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COLLEGE OF MEDICINE

ASSESSMENT THE LEVELS OF SPIRITUALITY, SELF-ESTEEM AND HOPELESSNESS AMONG PATIENTS WITH MAJOR DEPRESSIVE DISORDER IN SULAIMANI CITY

A DISSERTATION SUBMITTED TO THE COUNCIL OF COLLEGE OF MEDECINE
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وَمَا أُوتِيتُم مِّن الْعِلْمِ إِلاَّ قَلِيلاً

صدق الله العظيم

سورة الإسراء – ايه ٨٥

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Supervisor's Certificate

I hereby certify that the dissertation entitled (Assessment the levels of spirituality, self-esteem, and hopelessness among patients with major depressive disorder in Sulaimani City).Was prepared under my supervision at the department of Psychiatric and Mental Health Nursing, College of Nursing, University of Sulaimani in partial fulfillment of the requirements for the degree of

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In view of the available recommendations, I forward this dissertation for debate by the examining committee.

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Dedication

To my wife, Hawraz, *who's always accepted me for me and supported my hustle, drive, and ambition: you are and always will be my perfect wife and mother to our children.*

To my children, Tatvan, Fro, Pao, Nvo, and Tio *and my great-great-great-great-grandchildren who I will never have the pleasure of meeting: I want you to know where you came from.*

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Abstract

Background:

Major depressive disorder has been associated with greater morbidity and mortality. Many researchers have been sought complex association between depression with spirituality, self-esteem and hopelessness. The levels of severity of such factors can play role in the causes, recovery and predictor of depression.

Objectives:

The main objective of this study is to assess the levels of spirituality, self-esteem and hopelessness among patients with major depressive disorder.

Methods:

A quantitative descriptive design, conducted at psychiatric clinic in Ali Kamal medical consultation center in Sulaimani City. A non-probability, convenient sampling was recruited of 150 patients with major depressive disorder attending the psychiatric clinic. The data were collected from December, 21st, 2017 to April 1st, 2018 by the researcher of current study through the utilization of structured Face-to-Face interview guided by the questionnaire.

Result:

The result shows that the patients with major depressive disorder experience high spirituality value, low self-esteem and moderate level of hopelessness.

Conclusions:

The study conclude that high spirituality value on its own the strongest significant factor may represents emotional source and possibly used to handle or cope with depressed mood by the patients.

Recommendation:

The recommendation is that cognitive behavior therapy which utilizes a group therapy may be successful at reducing internalized stigma, improving self-esteem and reduction the feeling of hopelessness.

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Abbreviations	
Abbreviations	**Descriptions**
ACA:	American Counseling Association.
ANOVA:	Analysis of variance
APA:	American Psychiatric Association.
BHS:	Beck Hopelessness Scale.
CSEI:	Cooper Smith self-esteem inventories.
CSEI-AD: Cooper Smith self-esteem inventories for adults forms.	
CSEI-SC: Cooper Smith self-esteem inventories for school forms.	
DOH:	Directory of Health.
DSM: Diagnostic and statistical manual of mental disorder.	
Et al:	Others
EWB:	Existential well-being.
HPA:	Hypothalamic-pituitary-adrenal**.**
HTTLPR: Serotonin Transporter linked polymorphic region	
ICD:	International classification of disease
MD:	Major depression
MDD:	Major depressive disorder.
MMD: Makeup and susceptibility to major depression disorders.	
NANDA: North American Nursing Diagnostic Association.	
ORT:	Object relation theory.
PWB:	Psychological well-being.
RWB:	Religious well-being.

SES:	Self-Esteem Scale.
SPSS:	Statistical package for social science.
STIHS:	State-trait hopelessness scale.
SWB:	Subjective well-being.
SWB:	Spiritual well-being.
SWBS:	Spiritual well-being scale.
UCLA:	University of California at Loss Angels**.**
WHO:	World health organization.

List of Symbols	
Symbols	**Description**
SD:	**Standard Deviation.**
f:	**Frequency.**
Qol:	**Quality of Life**
%:	**Percent**
p:	**P value**
>:	**Greater than sign**
<:	**Less than sign**
=:	**Equal to**
X:	**Mean**
t:	**T test**
∓:	**Minus-plus**
$\bar{x}$:	**Calculated mean**
Df:	**Degrees of Freedom**
F:	**F value**

Chapter One
Introduction

CHAPTER ONE

Introduction

1.1. Introduction

The World Health Organization, 1946 defined health as state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. However, more recent definitions of health have included emotional and spiritual dimensions (Fortinash and Warret, 2012). To ignore any of these components would omit significant part of well-being, with equally significant consequences (Ahmad, Altaf and Jan 2016; Moritz et al, 2011). There is a growing belief that major depressive disorder can be associated with increased feelings of loss and powerlessness which can lead to a cycle of loss: feeling of powerlessness, leading to hopelessness, and can lead to a sense of despair, which in turn feels back into a deeper sense of loss . This cycle may continue overtime, perhaps leading to a suicidal behavior (Kavrani et al, 2011).

Research findings indicated an association between spirituality, self-esteem and hopelessness with major depressive disorder (Avila, 2014, Schneider, 2012). It can be the contributory factors to depression (Yaacob et al 2009).

Depression has become one of the most common mental disorder with high prevalence throughout a lifetime (APA, 2000). It effects approximately 3.6% of the global population in 2013 (Ahmad, 2017). Major depressive disorder has been associated with greater morbidity, mortality. The impact of the depression on patients well-being and quality of life has been shown to be equal or greater than several other major chronic medical condition (Casnas et al, 2012).

The degree of variation among people with major depression in term of symptoms, course of illness and responses to care and treatment indicates that depression may have a number of complex and interacting factors underlying the variations (Ahmad, Altaf and Jan, 2016; Uba, 2012, Haster, 2010). There are multi causal origins, such us biologic, psychologic, social and cognitive factors converge to development of depression. Each factor helps to explain some aspect of depression, but none fully accounts for their development (Messie, 2012; Boyd, 2008).

The cognitive model of depression points to errors of logical thinking as causative factor of depression. Beck, 1967 proposed a trial of thinking (schemata) that gives rise to the development of depression, which they are; negative, self-deprecation view of self; pessimistic view of the world, so that life experiences are interpreted in a negative way; and the believe that negativity will continue into the future, promoting a negative view of future events (Fortinash & worret, 2012).

These mind-sets result in the misinterpretation of events and situations, so that the subject's cognitive schema of self as worthless and the world and future as hopeless. This faulty cognitive processing leads to assumption and continued errors of logic that result in depressive symptoms and an ongoing negative view of life (Aseltine and Demartino, 2004).

Yalom and Almond (2008) studied the condition under which an individual develops meaning in life, they found that positive spirituality value, self-esteem and hope may help to gain meaning in life and associated meaningfulness to contact with self, other and the world. Thus enhancing spiritual well-being, self-esteem and hope for subjects with depression is considered important mental health strategy within holistic approach of nursing (Avila, 2014, Uba et al, 2012; Mortiz et al, 2011, Boyd, 2008).

Spirituality is broad concept comprise many perspective in general, it includes a sense of connection to something bigger than ourselves, and it typically involves a

search for meaning in life. As such, it is a universal human experience, something that touches us all. Individuals may describe a spirituality experience as sacred or transcendent or simply a deep of aliveness and interconnectedness (Bonelli and Koeing,2013).

Depression has been studied in relation to spiritualty and it appear that spirituality does help people maintain their mental health (Koenig, Mc Cullough and Larson, 2001). Spirituality may play a role in depression prevention and recovery. Some studies indicate that more spirituality involved individuals experience fewer depressive symptoms and faster recovery from a depressive disorder than those with less spirituality involvement (Mortiz et al, 2011). It has been suggested spirituality acts as a coping resource or protective factor against depression (Valdez et al, 2014).

According to Russell's model as well-being spirituality is not necessarily religious aspect, but rather an individual's philosophy; value and meaning of life (Perrin & Mc Dermot, 1997). Is define as a personal connectedness with a higher divine natuer (Fortinash and Warret, 2012). Such connectness may contributes to lessening depression.(Doolittle and farrel, 2004). Also, Avila (2014) reported that spirituality is a significant predictor of depression should be considered on area of study. Other Studies show a positive relationship between spirituality, self-esteem and psychological well-being (Umana & Taylor, 2004).

In the view of Kernis (2006) self-esteem can both lead to and result from clinical depression. Self-esteem has been regarded as an essential component of mental health. It is the personal judgment of worthiness that expressed in attitude the person hold toward himself (Yousafzai and Siddiq: 2007) higher self-esteem tend to report more positive affective states, grater wellness and more life satisfaction (Uba et al, 2012). Low self-esteem has been frequent finding in depression and

suicide behavior (Ahmad, Altaf and Jan, 2016). Recent empirical studies using longitudinal data and cross-lagged regression models have consistently supported the idea that self-esteem negatively predicts depression (Orth and Robins, 2013).

