%. Other parameters of the formula were adopted based on a similar study (22). Minimum sample size for each group was obtained equal to 10 (totally 20 subjects needed). Taking into account probable leaves during the course of study, 17 participants were selected for each group. The participants were selected through convenient sampling method and then they were grouped randomly. Inclusion criteria were desire to participate, no hearing and visual impairment, more than 18 years of age, hardly curable disease of the patient, reading/writing literacy, and belief in Islam. In addition, the person accompanied the patient during the study was required to be a family member (e.g. spouse, child, or parent).

Exclusion criteria included leaving the study, discharge from the hospital or death, and missing more than one intervention sessions.

Study tool was Spielberger's state-trait anxiety inventory (STAI) consisting of 40 questions (20 on anxiety state and 20 on anxiety trait). State anxiety scale is comprised of 20 statements that evaluate the respondent at the moment of filling out the questionnaire. Trait anxiety scale is also comprised of 20 statements about general and ordinary feelings. The respondent is needed to choose one alternative for each question that describes them the best (1: very low, 2: low, 3: high, 4: very high). Minimum and maximum scores of the both scales are 20 and 80, respectively. Consistency coefficient of the test based on Cronbach's alpha was obtained equal to 0.66.

After securing required permissions from the officials of Kermanshah University of Medical Sciences (research plan code: 74252; ethics code: kums.rec.1394.39), the author visited the potential participants and gave them a brief introduction to the objectives and process of the study. The participants were randomly grouped into the control and intervention groups. Anxiety of the participants before the intervention was measured using STAI. Then, group spiritual-religious intervention sessions were held for the intervention group (eight sessions; 45 - 60 minutes, three times a week) based on Richards and Bergin's method with emphasis on Islamic rules. The content of the course was approved by religious experts beforehand.

The spiritual religious interventions included; 1- creating a trustful, sympathetic, and honest relationship with the nurse as the basis for an effective relationship throughout the course; 2- listening attentively to physical problems, mental concerns, and worries of the patients' family; 3- providing required spiritual support for the family members; 4- strengthening hope and inner force of the participants; 5- using positive sentences and promoting healthy and productive thoughts; 6- helping the family members to find a meaning in the disease assuming that none of the events in life are beyond God's will; 7- motivating the subjects to pray, chant, and read the Holy Quran; 8- encouraging the subjects to express their religious beliefs; 9- encouraging the subjects to consult with religious experts (clergymen); 10- encouraging the family members to visit those with whom they feel calm and peace; 11- ensuring the family members that the nurse will be always available for providing spiritual and mental supports; 12- repenting and asking God's forgiveness for the past sins and forgiving others for their faults and sins; 13- encouraging the family members to find the joy of listening to music; 14- encouraging the family members to create friendly relationships with friends and others; and 15- encouraging the family members to participate in religious and community activities and services.

After the intervention, the questionnaire was filled out once more by the participants in the control and intervention groups. In observance of ethics, the intervention package was prepared in an educational CD and provided to the participants in the control group after the study.

4. Results

Internal consistency results based on chi squared (for qualitative variables) and independent t-test (for quantitative variables) showed no significant statistical difference between the control and intervention groups in terms of age of the patient, age of the family members, religion, job,

income, number of children, and place of living; therefore, the both groups were homogenous with regard to these variables ($P > 0.05$).

The results of comparing mean scores of STAI in the control and intervention groups before and after the intervention are listed in the (Tables 1 and 2). Results of independent t-test in Table 1 showed that the mean scores of total Spielberger's anxiety in the intervention and control groups before the intervention were 117.41 and 111.88, respectively; which means that there was no significant difference in term of anxiety score between the two groups before the intervention ($P = 0.398$).

As listed in Table 2, the mean score and SD of state anxiety in the intervention and control groups are 43.18 ± 1.82 and 53.65 ± 2.26 , respectively. Moreover, the mean score and SD of trait anxiety in the intervention and control groups are 41.00 ± 2.41 and 53.35 ± 2 , respectively. The result support a significant relationship between these variables ($P < 0.001$).