When low self- esteem is formed it effects all aspects of an individual's life (Al Khatib, 2007). Low self-esteem contributes to the development of a poor or negative self-image (Yaacob et al, 2009) and its partial mediator of the relationship between hopelessness and depression (Uba et al, 2012). Understanding self-esteem is important for interventions and prevention of depression (Ahmad, Altaf and Jan, 2016).

Hope is the center to positive psychological functioning approach. It is especially important in dealing with stress and adversity. In psychological term, hope can be defined in part, as a positive perceptual bias that facilitates the discovery and retention of favorable future outcome .Hope is a potent quality of life variable because its impact on the mental, social, physical functioning of the individual(Scioli,2007). Some studies suggested that hope and spirituality; as hope is typically a spiritual experience, would serve as stronger buffers against depression, imagined loses, helplessness and despair as compared to self-esteem.

Other studies reported that higher hope scores were positively correlated with greater scores of positive emotions, and there was little relationship between trait hope and negative emotions.(Avila,2014)

In the view of Tuck (2012) hopelessness is a negative emotion characterized by a lack of hope, optimism and passion. Hopelessness is both a cause and symptom of depression, and in the context of depression a strong predictor of suicide according to previous studies (Mohammed T, 2012; Hepp et al. 2004). Lubow (2011) noted that hopelessness can be a passing part of a depressive episode, or even a brief aspect of grief. But also, hopelessness can be a long term pattern of thinking and

feeling, and it is almost inevitably the result of trauma. Living feeling hopeless is very painful.

Symptoms of depression relating to apathy and lack of motivation (helplessness expectancy) and sad affect (negative outcome expectancy) as well as other symptoms of depression are believed to flow from this condition of hopelessness (Frotinash & Warret, 2012). Other studies show that hopelessness also lead to low self-esteem (Ahmad, Altaf and Jan, 2016) and may lead to ineffective problem solving in depressed patient with suicidal ideation (Kaviani et al, 2011). Unfortunately, hopelessness condition is converted into specific symptom pattern of depression and remain elusive (Fortinash &Warret, 2012).

Hence, the spiritualty, self-esteem and hopelessness are intervened together in depression need to be studied according to basic empirical ground.

1.2 Importance of the study

Major depressive disorder has become one of the most mental disorder associated with morbidity, mortality and become the second foremost source of disease related disability among all ages. Effective assessment, treatment and prevention resets on accurate predictors. The contributory predictors are many and varied, among some of the many predictors or factors are spirituality, self-esteem and hopelessness.

Numerous studies have sought complex association between depression with the factors of spirituality, self-esteem and hopelessness. The level of severity of such factors can play role in the causes, recovery and predictors of depression (Huguelet, 2011; Avila, 2014; Yousafzai and sidiqi, 2007). In previous systematic review of studies pointed out that spirituality, self-esteem and hopelessness in depression were representing under studied variables (Rew & Wons, 2006).

The current study designed to identify such factors among patients with major depressive disorder, identifying the level of severity of these factors are expected to have particular important for nursing interventions and prevention of major depressive disorder.

There have been some studies conducted on the unique factor such as spirituality and depression (Mortiz et al, 2011; Phillipe, Lakin and Paragment, 2002), self-esteem and depression (Ahmad , Altaf and Jan, 2016; Yousafzai and siddiqi, 2007) hopelessness and depression (Neus Baptist et al, 2014). The previous studies sought to study depression in terms of spirituality, self-esteem and hopelessness is limited. Furthermore no study has investigated the levels of spirituality, self-esteem and hopelessness in outpatients with major depressive disorder in the psychiatric-mental health nursing in Sulaimani city and even in Iraq.

According to the above mentioned issues highlighted for the present study. The current study emphasis the necessity for such investigation to draw a more detail picture of the complexity and extend the variables in depression which is particularly important for intervention and care.

In the present study an attempt was made to assess the levels of spirituality, self-esteem and hopelessness among Kurdish community-patients diagnosed with major depressive disorder in Sulaimani city.

1.3 statement of the problem:

The problem of the present study was “Assessment the levels of spirituality, self-esteem, and hopelessness among patients with major depressive disorder in Sulaimani City”.

1.4 The objectives of the study:

1.4.1 General objective:

The main objective of this study was to assess the levels of spiritualty, self-esteem and hopelessness in patients with major depressive disorder attending the psychiatric outpatient clinic at Ali Kamal consultation center in Sulaimani City.

1.4.2. Specific objectives

1. To identify the sociodemographic characteristics of the patients including age, gender, marital states, level of education, occupation, economic status and residency area.

2. To find out the psychiatric history characteristics of the patients including duration of illness, number of hospitalization, suicidal attempts and family history of mental illness.

3. To determine the levels of spirituality, self-esteem and hopelessness of the study patients.

4. To find out the significant differences between patient's levels of spirituality, self-esteem and hopelessness in regard to sociodemographical and psychiatric history characteristics.

5. To find out the relationship between the level of severity of spirituality, self-esteem, hopelessness among study patients.

1.5 Definition of terms

1.5.1 Assessment

Theoretical definition

A systematic collection of data about individual's health status, concerns mainly with current problems, needs that may hinder the achievement of optimal health and well-being (Haber et al, 2007).

Operational definition

A systemic data collection done by the researcher through face- to – face interview with adult outpatients with major depressive disorder regarding their status condition which including spiritualty, self-esteem and hopelessness by using the questionnaire of the present study.

1.5.2 Spirituality

Theoretical definition

Is that part of an individual that deals with transcendent and universal, may take expression in religion and ritual but not limited to those things but rather an individual's philosophy, value and meaning of life (Fortinash & warret, 2012).

Operational definition

The internalized faith, value, and belief may take expression in existential and religious behaviors by patients with major depressive disorder and that's measured by Elison-Paluzian-spiritual well-beings scale.

1.5.3 Self-esteem

Theoretical definition

It is the personal judgment of worthiness that is expressed in the attitude the person holds toward himself (Al Khatib, 2007).

Operational definition

It is the extent to which the patient with major depressive disorder values himself or herself and that's measured by Rosenberg- self-esteem scale

1.5.4 Hopelessness

Theoretical definition

It is an emotion characterized by a lack of hope, optimism and passion (Huguelet, 2016).

Operational definition

It is subjective emotion of the patient with major depressive disorder which has a negative view point for the future, losing motivation, control, and confidence to reach one's goal that's measured by Beck hopelessness scale.

1.5.5 Major depressive disorder

Theoretical definition

Is a mental illness defined in the Diagnostic and statistical manual of mental disorder-5 that presents with depressed mood, loss of interest or pleasure, decreased energy, feelings of guilt, low self-worth, disturbed sleep or appetite, and poor concentration may occur with psychotic symptoms (DSM-5, 2013).

Operational definition

It is a mental illness that diagnosed by the consultant psychiatrist in Ali Kamal medical consultation center currently with non-psychotic symptom.

1.5.6. Patient

Theoretical definition

A person receiving or registered to receive medical treatment (Cambridge Academic Dictionary, 2018).

Operational definition

Outpatient with major depressive disorder attending the outpatient psychiatric clinic at Ali Kamal consultation center in Sulaimani City for treatment or follow up.

Chapter Two
Literature Review

CHAPTER TWO

Review of literature

2.1 Depression:

2.1.1 Historical background:

In Latin the word depression itself was derived from the verb "deprimere" meaning in English "press down". The word "demission" in Latin meaning depression means mour or glooming (Taylor & Fink, 2006). Being depressed meant to subjugate or to bring down in spirit (Wolpert, 1999).

In the time of Greek, Romans, Babylonian, Egyptian and Hebrew Depression had been identified. The ancient Greek physician; Hippocrates in the fourth century B.C, was most likely the first ever describe illness and named Melancholia. Melancholia refers to Melas (black) and chole (bile), linked for its etiology upon excess of black bile in the brain (Videbeck, 2001). Hippocrates writings not only define depression in similar ways as current works but also use context to differentiate ordinary sadness from depressive disorder (Horwits et Al, 2016). Aristotle (384-322 B.C) had been associated Melancholia with men, the newer concept abandoned these associations and became more associated with women (Radden, 2003).

The subsequent to Greek Romans medicine almost too new developments in medical thinking about melancholy occurred until the end of the eighteen century (Davison, 2006).

In the 11th century, the Persian physician Avicenna described Melancholia as a depressive type of mood disorder in which the person may become suspicious and develop certain type of phobia. During 8th century Johan

Christian Heinorth a German physician argued that Melancholia was a disturbance of the soul due to moral conflicts within the patient (Horwitz et al, 2016).

The psychiatrists Emil Kareplin (1856-1926) may had been the first to use depression as the overarching term, referring to different kinds of Melancholia as depressive states (Shorter, 2013). Kareplin is most notably known as the father of nosology in psychiatry (Kaplin&Sadock, 2003). He was the pioneer in the field of biological psychiatry, arguing that depression and often mental disorders are brain disease (Lowis, 2012).

Sigmund Schlomo Frued (1856-1939) an Austrian neurologist and the founder of psychoanalysis, had been linked the state of Melancholia to Mourning. He theorized that objective &subjective loss result in severe Melancholic symptoms more profound than mourning; not only is the outside world viewed negatively but the ego itself is comprised (Carhart-Harris et al, 2008). The patient's decline of self-perception is revealed in his belief of his own blame, inferiority, and unworthiness (Michel, 2012).

Adolf Meyer (1866-1950) was one of the most influential figures in psychiatry in the first half of the twentieth century ,put forward a mixed social and biological frame-work emphasizing reactions in the context of the an individual's life and argued that the term depression should be used instead of Melancholia (Pakel,2008).

A half century age, diagnosed depression was either endogenous; psychotic (Melancholia) considered a biological condition, and reactive (neurotic) reaction to stressful events. The term major depressive disorder was introduced in the mid-1970s based on patterns of symptoms called diagnostic criteria, and was incorporated into the Diagnostic and statistical manual of mental disorders DSM-III in 1980(Robinson et Al, 2008).

In the DSM-IV, 1993 the major depression are grouped under mood disorders, while in DSM-V in 2013 the major depressive disorders changed to be a separated disorders. (Salih, 2016; APA, 2013)

2.1.2 Depressive Disorders:

2.1.2.1 Classifications:

On the new edition of Diagnostic and statistical manual of mental disorders (DSM-5) the section of depressive disorders has been separated from bipolar related disorders, unlinked on the DSM-IV, the section without the opposite pole of elation of manic or hypomanic symptoms (Rahim,2015).

The common feature of all depression disorders is the sad, empty or irritable mood accompanied by somatic and cognitive changes that significantly affect the individual's capacity to function (Salih M ,2016) the section of depressive disorders according to DSM-V,2013 includes :-

- Distributive mood dysregulation disorder.
- Major depressive disorder.
- Persistent depressive disorder (dysthymia).
- Premenstrual dysphoria disorder.
- Substance/medication induced depressive disorder.
- Unspecified depressive disorder (APA, 2013).

Major Depressive Disorder:

Major depressive disorder, also known as unipolar, clinical depressive disorder is single or recurrent episode is describe in term of severity; as mild, moderate and severe. Also, specified as partial remission, in full remission and unspecified. Additional specification such as catatonia , Melancholia, typical feature, anxious distress, mixed features , mood congruent psychotic feature, mood-in congruent psychotic features, per

partum onset and seasonal pattern in pattern exist for major depressive disorder (DSM-5,2013).

2.1.2.2 Diagnostic criteria of major Depressive Disorder:-

The diagnostic and statistical manual of mental Disorder-V (DSM-5) published by the American Psychiatric Association (APA, 2013) gave the standard criteria for major depressive disorder based on single episode or current. The criteria are:-

A. Five (or more) of the following symptoms have been present during the same 2-week period and represent a change from previous functioning; at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure.

1. Depressed mood most of the day , nearly every day, as indicated by either subjective report (feel sad, empty, and hopeless) or observation made by others (appears tearful)
2. Markedly diminished interest or pleasure in all activities.
3. Significant weight loss when nor dieting or weight gain (a change of more than 5% of body weight in a month and changing appetite.
4. Insomnia or hypersomnia nearly every day.
5. Psychomotor agitator or retardation nearly every day.
6. Fatigue or loss of energy nearly every day
7. Feeling of worthlessness or excessive or in appropriate guilt (which may be delusional.
8. Diminished ability to think or concentrate, or indecisiveness.
9. Recurrent thought of death, recurrent suicidal ideation without a specific plan for committing suicide.

B. The symptoms cause clinically significant distress or impairment in social, occupational or another important area of functioning.

C. The episode is not attributed to the physiological effects of a substance or to another medical condition.

D. The occurrence of the major depressive episode is not better explained by schizoaffective disorder, schizophrenia, schizophreniform disorder, delusional disorder, or other specified and unspecified schizophrenia spectrum and other psychotic disorder.

E. There has never been a manic episode or a hypomanic episode (APA, 2013)

2.1.2.3 Etiology

Multiple theories have been developed to the cause of major depressive disorders. None theory fully explained the complexity of the illness. Many studies support the premise that major depressive disorder has multi causal origins, in which biologic, psychologic, social and cognitive factors converge to promote the development of depression (Fortinash & Worret, 2012). In general, these etiologic factors grouped into neurobiological and psychosocial. These factors are:-

Biological factors:-

A:1 Neurotransmission Disturbance. It's believed that monoamine neurotransmitter system, especially those of norepinephrine and serotonin , their metabolites, and their receptors are somehow altered during episodes of depression (Hardeveld,2013; Ahmad D ,2016) more recent research on neurotransmission has focused on the altered sensitivity of neuronal membranes in mood disorders. In response to a decrease or increase in availability of neurotransmitters, it appears, overtime, there is a change in the sensitivity or density of presynaptic and postsynaptic receptors specific to a particular neurotransmitter. This results in delayed postsynaptic

receptor-mediated responses. Receptor change theories propose that there is an underactivity of neurotransmission in depression (Mulinari, 2012).

A: 2 Neuroendocrine Dysregulation

Studies indicate that dysregulation of the hypothalamic-pituitary-adrenal (HPA) axis is associated with depression. The HPA axis controls physiologic responses to stress.

Hyperactivity of the HPA axis is often evident in depression. Up to 50% of patients with moderate to severe depression exhibits elevated serum cortisone level (Haster, 2010). The functioning of HPA axis is related to the 24 Hours cycle of cardiant rhythms that control physiologic processes. With mood disorder, cyclic pattern are distrusted. Blood cortisol is normally at a low level in the early morning and highest in late afternoon. Sleep-wake cycles are distributed in depression. Patient experience decreased shallow, slow delta wave sleep, thus fragmenting the sleep-wake cycles (Fortinash & Warret, 2012).

A: 3 Genetic transmissions

A relationship between genetic makeup and susceptibility to major depression disorders (MMD)has long been suspected on the basis of family and twin studies (Boyd, 2008) Twin studies has estimated MMD'S degree of heritability to be 0.33 in confidence interval 0.26-0.39 (Wurtman, 2005).

Among families exhibiting an increased prevalence of MMD risk of developing the illness was enhanced in members exposed to a highly stressful environment (Wurtman, 2005).

Twin and family studies give us the estimates and typically it’s a 40% heritability for depression and 60% seems to be independent environment (Fabian R, 2018)

The gene products of greatest interest to present are those involved in the synthesis and action of serotonin, among them the serotonin-uptake protein localized within the terminals and dendrites of serotonin-releasing neurons. It has been found that the platelet serotonin uptake is low in some patients with MDD. Also is highly correlated in twins (Aiken C, 2018). Aiken found that the serotonin transporter promoter gene's short allele (5-HTTLPR) has been linked with depression, particularly in the variation of the genes interact with stress (Aiken, 2018).

Although heredity is a significant factor the concordance rate for monozygotic twins is not %100 (Kelsoe, 2005) and it is not a single depressive gene that causes depression but most likely a combination of genes that confers rise (Aiken, 2018), then genetic alone donate account for depressive disorder (Rice et al, 2002).

B: psychosocial factors:-

B.1 a Psychoanalytic theory:-

This theory focused on theme of the loss either real or symbolic. According to Sigmund Freud, in depression the loss generates, hostile feelings toward the loss object that are turned inward onto the self-creating guilt and loss of self-esteem (Fortinash & Worret, 2012).

Depression is viewed together with loss and aggression. The loss of an object either physical or emotional in compound by the development of anger (Boyd, 2008).Psychoanalytic historically believed that depression was caused by anger converted into self-hatred. The parents who are inconsistent create unpredictable hostile world for the child as a result he/she feels alone, confused, helpless and ultimately angry. This occurs in childhood, creating a vulnerability to real or perceived loss throughout adulthood that results in period depression (McLeod, 2015).

B.2 Cognitive theory:-

Cognitive theory of depression points to errors of logical thinking as causative factors for depression. This theory assumes that mood is influenced by underlying cognitive structure, some of which are fully conscious these cognitive structures, or schemata, may be shaped by early life experiences and predisposed to negative processing of information. In a diatheses-stress model, when persons predisposed to depression with negative schemata encounter stress, the negative processing is activated, resulting in depressive thinking (Fortinash & Worret, 2012, McLeod, 2015).

The cognitive theorist, AronBeck identified a trade of thinking that are thought were responsible for depression which is

- Negative, self-depreciating view of self.
- Pessimistic views of the world so that life experiences are interpreted in a negative way
- The belief that negativity will continue into the future, promoting a negative view of future events.