Also, mean scores of STAI before and after the intervention for the intervention and control groups are listed in Table 3 and 4). As listed in Table 3, there is a significant difference between mean score and SD of state anxiety in the intervention group before (62.53 ± 2.10) and after (43.18 ± 1.82) the intervention ($P < 0.001$). Moreover, there is a significant difference between mean and standard deviation of trait anxiety in the intervention group before (54.88 ± 2.48) and after (41.00 ± 2.41) the intervention ($P < 0.001$). Finally, based on paired t-test, there is a significant difference between mean score and standard deviation of total anxiety in the intervention group before (117.41 ± 4.189) and after (84.18 ± 4.083) the intervention.

As listed in the (Table 4), there is no significant difference between mean score and SD of state anxiety in the control group before (56.47 ± 2.56) and after (53.65 ± 2.26) the intervention ($P < 0.068$). Moreover, based on paired t-test, there is no significant difference between mean score and SD of trait anxiety in the control group before (55.41 ± 2.56) and after (53.35 ± 2) the intervention ($P < 0.140$). Finally, here is no significant difference between mean score and SD of total anxiety in the control group before (111.88 ± 4.909) and after (107.00 ± 3.872) the intervention ($P = 0.053$).

5. Discussion

The effects of spiritual-religious intervention on anxiety in family of the patients in ICU was examined. Family nursing in ICU not only helps the family but also helps the patient; however in practice, only the patient receives all the attention (5, 10, 12, 14, 21, 33). The patient and their family must be considered as one unit and the latter must

not be neglected in favor of the former (34, 35). Therefore, the role that the family plays for the patient must be considered in a nursing care program as important as the patient. Clearly, nurses need to adopt different methods to recognize the needs of the family and attenuate anxiety and stress in it (5, 10). Spiritual intervention among other nursing intervention leads to a balance among the body, psyche, and spirituality, which leads to a complete health from all aspects. Thereby, nurses need to survey the spiritual needs as a part of community-based care (28-32).

Comparison of anxiety in family members of ICU patients in the intervention and control groups before and after spiritual-religious intervention indicated no significant difference in mean score of anxiety in two groups before the intervention. There was a high level of anxiety in the both groups. Consistent with our findings, Bandari et al. (36), Rabie et al. (10), and Pochard et al. (37) confirmed a high level of anxiety in family members of the patients in ICU.

Usually, the family members of patients face anxiety due to variety of causes and factors. Watching all those pipes and wires attached to their loved one, visiting their patient through a wall of glass, limitations on face to face visit, fragile financial condition and concerns about costs of medical services, and changes in the roles are some of the factors effective on increase in the risk of anxiety in family (10, 14). Therefore, an ICU is a stressful environment for the patient and the relatives so that people tend to suffer high level of anxiety when they experience such an environment. Another explanation for high level of stress in ICU is that most of the patients in ICU are critically ill or in their death beds (10, 14-16).

The results also showed a significant difference between mean scores of anxiety of the intervention and control groups after the intervention. Stress in family members after the intervention in the intervention group decreased significantly. Consistent with our results, Schleder et al. showed that, more than negative strategies of spiritual-religious adaptation, family members of the patients in ICU tend to use positive strategies of spiritual-religious adaptation. In addition, all the participants believed in God and stated that spirituality was helpful for them to adapt to the stress of experiencing one of their loved ones being hospitalized (38). Bazrafshan et al. showed that religious beliefs function as a defense against psychological problems and self-harming behaviors. By educating such adaptation strategies, the nurses can help individuals prone to mental problems (39, 40). Tajbakhsh et al. showed that utilizing spiritual-religious care attenuated anxiety after a coronary artery bypass surgery (28). Ghahari et al. indicated that religious-spiritual interventions, given the preventive effect of spirituality and reli-

Table 1. Mean score of STAI in the Control and Intervention Groups Before the Intervention (2015)

Spielberger's Anxiety	Group	Mean Score \pm SD	Df	Independent T-Test	P Value	Level of Confidence = 95%	
						Upper Limit	Lower Limit
State anxiety	Intervention	62.53 \pm 2.10	32	1.83	0.077	12.80	-0.684
	Control	56.74 \pm 2.56					
Trait anxiety	Intervention	54.88 \pm 2.48	32	-0.149	0.883	6.71	-7.769
	Control	55.14 \pm 2.56					
Total	Intervention	117.41 \pm 4.189	32	0.857	0.398	18.68	-7.617
	Control	111.88 \pm 4.909					