These mind-self results in the misinterpretation of events and situations, so that the client's cognitive schema of self as worthless and the world and future as hopeless are supported. This faulty cognitive processing leads to assumptions and continued errors of logic that result in depressive symptoms (Disner, et al, 2011; Fortinash & Worret, 2012; McLeod, 2015)

B: 3 Learned helplessness theory:-

Helplessness is a phenomenon in humans when they have been conditioned to aspects suffering without a way to escape it. When human come to believe that they have no control what happens to them they begin to think,

feel and act as if they are helpless. This phenomenon is called learned helplessness (cherry, 2017).

The learned helplessness theory is actually a variant of the cognitive theory, tracing the determinate of depression to altered cognition. According to the original theory of Seligman, stated that stressful events that are experienced as uncontrollable result in the development of helplessness, apathy, powerlessness and depression (Fortinash & Worret, 2012). Then Seligman and colleges modified this theory and suggested that the primary issue is the person's expectation that external events are uncontrollable. This causal attribution regarding current events, combined with the person's perception of past uncontrollable experiences, yield the expectation that the event or situation cannot be controlled. This, in turn results in helplessness, passivity, and sadness, which lead to other symptoms of depression, such as decreased appetite and low self – esteem (Dowd, 2004).

More recently a hopelessness theory was developed as a response to learned helplessness theory of depression (McLeod, 2015). This theory proposed that the causal attribution formed by individuals in response to negative life events influences their risk for becoming depressed. It was hypothesized that individual form causal attributions along three different dimensions, from internal to external, stable to unstable, and from global to specific. According to this theory, those who attribute a negative event to internal, stable and global causes were at greater likelihood of developing depression. This theory predict that an individual who has an argument with an acquaintance is more likely to become depressed if they interpret this event as a product of their poor interpersonal ability (internal) which they belief will never change (stable) and will negatively influence all their other social interaction (stable) (Liue et al, 2015 and McLeod, 2015).

This theory presents hopelessness as a sufficient cause of depression and individual's inferred negative outcomes and negativity about self as key elements of depression (Liu et al, 2015)

C: Stress factor:-

It is widely acknowledged that there appears to be some type of relationship between life events and the onset of depression. The Diatheses-stress model suggests that people have different degrees vulnerabilities or predispositions for developing depression (Nemad, Reiss and Dombeck, 2018). The model suggest that having a propensity towards developing depression alone is not enough to trigger the illness. Instead an individual's diathesis must interact with stress life events of social, psychological or biological in nature in order to prompt the onset of depression (Nemade, Reiss and Dombeck, 2018 ; Hankin et al, 2004).

2.1.2.3 Epidemiology:

Depressive disorder are major public health problems, with prevalence of major depressive disorder 3.6% of global population (Global burden of disease study, 2015), in Europe of 8.56% (Casan et al, 2012). It is currently highly prevalence in both high and low to middle income countries (Kessler & Bromet, 2013). In Iraq, the prevalence of major depressive disorder was estimated at 932:100.000 in adults (Al Hasnawi et al, 2009).

It is strikingly affects more female than males as 5.6% vs 3.4% (Ustun, 2004). The most frequent age of onset for major depressive is the 25-44 year age-group; people in younger age group have an increasing risk of developing depression.

Data indicate that the onset of depression at an early twenties or at ages 55 or over predicts a more protracted, chronic course (Fortinash & Worret,

2012). Studies indicate that 10% to 15% of completed suicides are committed by persons specifically with major depressive disorder. Depression is major factor for person attempting suicide as well (Mohammad T, 2012).

2.1.2.4 Major depressive disorder treatment:-

There are several treatment methods for depression disorder. These approaches include antidepressant medications, psychotherapy and electroconvulsive therapy (ECT) and other somatic therapies. The ECT is generally avoided, except in extreme circumstances.

1. The psychopharmacology treatment various types of antidepressant medications are used to treat persons with major depressive disorder. These include selective serotonin reuptake inhibitors (SSRIs), tricyclic antidepressants (TCAs) and mono oxidase inhibitors (MAOIs) (Fortinash & Worret, 2012).

   The SSRIs are considered to be most tolerable and safest antidepressants have greater. The MAOIs antidepressants have greater side effects and associated with greater risk of toxicity (Boyd, 2008).

2. Psychotherapeutic intervention

   The types of psychotherapy that have been used to treat major depressive include; cognitive-behavior therapy, interpersonal relationship therapy and psychodynamic therapy. Each of these therapies differs with respect to the underlying theoretic frame work, goals, and approach. (Mohammad, 2012).

- Cognitive-behavior therapy (CBT)

  This is a structure therapy, focus on assisting patients in recognizing perceptual and cognitive errors, instructing patients to perceive external problems realistically to change patterns of thinking or behavior that are

behind patients emotional difficulties (Martin, 2019). CBT helps patient with major depression to correct their misinterpretation (Lampe et al, 2013)

- Interpersonal therapy

  This therapy views depression as developing from pathologic early interpersonal relationship patterns that continue to be repeated in adulthood (Fortinash & Worret, 2012). This type of therapy is designed to help depressed patients with their daily activities and their social relationship (Bordbar and Farid Hosseini, 2012).

- Psychodynamic therapy

  The psychodynamic therapy is derived from the psychodynamic theory by Frued. In this therapy , depression is viewed as a result of early childhood loss of a love object and ambivalence about the object; introjection of anger onto the ego, resulting in blockage of the libido; and unresolved intrapsychic conflict during early child hood psycho sexual development. Thus self-esteem is damaged and eroded, with repetition of the primary loss pattern occurring throughout life. The therapist is helped the depressed patient to uncover repressed experience feeling, defenses and interpret patient's current behavior. For some patient's, psychodynamic therapy assists in developing insights that promote behavioral changes (Fortinash & Worret, 2012; Marrion and Valfree, 2005).

2.1.2.5 Major depressive disorder; Nursing process:-

2.1.2.5.1 Assessment

Assessment of the client with depression includes information about his/her Presenting problem and mental status, past psychiatric history, social and developmental history, family history, and physical health history (Frederiksy *et al*, 2006; Fortinash and Warret, 2000). Assessing the history is important to determine any previous episodes of depression, treatment,

and client's response to treatment. The nurse also asks about family history of mood disorders, suicide, or attempted suicide (Boyd,2008).

The nurse can collect data from the client and family or significant others, previous chart information, and others involved in the support or care (Gournay,2009).

2.1.2.5.2 Nursing Diagnosis:

The North American Nursing Diagnosis Association (NANDA) (2000)

listed the following relevant diagnoses for patients with major depressive disorder :

- Communication; impaired verbal.
- Coping; defensive, ineffective individual.
- Self-care deficit; bathing, hygiene, dressing/ grooming, feeding.
- Sleep pattern disturbance.
- Social interaction; impaired
- Nutrition, altered
- Constipation
- Thought process; altered.
- Violence; risk for: directed as others, self-directed.
- Spiritual distress/ distress the human spirit
- Hopelessness
- Powerlessness

2.1.2.5.3 Implementation:

The plan of action for clients with depressive disorder varies depending on

Many issues. In the short term, nursing and collaborative interventions are

Available that is effective in reducing the acuity of the episode and promoting more optimal functioning. With the current trend of short- term hospitalizations, and community care and treatment (Townsend, 2011).

2.1.2.5.4 Nursing Interventions:

Nursing interventions for clients with depressive disorders span a wide

range of biopsychosocial areas, with consideration of the effects of depression on physiological, cognitive, psychologic, behavioral and social spheres.

The interventions are the followings:-

1- Communicate to client that crying is acceptable. Use of touch is

therapeutic and appropriate with most clients. Knowledge of cultural influences specific to the client is important before using touch technique.

2- Assist client in problem solving as he or she attempts to determine

methods for more adaptive coping with the experienced loss. Provide positive feedback for strategies identified and decisions made. Positive feedback increases self-esteem and encourages repetition of desirable behaviors.

3- Help client to recognize and focus on strengths and accomplishments.

Minimize attention given to past (real or perceived) failures. Lack of attention may help to eliminate negative ruminations.

4- Encourage client to take as much responsibility as possible for own self care practices. Providing client with choices will increase his or her feelings of control.

5- Identify ways in which client can achieve. Encourage participation in

these activities, and provide positive reinforcement for participation, as well as for achievement.

6- Provide positive reinforcement for client's voluntary interactions with others. Positive reinforcement enhances self-esteem and encourages repetition of desirable behaviors.

7- Reinforce and focus on reality. Talk about real events and real people. Use real situations and events to divert client away from long, purposeless, repetitive verbalizations of false ideas.

8- Teach client to intervene, using thought-stopping techniques, when irrational or negative thoughts prevail.

9- Encourage client to reach out for spiritual support during this time in whatever form is desirable to him or her. Assess spiritual needs of client and assist as necessary in the fulfillment of those needs.

10- Create a safe environment for the client. Remove all potentially harmful objects from client's access (sharp objects, straps, belts, ties, glass items).Supervise closely during meals and medication administration. Perform room searches as deemed necessary. Client safety is a nursing priority.

11- In collaboration with dietitian, determine number of calories required to provide adequate nutrition and realistic (according to body structure and height) weight gain.

12- Develop trusting relationship with client. Show empathy and caring. Be honest and keep all promises. Trust is the basis for a therapeutic relationship.

13- Convey an accepting attitude, and enable the client to express feelings

openly. An accepting attitude conveys to the client he or she is a worthwhile person. Trust is enhanced.

14- Spend time with client to convey acceptance and contribute toward feelings of self-worth.

15- Encourage participation in group activities from which client may receive positive feedback and support from peers.

16- Help client set realistic goals. Unrealistic goals set the client up for failure and reinforce feelings of powerlessness.

17- Weight client daily. Weight loss or gain is important assessment information.

18- Administer antidepressant medication at bedtime so client does not become drowsy during the day.(Rohads and Murphy, 2015, Morrison-Valfree, 2005).

2.1.2.3.5 Evaluation:

Nurses evaluate clients' progress by measuring their achievement of identified outcomes. Data that support or refute achievement of outcomes are collected from personal observations, clients, clients' family and friends, and other health care providers. Evaluation occurs throughout hospitalization and may be continued by community mental health providers after clients have been discharged. Nurses working in community settings, such as psychiatric home care, may be evaluating outcomes for clients who have never been admitted to an inpatient setting (First and Tasman, 2006; Fontaine, 2003).

With decreasing lengths of stay in hospitals, nurses in inpatient psychiatric

units may not see dramatic changes in client's symptoms. However , they must see some clear progress related to priority short-term outcomes, such as absence of imminent suicidal intent, a plan for addressing the potential return of suicidal ideation after discharge, the ability to conduct self-care activities, some alleviation of neuro vegetative symptoms of depression (sleep, loss of appetite, fatigue, psychomotor retardation), improvement of cognitive functioning and communication, and initial understanding of the disorder and its treatment, including necessary self-care management. Referrals are made to therapists, psychiatrists, home care and community mental health agencies, and partial hospitalization programs for continued care in the community (Melnyk and Lusk, 2013; Fontaine, 2008).

Nurses working with clients in the community see improvement in longer term outcomes such as improved socialization, return to usual activities, reduction in negative thinking, increased self-esteem, use of new coping strategies, resumption of family/work roles, continued improvement in cognitive progress (e.g., attention and concentration), decreased or absence of fatigue, and adherence to regimens. For some clients, these outcomes become evident within weeks for starting psychotherapy or somatic treatment regimens. For others, improvement may require months before longer-term outcomes are achieved. Recent data suggest that return to previous levels of functioning after an episode of depression takes longer than previously thought, particularly if clients have had multiple episodes (Varcarolis, 2011; First and Tasman, 2006).

2.2 Spirituality:

2.2.1: An overview

During the past 50 year, from an almost exclusive emphasis on the Importance of physical health to a more balanced perspective that now

promotes the achievements of wellness through the pursuits of holistic health (Rhoads and Murphy, 2015).

The concept of health is now generally viewed as a holistic, multidimensional phenomenon that includes not only physical, but also emotional intellectual, occupational, social, and spiritual components (Nelson, 2009). The high levels of wellness cannot be achieved without a balance in the various dimensions of health (Christmas & Vanhorn, 2012).

Historically, the majority position of psychiatry think that psychiatry has nothing to do with spirituality & religion (Verghese, 2008). And in the psychology the matter of spirituality has traditionally fallen outside of its domain (Chirban, 2013).

Today psychiatrists, psychologists and clinicians are increasingly respond to the idea that spirit as integral in the life of the person and believe that spirituality are important in the life of their patients (Bonelli & Loenig, 2013). A cording to Russell's model of well-being, spiritual health forms the overall umbrella under which all other dimensions are united. Russell's model viewed spirituality is not necessarily religion, but rather, an individual's philosophy, value, and meaning of life (Perrin & Me Dermott, 1997).

2.2.2 Spirituality: A dimension of the person

The human spirit is heavenly component of human's non-material makeup, the part that is impersonal or universal (Avila, 2014).

Spirituality is a worldwide acknowledged concept, it is an intimately connected to the super natural and religion, although extended beyond religion (Christmas &Vanhorn, 2012).

In contemporary usage spirituality has a number of common meaning and definitions in the scholarly literature also vary. These deference's reflect the fact that spirituality is aboard term encompassing multiple domains of meaning that may differ among various cultural, national and religious group (Nelson, 2009). Nelson, 2009 noted that spirituality is used to denote the experiential and personal side of our relationship to the transcendent or sacred.

The American Counseling Association- ACA, 2005 defining the spirituality as a capacity and tendency that is innate and unique to all person. This spiritual tendency moves the individual toward knowledge, love, meaning, peace, hope, transcendence, connectedness, compassion, wellness, growth and development of a value system. Spirituality encompasses a variety of phenomena, including experiences, beliefs, and practices. Spirituality is approached from a variety of perspectives, including psycho-spiritual, religious and transpersonal. While spirituality is usually expressed through culture (ACA, 2005).

Thoreson (1998) defined spirituality operationally as the need to transcend or rise above every day material or sensory experience one's relationship to God or some other higher universal power, force, or energy, the search for greater meaning, purpose and direction in living, and healing by means of non-physical kind of intervention. Chriban (2013) stated that the person's spirituality encompasses an understanding of the scared, of the holy, of faith and all those things that are not physical. It addressed the core images regarding humanity, the divine and relationship between humanity and divine their images can be healing and sustaining or they may be punitive and crippling (Chirban,2013).

Individual's spiritual-health have two characteristics; internal and external. Internally, spiritual health seems to provide the individual with life purpose, ultimate meaning oneness with nature and beauty, a sense of connectedness with other, deep concern for a commitment, peace, hope and fulfilment. Externally, spiritual-health of individuals express themselves through trust, honesty, integrity, altruism, compassion and service. In addition, these characteristics regularly communicate with higher power or larger reality that transcends an observable physical reality (Avila, 2014, Philips Lakin and Pargament, 2002).

The role of the spirituality in life not optional, it is a response to the need for human wholeness. To miss an essential part of the person (Wommacle, 2010). In the treatment of illness, it is important to attend to the spiritual dimension of a person (Chirban, 2013).

2.2.3 Spirituality and Religion:

Spiritualty and religiosity are related and overall but is not the same (Cohen et al, 2012). Religiosity is a specific set of beliefs and practices usually within an organized and formal group or it may be a less formal and more individual set of beliefs and practices (Philips, Lakin and Paragment, 2002).

Religion is institutionalized spirituality, thus there are different sets of beliefs, traditions, and doctrines. Spirituality is the common factor in all these religions (Verghese, 2008).

In this regard, Christmas and Van Horn (2012) stated that, although a spiritual tendency is described as a global and overarching issue, it affects people in different and personal ways. How that spiritual tendency fits into people's individual lives is what makes it meaningful to them. This broad basis helps to distinguish spirituality from organized religion, which can be

described as a particular set of beliefs and practices with which people affiliate themselves. Some forms of spirituality include a belief in God or higher power and some do not.

Religion is more prescriptive of the beliefs and followed by its adherents (Young & Cashwell, 2011). In addition, Young and Cashwell,2011, described the relationship between spirituality and religion as religion provides a structure for human spirituality, including narratives, symbols, beliefs, and practices, which are embedded in ancestral traditions, cultural traditions, or both.

Spirituality is broader than culture and instinctive to humanity while religion provides a cultural framework within which people's spiritual beliefs can develop and grows (Christmas and Horn, 2012).

It is possible that religions can lose their spirituality when they become institutions of oppression instead of agents of good will, peace and harmony. They need periodical revival to put spirituality in place (Philips, Lakin and Pargament, 2002).

Recent research has suggested that religion and spirituality can be a resource or a burden for person with serious mental illness. Religious resources and coping methods have been associated with both positive "feeling a source of comfort from God" and negative outcomes "guilt over being angry with God" (Bussema & Bussema, 2000).

Psychiatric symptoms can have a religions content for example, the loss of interest in religions activities is a common symptom of depression. Too much and distorted religious practice are common in schizophrenia. The spiritual background of the patients will help in the interventions of psychiatric disturbance (Verghese, 2008).

2.2.4 The goals of spirituality

Summarized as follows:

- Providing an image of the diving, humanity and understanding of the relationships between divine and humanity.
- Helping to examine thought of divine reward, punishment or neutrality.
- Helping to give belief and meaning to life.
- Helping to find a sense of duty, vocation or moral obligation, to examine one's experience of the divine and sacred.
- Helping to cope with situations that conflict with spiritual understanding.
- Providing a format for spiritual ritual and practices.
- Providing a faith community.
- Providing authority and guidance for one's system of belief, meaning and ritual.(Chirstmas and Van Horn, 2012).