Table 2. Mean Score of STAI in the Control and Intervention Groups After the Intervention (2015)

Spielberger's Anxiety	Group	Mean Score \pm SD	Df	Independent T-Test	P Value	Level of Confidence = 95%	
						Upper Limit	Lower Limit
State anxiety	Intervention	43.18 \pm 1.82	-3.608	32	< 0.001	-4.560	-16.381
	Control	53.65 \pm 2.26					
Trait anxiety	Intervention	41.00 \pm 2.41	-3.947	32	< 0.001	-5.978	-18.727
	Control	53.35 \pm 2					
Total	Intervention	84.18 \pm 4.083	-4.056	32	< 0.001	-11.362	-34.285
	Control	107.00 \pm 3.872					

Table 3. Mean Score of STAI Before and After the Intervention in the Intervention Group (2015)

Spielberger's Anxiety	Intervention Group	Mean Score \pm SD	Df	Independent T-Test	P Value	Level of Confidence = 95%	
						Upper Limit	Lower Limit
State anxiety	Before	62.53 \pm 2.10	8.045	16	< 0.001	-14.25	-45.24
	After	43.18 \pm 1.82					
Trait anxiety	Before	54.88 \pm 2.48	5.515	16	< 0.001	-8.546	-19.22
	After	41.000 \pm 2.41					
Total	Before	117.41 \pm 4.189	7.208	16	< 0.001	-23.46	-43.01
	After	84.18 \pm 4.083					

gion against mental disorders, can be highly helpful for cancer patients to deal with depression and anxiety (41). Lotfi Kashani et al. stated that spiritual interventions were effective on decreasing anxiety in the mothers of children with cancer (42). Thereby and based on the findings, spiritual-religious interventions are effective on decreasing anxiety in the family of patients in ICU. This result is consistent with other studies (22, 28, 38, 41, 42).

The findings indicated effectiveness of the spiritual-religious intervention on attenuation of anxiety in the

family members of patients in ICU. Therefore, nurses in ICU can utilize such inexpensive methods to decrease anxiety in the family members of patients.

Acknowledgments

The authors wish to thank all the ICU personnel of Imam Reza Hospital who made a great contribution to the Study. We also express our gratitude to the family members who participated in the study. This work was performed in partial fulfillment of the requirements for MSc

Table 4. Mean Score of Spielberger's Test Anxiety Inventory Before and After the Intervention in the Control Group (2015)

Spielberger's Anxiety	Control Group	Mean Score \pm SD	Df	Independent T-Test	P Value	Level of Confidence = 95%	
						Upper Limit	Lower Limit
State anxiety	Before	56.47 \pm 2.56	-1.96	16	0.068	0.236	-5.88
	After	53.65 \pm 2.26					
Trait anxiety	Before	55.41 \pm 2.56	-1.56	16	0.140	0.748	-4.87
	After	53.35 \pm 2					
Total	Before	111.88 \pm 4.909	-2.09	16	0.053	0.082	-9.85
	After	107.00 \pm 3.872					

degree in Nursing of Anahita Heydarian, in Faculty of Nursing and Midwifery, Kermanshah University of Medical Science, Kermanshah, Iran.

Footnote

Conflict of Interest: Here are not any conflicts of interest in financial issues with any individual or third party.

References

1. Imanipour M, Heidari Z, Seyedfatemi N, Haghani H. Effectiveness of informational support on anxiety among family carers of patients undergone open heart surgery. *Journal of hayat*. 2012;**18**(3):33-43.
2. Miller TA, Dimatteo MR. Importance of family/social support and impact on adherence to diabetic therapy. *Diabetes Metab Syndr Obes*. 2013;**6**:421-6. doi: [10.2147/DMSO.S36368](https://doi.org/10.2147/DMSO.S36368). [PubMed: [24232691](https://pubmed.ncbi.nlm.nih.gov/24232691/)].
3. Rosland AM, Kieffer E, Israel B, Cofield M, Palmisano G, Sinco B, et al. When is social support important? The association of family support and professional support with specific diabetes self-management behaviors. *J Gen Intern Med*. 2008;**23**(12):1992-9. doi: [10.1007/s11606-008-0814-7](https://doi.org/10.1007/s11606-008-0814-7). [PubMed: [18855075](https://pubmed.ncbi.nlm.nih.gov/18855075/)].
4. Mayberry LS, Osborn CY. Family support, medication adherence, and glycemic control among adults with type 2 diabetes. *Diabetes Care*. 2012;**35**(6):1239-45. doi: [10.2337/dci11-2103](https://doi.org/10.2337/dci11-2103). [PubMed: [22538012](https://pubmed.ncbi.nlm.nih.gov/22538012/)].
5. Hoseini Azizi T, Masoudynia M, Ehsaee MR, Esmaily H, Hasanazadeh F. The effect of family's supportive presence on the recovery of patients with brain injury in intensive care unit: A randomized clinical trial. *J Urmia Nurs Midwifery Faculty*. 2014;**11**(12):977-87.
6. DiMatteo MR. Social support and patient adherence to medical treatment: a meta-analysis. *Health Psychol*. 2004;**23**(2):207-18. doi: [10.1037/0278-6133.23.2.207](https://doi.org/10.1037/0278-6133.23.2.207). [PubMed: [15008666](https://pubmed.ncbi.nlm.nih.gov/15008666/)].
7. Zhang X, Norris SL, Gregg EW, Beckles G. Social support and mortality among older persons with diabetes. *Diabetes Educ*. 2007;**33**(2):273-81. doi: [10.1177/0145721707299265](https://doi.org/10.1177/0145721707299265). [PubMed: [17426302](https://pubmed.ncbi.nlm.nih.gov/17426302/)].
8. Kang CM, Chang SC, Chen PL, Liu PF, Liu WC, Chang CC, et al. Comparison of family partnership intervention care vs. conventional care in adult patients with poorly controlled type 2 diabetes in a community hospital: a randomized controlled trial. *Int J Nurs Stud*. 2010;**47**(11):1363-73. doi: [10.1016/j.ijnurstu.2010.03.009](https://doi.org/10.1016/j.ijnurstu.2010.03.009). [PubMed: [20371056](https://pubmed.ncbi.nlm.nih.gov/20371056/)].
9. Poorkiani M, Shekhalipour Z, Jourkeshand F, Bazrafshan MR. The General Health Level of Bachelor Degree of Nursing and Operation Room Students. *Res J Med Sci*. 2016;**10**(7):822-7.
10. Rabie SS, Avazeh A, Eskandari F, KHALEGH DMT, Mazloom S, Paryad E. A survey on psychological and environmental factors on family anxiety of the hospitalized patients in intensive care units. *Iran J Crit Care Nurs*. 2011;**3**(4):177-82.
11. Carlson EB, Spain DA, Muhtadie L, McDade-Montez L, Macia KS. Care and caring in the intensive care unit: Family members' distress and perceptions about staff skills, communication, and emotional support. *J Crit Care*. 2015;**30**(3):557-61. doi: [10.1016/j.jcrc.2015.01.012](https://doi.org/10.1016/j.jcrc.2015.01.012). [PubMed: [25682345](https://pubmed.ncbi.nlm.nih.gov/25682345/)].