2.2.5 Spirituality models and mental health:

There is a complex connection between spiritual wellness &mental health. These connections explain in medical & psychological model.

2.2.5.1 Medical model

Mental and psychological health is the normal state of human functioning and can be defined as a condition in which the person is functioning well in their environment with minimum of personal distress. A person is healthy in the absence of problems (Nelson, 2009).

Recently the medical model now allows for the possibility that spiritual problems might be considered as treatment issues. These changes were spearheaded by a group as Tran's personal psychiatrists, and the

modifications are part of an overall trend toward greater cultural sensitivity in diagnosis and treatment. In addition to revising codes of ethics for the helping professions to require respect for client religious belief, the NANDA has been include the diagnosis category of religion and spiritual problem. This category can be used when the focus on clinical attention is a religious or spiritual problem. Spiritual problems could include spiritual experiences or dealing with problems that have spiritual component such as terminal illness an addiction fraud associated with negative mental health. (Koenig, 2006).

2.2.5.2 Psychological model

In this model, the human health is conceptualized as more than an absence of illness. Instead, an attempt is made to propose a broader vision of what the good life or goal of human existence is like and how it should be achieved (Hardy, 2000). The psychological model of positive mental health is equated with happiness, the short-term experience of pleasure and avoidance of negative emotions (Pressman and Cohen, 2005) or subjective well-being (SWB) which is the individually evaluation of the quality of their lives. This approach is based upon the model claim that the self-interest of the individual in seeking pleasure and avoiding pain is the fundamental human motive (Mitchell & Whollery, 2004). In the eudaimonic approach, mental health is through of as a dynamic process rather than an end state of pleasure and is described in somewhat broaden terms as psychological well-being, the position of fully functioning individual who engages life, seeking to actualize their potential and find meaning, develops quality relationships and develops competence and seek to master the environment (Van Dierendonck and Mohan, 2006).

2.2.5.3. Islamic Views

In general, Islamic theory holds that each person comprises four parts; the heart, the intellect, the spirit (Ruh) and the self (Nafs). The spirit contains a template of potential for the person. And the self encompasses the biological and psychic aspects of the individual (our animal nature) (Nelson, 2009).

The four parts of the person are in harmony through belief, worship and submission to Allah. Individual can actualize this potential. Resisting it will lead to imbalance, discontent and the possibility one's power can become evil and will be abused for selfish ends. Individuals need to practice self-control and live in society that support this way of life. However, the exact nature of the path is different for every person (Nasr, 2002).

Although hospital for psychiatric care appeared in Islamic countries early in the 8th century, Muslims generally may see mental health difficulties as due to spiritual problems or weakness in faith. Islamic counselors working with Islamic clients generally see their spirituality, religion is as a resource that helps guard against problem like depression and suicide, as well as providing coping resources for other types of problem (Ali, et al, 2004).

2.2.5.4. Spiritual well-being as Mental Health Model

Nelson (2009) reported that some scholars note that spirituality, religion also produce a kind of well-being that is different from eudaimonic varieties described by psychiatrists. The spiritual well-being which has developed by Ellison (Ellison, 1982, Paloutzia & Ellison, 1982, Ellison & Smith, 1982), Ellison view of the spiritual well-being concept that, in addition to desires for pleasure or self-fulfillment, humans have needs for transcendence, "the sense of well-being that we experience when we find

purposes to commit ourselves to which involve ultimate meaning for life". This type of well-being provides integration, harmony, and freedom within the personality and it involves two types; religion well-being which is a vertical relation or well-being in connection to God, and the second type is existential well-being which include a horizontal relation to the world including a sense of life purpose and satisfaction.

Mansager (2000) stated that spiritual well-being can be an expression of spiritual health or maturity. It is different than psychosocial well-being because it goes beyond material aims (Van Dierendonck and Mohan 2006). Nelson (2009) added that spiritual well-being is associated with higher religious salience, participation and satisfaction, as well as better physical and psychological well-being, lower anxiety, and less depression.

In addition, spiritual well-being also related to self-actualization, as persons who have higher levels of self-actualization have grater spiritual well-being, stronger intrinsic religious commitment and greater frequency of spiritual experiences. Development of spiritual well-being related to less self-focus, healthy dependencies, and relationship with religious community. Unity and coherence of goals related to other positive characteristics such as freedom of compulsion, self-esteem, higher empathy, and helping behaviors (Nelson, 2009).

2.2.6 Spirituality and coping behavior:

Lazarus, 1991, defined coping behavior as an ongoing conditioned and behavioral efforts to manage specific external and / or internal demands that are apprised as taxing or exceeding the resources of the person (Salih, 2016). Coping is triggered as a result of cognitive appraisal as judgment that what people are comforting in stressful events. The appraisal is

depending on a number of cognitive factors, including beliefs about oneself, and the world, and the meaning of an event (Nelson, 2009).

There are several types of coping as Studied by Salih (2016):

- Emotion-focused coping; this type of coping focused on managing distressing emotions by changing attention to the event or problem or the meaning of what is happening. Example of this coping include wishful thinking, self-balance and tension reduction.
- Problem-focused coping: this type of coping involves trying to change what is causing distress by acting on the environment or self, by analyzing the problem and making a plan of action.
- Mix problem and emotion focused coping
- Religious coping, this type of coping uses the religious belief or practices to respond to perceived stress, loss and threat.

Pargament (2002) stated that religion coping used when events interpreted in relation to scared, and this enhances one's sense of meaning, control, comfort, intimacy or support. In addition, the outcome of this coping can be judged as good or bad depending on how it will meet situational demand, has a good balance of goals, and fits well to with the client's social system.

The styles of religious coping are as reported by Nelson, 2009 are:

1. Self-directory coping:

Individual acknowledges the presence of sacred but relies on one's self rather than God to solve a problem. This style negatively related to prayer, intrinsic motivation and positively related to feelings of personal control, self-esteem, but also higher levels of anxiety. Individuals with using this style who suffer from serious mental illness tend to have poorer outcomes.

2. The differing style:

In this style the responsibility of the event or problem is differed to God. This is positively related to religious involvement and negatively related to personal control and psychosocial competence.

3. The collaborative style

This style involves an active partnership between the individual and the God. The collaborative style is positively related to spiritual practices like prayer, religious salience and involvement, greater personal control, higher self-esteem and psychosocial competence. It is related to lower anxiety, less belief in control by chance, and higher God locus of control. In coping with serious mental illness, the collaborative style is related to more empowerment and participation in recovery enhancing activities (Nelson, 2009).

In this regard (Fortinash and Worret, 2012) stated that some major spiritual issue include the fear of death and loss, both of self and others. Spirituality allow one to cope with these feelings by providing a sense of hope and meaning to experience that would otherwise be crippling. Having a spiritual understanding that one's connection with creation is more than merely physical helps to ease the fear and pain of loss, feeling connected to the divine eases feelings of abandonment, grief, and alienation, as well as promoting a sense of self-acceptance. Spirituality is thought to be a key component in the healing process and an integral part of the client treatments plan (Frotinash & Worrel, 2012).

Spiritual / religious coping is widespread (Verghese, 2008). In a study published by Schuster et al (2001) found that 90 percent of Americans turned to their spiritual belief to cope with stress. This is also true in clinical settings. A study of 330 hospitalized medical patients found that 90

percent reported they used spiritual and religion practices to cope at least a moderate extent, and over 40 percent indicated that their spiritual belief were the most important factor that kept them going (Koenig,1998). In Canada Ginsburg et al (1995) found that the most common source of emotional support by depressed patients with lung cancer was either family, 79%, or their spiritual religion belief (44%). the most common of all coping strategies that investigators found was prayer (%40) (Zaza , Sellick & Hillier,2005).

Those with mental problems often rely on spirituality resources. Tepper et al (2001) found that 80% of patients (406) with persistent mental illness relied on spiritual beliefs to cope. Likewise, Russinova, Wewiorsk: and Cash (2002) found that those with schizophrenia and major depression reported that most common beneficial activity they engaged in spiritual activity study in USA. In Australia, D'Souza (2002) found that 79% among 79 psychiatric patients thought their therapist should be aware of their spiritual beliefs and 67% percent indicated that spirituality helped them to cope with psychological pain.

Koenig, Mecullough and Lanson (2001) examined the relationship between spirituality and mental health, focusing on depression, and reported statistically significant positive associations between spirituality involvement and better health.

The issues as loss, fear, death, abandonment, and feelings of alienation may be present in clients with both physical and psychiatric illness. Responses to these feelings can range from finding new meaning and strength, to acceptance, to grief, to a sense of hopelessness. It is often a spiritual intervention to first acknowledge and validate such feelings, and then help the client to look at wage to reestablish their life status in such a manner as

to encompass these experience (Fortinash & Worret, 2012), Fitchett (1997), identified those persons who at significant spiritual risk and described them as those who a high spiritual need, coupled with low spiritual resources to meet that need. These individuals have more risk for poor outcomes and should be primary focus for outcome-based spiritual care.