12. Shorofi SA, Jannati Y, Moghaddam HR, Yazdani-Charati J. Psychosocial needs of families of intensive care patients: Perceptions of nurses and families. *Niger Med J*. 2016;**57**(1):10-8. doi: [10.4103/0300-1652.180557](https://doi.org/10.4103/0300-1652.180557). [PubMed: [27185973](https://pubmed.ncbi.nlm.nih.gov/27185973/)].
13. Farahani MA, Gaeeni M, Mohammadi N, Seyedfatemi N. Giving information to family members of patients in the intensive care unit: Iranian nurses' ethical approaches. *J Med Ethics Hist Med*. 2014;**7**:9. [PubMed: [25512830](https://pubmed.ncbi.nlm.nih.gov/25512830/)].
14. Sarhadi M, Navidian A, Fasihi HT, Keykhaei A. Assessment of psychosocial needs of the family members of the patients hospitalized in ICU and CCU. *Iran J Crit Care Nurs*. 2014;**6**(4):251-60.
15. Adams JA, Anderson RA, Docherty SL, Tulskey JA, Steinhauser KE, Bailey DJ. Nursing strategies to support family members of ICU patients at high risk of dying. *Heart Lung*. 2014;**43**(5):406-15. doi: [10.1016/j.hrtlng.2014.02.001](https://doi.org/10.1016/j.hrtlng.2014.02.001). [PubMed: [24655938](https://pubmed.ncbi.nlm.nih.gov/24655938/)].
16. Wunsch H, Linde-Zwirble WT, Harrison DA, Barnato AE, Rowan KM, Angus DC. Use of intensive care services during terminal hospitalizations in England and the United States. *Am J Respir Crit Care Med*. 2009;**180**(9):875-80. doi: [10.1164/rccm.200902-0201OC](https://doi.org/10.1164/rccm.200902-0201OC). [PubMed: [19713448](https://pubmed.ncbi.nlm.nih.gov/19713448/)].
17. Rabie S, Khaleghduost T, Paryad E, Atrkar Ruoshan Z. Family and anxiety in intensive care units. *J Holistic Nurs Midwifery*. 2007;**17**(2):1-8.
18. Sauls JL, Warise LF. Interventions for anxiety in the critically ill: a guide for nurses and families. *Nurs Clin North Am*. 2010;**45**(4):555-67. vi. doi: [10.1016/j.cnur.2010.06.006](https://doi.org/10.1016/j.cnur.2010.06.006). [PubMed: [20971336](https://pubmed.ncbi.nlm.nih.gov/20971336/)].
19. Shafipour V, Moosazadeh M, Jannati Y, Shoushi F. The effect of education on the anxiety of a family with a patient in critical care unit: a systematic review and meta-analysis. *Electron Physician*. 2017;**9**(3):3918-24. doi: [10.19082/3918](https://doi.org/10.19082/3918). [PubMed: [28461865](https://pubmed.ncbi.nlm.nih.gov/28461865/)].
20. Kloos JA, Daly BJ. Effect of a Family-Maintained Progress Journal on anxiety of families of critically ill patients. *Crit Care Nurs Q*. 2008;**31**(2):96-107. quiz 108-9. doi: [10.1097/01.CNQ.0000314469.41507.cb](https://doi.org/10.1097/01.CNQ.0000314469.41507.cb). [PubMed: [18360139](https://pubmed.ncbi.nlm.nih.gov/18360139/)].
21. Chien WT, Chiu YL, Lam LW, Ip WY. Effects of a needs-based education programme for family carers with a relative in an intensive care unit: a quasi-experimental study. *Int J Nurs Stud*. 2006;**43**(1):39-50. doi: [10.1016/j.ijnurstu.2005.01.006](https://doi.org/10.1016/j.ijnurstu.2005.01.006). [PubMed: [16183062](https://pubmed.ncbi.nlm.nih.gov/16183062/)].