2.2.7 Spirituality and depression:

Spirituality in mental health plays an important role. For many offlicated individuals, their spirituality gives them a powerful sense of hope in the face of an often devastating and chronic illness (Christmas & Vanhorn, 2012). Serious mental illness can be associated with increased feelings of loss and power lessees, mental illness, especially chronic illness , such as depressive disorder, can lead to cycle of loss; feeling of powerlessness , leading to hopelessness, leading to a sense of despair which in turn feeds back into , a deeper sense of loss (Perrin and McDermoo, 1997)

When quality spiritual care is provided in a consistent and effective manner as a key part of multidisciplinary approach to treatment, evidence indicate that is significant benefit (Fortinash & Worret, 2012).

Addressing client spirituality issues may contributes to a decreased used of total system resources , in that client depression, anxiety maybe lessened , system control maybe more effective and these may be reduced number of client complaints, all of which result in an increased level of client Satisfaction (Perrin & McDermoo1997).

In this regards, the theological perspectives view depression as an essential part of spiritual development. Feeling bad can be an opportunity for further exploration and growth. Negative moods can have a regulatory function that motivates the person to make positive corrections in their life that attempts to remove the symptoms (Damasio, 2002; Dieker, 2005).

Corney (2005) noted that spirituality is an important dimension of treating the whole person., this holistic, incorporating rather than eliminating illness. Psychoeducation with well-designed spiritual content have been found to be helpful in increasing spiritual support (Lindgren and coursey,1995), reducing anxiety (McCorkle et al ,2005), reducing perfectionism and depression (Richard et al , 1993) , facilitating forgiveness (Rey et al ,2005) and increasing positive spiritual coping while decreasing depression (Tarakeshwar et al ,2005).

In a systematic review of the research prior to the year 2000 conducted by Koenig et al found over 100 quantitative studies that examined relationship between spirituality and depression, with the vast majority of these studies finding significantly fewer depressive disorder or depressive symptoms among those scored higher on spirituality scale (Koenig et al,2001). And if spirituality involvement is related to less depression, less anger and hosteling, lower rates of substance abuse, greater social support, and better coping with stress, its showed not be surprising that spirituality is also related to less suicide (Bonelli, Dew R and Vasegh, 2012).

2.2.8 Spirituality: Assessment

In the holistic Nursing approach the assessment of spirituality composes of three axes that are underlying state of individual's spiritual health, which includes:-

1. Meaning and purpose

   This axis assesses a client s ability to seek meaning and fulfilment in the life, manifest hope and accept ambiguity and uncertainty.

2. Inner strengths

   In this axis assess a client's ability to manifest joy and recognized strength, choices, goals and faith.

3. Inner connection:

This axis assess client's position self-concept , self-esteem, sense of self, sense of belonging in the world with others , capacity to pursue personal interest , ability to demonstrate love of self and self-forgiveness, meaning of religious activities ,a connectedness with a divinity , with life , with nature, with environment and capacity for concern for health (Fortinash & Worret, 2012; Dossey, 1998, and Burkhardt, 1989).

There are more than (50) published psychometric instruments which assess spirituality. Some of these instruments assess spirituality in one exists or more than one axis underlying spirituality construct such as spiritual beliefs (Reed, 1986), relationship with God or higher power (Kass, 1991), religious, need of inner peace, Existence needs (Bussing, 2010). However , the psychometric instrument of World Health Organization Quality Of Life, Spirituality, Religion and Personal Belief (WHO-QOL-SRPB,1998) and the psychometric instrument of spiritual well-being (SWB) of Ellison and Paloutzain (1982) found to be more applicable than other assessment tools in the area in mental health and research (Peterman et al, 2002, Genia, 2001).

In this study the spiritual well-being instrument (SWB) by Ellison & Paloutzian have been used to measure an underlying state of spiritual health. This assessment tool of spirituality used in the clinical and research.

2.3 Self esteem

2.3.1 The self and the self-esteem: conceptualization

The self is designated in common speech by the pronouns of the first person singular; me; my; mine and myself as noted by Cooley, 1902(Squirrel, 2017). James, 1910, view the self as having a unity as well as being differentiated and as being intimately associated with emotion (Guenther&Mark,2017). Mead, 1934 noted that the self emerges from a

process of social communication that enables viewing of oneself as a whole, from the perspective of others (Hankin, 2001). Also Sullivan reported that the self develops out of experience particularly out of social interaction with significant others (Robert, 1999).

Moreover, Freud's view the self as a multi-tiered, divided among the conscious preconscious and unconscious. The conscious self is governed by reality principles and unconscious self-embodies or mode of operation that precedes the development of all other forms of our mental functioning (Mungal, 2009).

The term self-esteem comes from a Greek word meaning "Reverence for self". The self-pertains to the value, beliefs, and attitude, that human hold about themselves (Ahmad, 2017; Hewitt, 2009). Self-esteem play a central role in a number of psychological, social &cognitive theories, each of which offers its own definition of the term (Ahmad, 2017; Abdul-Kalek, 2016).

The typology of definition of self-esteem, mostly consisted of three types:

-self-esteem as competence: Early definition was developed by William James 1890. He defined self-esteem in terms of action, in particular, action that is successful or competent.

Thus James definition focus on behavioral outcomes and the degree of discrepancy between one's ideal "self-real self" (Guenther & Mark, 2017; Crocker and park, 2003). James, recognized that human has the capacity to view themselves as objective and to develop feeling and attitude toward self (Nayler, 2010).

2.3.2 Self-esteem as worthiness

Morris Rosenberg, He view self-esteem in terms of a particular type of attitude that is based on the perception of a feeling, a feeling about one's worth or value as person (Mungal, 2009). According to Rosenberg self-esteem is a positive or negative orientation toward oneself; an overall evaluation of one's worth people are motivated to high self-esteem, and having it indicates positive self-regard ,not egotism. According to Rosenberg, self-esteem relies on two factors; the reflected appraised and social comparison. Rosenberg viewed self-esteem as favorable or unfavorable attitude that people have about themselves, which is a result of the influence of culture , society , family and inter personal relationship. He refers self-esteem as positive or negative attitude toward self (Ahmad, 2017).

Robin et al (2012) defined self-esteem as an individual's positive or negative attitude toward the self as a whole. Copper Smith's definition of self-esteem to which the person believes himself to be capable, significant and successful and worth (Guenther and Mark, 2017).

2.3.3 Self-esteem as competence and worthiness

Nathaniel Branded (1969, 1997) defined self-esteem as the "disposition to experience oneself as competent to cope with the challenges of life and deserving of happiness "(Branded, 1997).

Branded view of self-esteem has two interrelated aspects; it entails a sense of personal efficacy and a sense of confidence and self-respect. It is the conviction that one is competent to live and worthy of living (Foddis, 2016).

Also, numerous scholar defines self-esteem such as Elder et al (2012) defined self-esteem is the evaluation one makes toward the self in reference to the self-worth, self-respect and self-acceptances.

2.3.4 Self-esteem theories:-

For many years plenty of researchers regarding self-esteem, there still exist controversies concerning its nature, sources and functions. The most existing self-esteem theories refers to:-

- **Traditional theoretical approach:**

William James, referred self-esteem to interpersonal sources (Nayler, 2010). James pointed out that each person is born into a self of possible social roles or identities created by factors such as history, culture, family, interests, and circumstance. Over time people find themselves becoming invested in some of these "selves "more than others, which creates certain priorities. Over the same time person's also develop an overall sense of how well or poorly we have lived up to these expectations, which give individuals their self-esteem and an "average feeling tone "(Nayler, 2010). James view self-esteem is something that involves areas of life that matter to a person in terms of the individual's identity, how well the person has done in them, and the fact that the person must continue to be concerned with them over time (Hewitt, 2005).

Adler, understood self-esteem in terms of drive toward superiority that motivated people to reach higher levels social status (Fortinash & Worry, 2012).

2. Social learning traditional approach

This approach referred self-esteem to interpersonal character. The psychologists Cooley; 1902; Mead, 1945 and Sullivan, 1953).They

identified that the self-esteem emerges from a process of social communications that enables viewing of oneself as a whole, from the perspective of significant others (Squirrel, 2017; Guenther & Mark, 2017). Rosenberg, 1965 pointed out that understanding self-esteem as attitudinal phenomena created by social and cultural forces and added that self-esteem is built on an evaluation of the self in comparison with others (Nayler, 2010; Mungal, 2009). Rosenberg defined self-esteem as positive or negative toward a particular object namely the self (Ahmad, 2017).

Cooper Smith at about the same time as Rosenberg, identified that self-esteem based on worthiness & social learning and it begins early life. The self-esteem builds or falls from that early childhood baseline through positive and negative experience. Cooper Smith added that self-esteem is learned and could be modify it when necessary (Lachowicz-TabaczeK & Sniecinska, 2011).