22. Saeidi TZ, Asadzandi M, Ebadi A. The effect of spiritual care based on Ghalbe Salim Model on the sleep quality of the patients with coronary artery disease. *J Nurs Educ*. 2014;**1**(3):45-53.
23. Moeni M, Taleghani F, Mehrabi T, Musarezaie A. Effect of a spiritual care program on levels of anxiety in patients with leukemia. *Iran J Nurs Midwifery Res*. 2014;**19**(1):88-93. [PubMed: 24554966].
24. Davis B. Mediators of the relationship between hope and well-being in older adults. *Clin Nurs Res*. 2005;**14**(3):253-72. doi: 10.1177/1054773805275520. [PubMed: 15995154].
25. Meraviglia M. Effects of spirituality in breast cancer survivors. *Oncol Nurs Forum*. 2006;**33**(1):E1-7. doi: 10.1188/06.ONF.E1-E7. [PubMed: 16470229].
26. McCoubrie RC, Davies AN. Is there a correlation between spirituality and anxiety and depression in patients with advanced cancer? *Support Care Cancer*. 2006;**14**(4):379-85. doi: 10.1007/s00520-005-0892-6. [PubMed: 16283208].
27. Breitbart W, Rosenfeld B, Gibson C, Pessin H, Poppito S, Nelson C, et al. Meaning-centered group psychotherapy for patients with advanced cancer: a pilot randomized controlled trial. *Psychooncology*. 2010;**19**(1):21-8. doi: 10.1002/pon.1556. [PubMed: 19274623].
28. Tajbakhsh F, Hosseini M, Sadeghi Ghahroudi M, Fallahi Khoshkenab M, Rokofian A, Rahgozar M. The effect of religious-spiritual care on anxiety post surgery coronary artery bypass graft patients. *Iran J Rehabil Res Nurs*. 2014;**1**(1):51-61.
29. Momennasab M, Moattari M, Abbaszade A, Shamshiri B. Spirituality in survivors of myocardial infarction. *Iran J Nurs Midwifery Res*. 2012;**17**(5):343-51. [PubMed: 23853646].
30. Nelson C, Jacobson CM, Weinberger MI, Bhaskaran V, Rosenfeld B, Breitbart W, et al. The role of spirituality in the relationship between religiosity and depression in prostate cancer patients. *Ann Behav Med*. 2009;**38**(2):105-14. doi: 10.1007/s12160-009-9139-y. [PubMed: 19806413].
31. Schulz E, Holt CL, Caplan L, Blake V, Southward P, Buckner A, et al. Role of spirituality in cancer coping among African Americans: a qualitative examination. *J Cancer Surviv*. 2008;**2**(2):104-15. doi: 10.1007/s11764-008-0050-5. [PubMed: 18648979].
32. Bekelman DB, Dy SM, Becker DM, Wittstein IS, Hendricks DE, Yamashita TE, et al. Spiritual well-being and depression in patients with heart failure. *J Gen Intern Med*. 2007;**22**(4):470-7. doi: 10.1007/s11606-006-0044-9. [PubMed: 17372795].
33. Omari FH. Perceived and unmet needs of adult Jordanian family members of patients in ICUs. *J Nurs Scholarsh*. 2009;**41**(1):28-34. doi: 10.1111/j.1547-5069.2009.01248.x. [PubMed: 19335675].
34. Abazari F, Abbaszadeh A. Comparison of the attitudes of nurses and relatives of ICU and CCU patients towards the psychosocial needs of patients relatives. *J Qazvin Univ Med Sci*. 2001;**5**(3):58-63.
35. Naderi M, Rajati F, Yusefi H, Tajmiri M, Mohebi S. Needs of intensive care unit patient families. *J Health System Res*. 2013;**9**(5):473-83.
36. Bandari R, Heravi KM, Rejeh N, Zayeri F, Mirmohammadkhani M, Montazeri A. Anxiety prevalence and its associated demographic factors in family members of patients hospitalized in the intensive care unit: a cross-sectional study in Tehran. *Daneshvar*. 2012;**20**(103):1-10.
37. Pochard F, Darmon M, Fassier T, Bollaert PE, Cheval C, Coloigner M, et al. Symptoms of anxiety and depression in family members of intensive care unit patients before discharge or death. A prospective multicenter study. *J Crit Care*. 2005;**20**(1):90-6. [PubMed: 16015522].
38. Schleder LP, Parejo LS, Puggina AC, Silva MJP. Espiritualidade dos familiares de pacientes internados em unidade de terapia intensiva. *Acta Paulista de Enfermagem*. 2013;**26**(1):71-8. doi: 10.1590/s0103-21002013000100012.
39. Bazrafshan M, Jahangir F, Shokrpour N. What Protects Adolescents from Suicidal Attempt: A Qualitative Study. *Shiraz E-Medical Journal*. 2017;**18**(9).
40. Rafi Bazrafshan M, Sharif F, Molazem Z, Mani A. The Effect of Paternal Addiction on Adolescent Suicide Attempts: A Qualitative Study. *Int J High Risk Behav Addict*. 2016;**5**(3). e22588. doi: 10.5812/ijhrba.22588. [PubMed: 27818961].
41. Ghahari S, Fallah R, Bolhari J, Moosavi SM, Razaghi Z, Akbari ME. Effectiveness of cognitive-behavioral and spiritual-religious interventions on reducing anxiety and depression of women with breast cancer. *Know Res Appl Psychol*. 2012;**13**(4):33-40.
42. Kashani FL, Vaziry S, Arjmand S, Mousavi SM, Hashmyh M. Effectiveness of spiritual intervention on reducing distress in mothers of children with cancer. *Med Ethics J*. 2016;**6**(20):173-86.