3. The humanistic traditional self-esteem approach

Abraham Maslow, 1954, regarded self-esteem as a basic human need (fig_1_) that plays role in both development and behavior. Also, Rogers, 1961 referred self-esteem in regard to self-acceptance and congruence and which are seen as necessary for healthy human functioning (Townsend, 2009).

According to the humanistic perspective, self-esteem emerges naturally in the stage of development, providing an individual receives a sufficient degree of unconditional positive regard (Ismail &Mustafa, 2015).

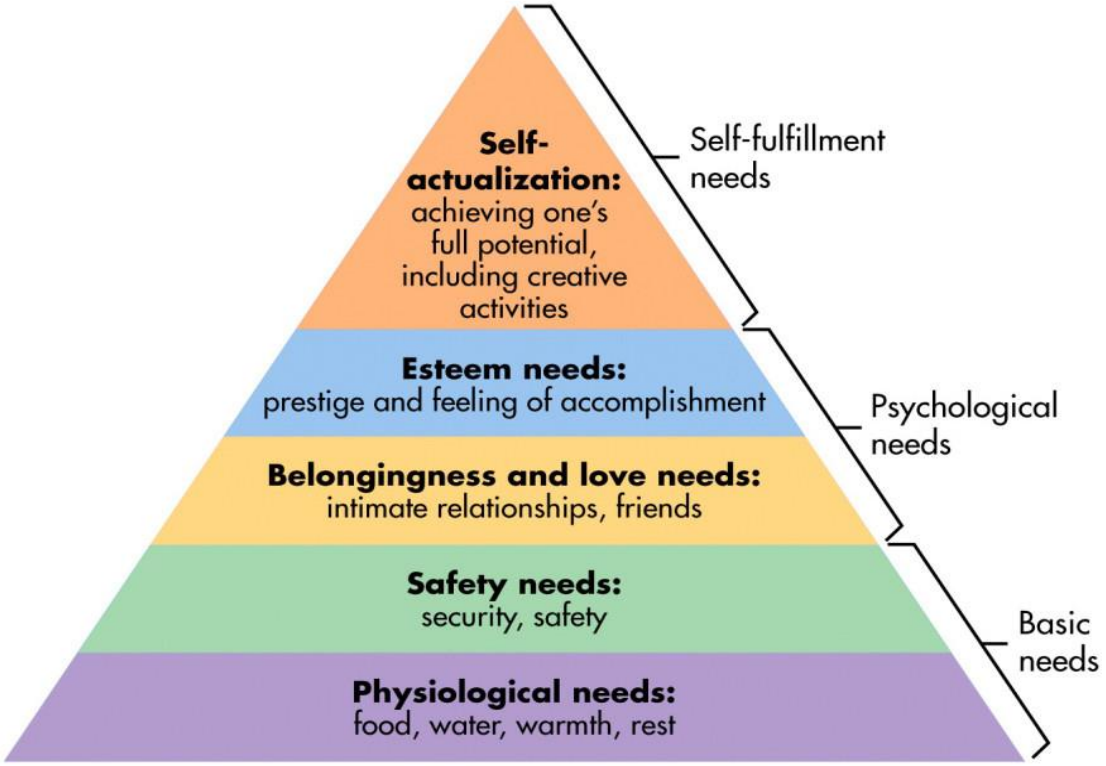

Fig. 1 : Maslow's Hierarchy of need

4. Cognitive experimental self-theory approach

This is one of the first cognitive theories of self-esteem developed by Seijmour Epstein (Epstein, 2012)

According to this approach that humans operate by two fundamental information-processing system; a relational system and an experimental system. The two systems operate in parallel and are interactive individual automatically construct an implicit theory of reality in their experiential system. (Kernis, 2006)

Epstein's, as noted, there are two facet of self-esteem with each system self-esteem as a belief and self-esteem as a need or motive. The self-esteem as belief in the rational correspond to a person's conscious evaluation of the self (Epstein, 2012) self-esteem influences behavior, thoughts and

emotions in its capacity both basic schema and as basic human need (Epstein, 2012).

5. The evolutionary Approach

This is called sociometer theory. Heatheron and Wyland pointed that people appear to possess a psychological mechanism (sociometer) that monitors their interpersonal worlds for information relevant to relational value, alerts them through unpleasant emotions and lowered state of self-esteem when their relationship value is lower than desired or declining and motivates behavior that helps to enhance relational value and hence self-esteem (Leary, 2005; Heatherton and Wyland, 2018).

2.3.5 Self-esteem and depression: models of relationship

Self-esteem and depression are strongly correlated, yet little about their prospective effects on each other (Orthodox, Robin and Widaman, 2012).

1. The vulnerability model: this model states that low self-esteem is a risk factor for future depression. Low self-esteem might contribute to depression through interpersonal and intrapersonal pathways (Donnellan et al, 2005; Ottenbreit & Dobson, 2004).

- The interpersonal pathway is that individuals with low self-esteem seek negative feedback from their relationship's partners to verify their negative self-concept, which may further degrade their self-concept (Joiner2000), low self-esteem motivates social avoidance, there by impendency social support which has been linked to depression (Murray et ale,2002). The individuals with low self-esteem engage in anti-social behavior such as aggression and substance abuse that might contribute to their feeling excluded and alienated from others (Donnellan et al, 2005).

- An intrapersonal pathway contributes to depression through rumination. The tendency to ruminate about negative aspects of the self is closely linked to depression (Jelena &Alloy, 2001).

2. The scar model: this model is in contrast to the vulnerability model state that low self-esteem correlates of depression and it might be a consequence of depression rather than a causal factor. It is conceived that the self-esteem permanently changed by the experience of depression (Shahar & Davidson, 2003). Depression might impair an individual's self-esteem through intrapersonal pathways. A possible intrapersonal pathway is that experience of depression might influence self-esteem by persistently alerting the way in which individuals process self-relevant information. The chronic negative mood associated with depression may lead the individual to selectively attend to, encode, and retrieve negative information about the self, resulting in the formation of more negative evaluation. An interpersonal pathway is that depressive episodes may damage important sources of self-esteem such as close relationship or social networks, or depression might change how the individual is perceived by others (Joiner, 2000).

3. .In addition to the vulnerability model &scar model, the common factor model argued that self-esteem and depression are essentially one construct and should be conceptualized as opposed endpoint on a continuum (Watson, Suls & Haig 2002). They added that low self-esteem and depression are both assumed to drive from the broader construct of negative emotionality.

4. The contemporary models of depression emphasized the role of low self-esteem in the etiology of depressive disorder (Evraire & Dozois, 2011, Morley & Moran, 2011). Swislo and Orths (2013) devised two models, the

vulnerability and scar models in their metal-analysis longitudinal study, found a total of 53 studies published in the year,1984,2000,2010. The study indicated that low self-esteem had role in causes of depression. In addition, other studies suggested that self-esteem fluctuation is a factor in the etiology and maintenance of depression. Low self-esteem is more prevalent among depressed people and can predict a depression onset (Kernis, 2006). However, a major problem exists in examining the relationship between self-esteem and depression, self-esteem may be part of definition of an illness and in no way a causal (Uba et ale, 2012). The findings by Franck et al, (2007), revealed that low self-esteem on its own dose not predict future episodes. Nonetheless it may do so interaction with other factors such as stress, hopelessness.

2.3.6 Low self-esteem: characteristics

Individuals with low self-esteem are believed to be psychologically distressed and perhaps even depressed (Kernis, 2005). People with low self-esteem see the world through a more negative filter and their general dislike for themselves colors their perception of everything around them. Substantial evidence shows link between low self-esteem and depression, shyness, loneliness and alienation. Low self-esteem is aversion for those who have it (Altman & Roth, 2018). According to Rosenberg. On individual with a high level of self-esteem considers himself a person of worth, and to low self-esteem means that the individual consider himself inadequate and deficient as a person (Kernis, 2005). The most common characteristics of individuals with low self-esteem they have negative feeling of life, perfectionist attitude, mistreating others, blaming behavior, fear of taking risk, feeling of being unloved and unlovable and dependence; letting others make decisions (Ahmad D ,2017).

2.3.7 Self-esteem: measures

There are several measures of self-esteem; unfortunately, the majority of these measures have not performed. And some measures are better than others. The instruments that measures self-esteem generally fall into one of four categories each with certain limitations: behavioral trace report, direct observation, projective techniques and self-report (Robins, 2012; Schmitt, 2005).

A study reviewed 35 self-esteem measures had pointed out four to be superior: Rosenberg's self-esteem, the Janis-Fielcl feeling of inadequacy scale, the cooper smith self-esteem inventory and the Tennessee self-concept scale (Heatheron &Wyland, 2018). In experimental test of eight measures of self-esteem including projective, interviews, self-report and peer rating, Diene, 1985 found that the Rosenberg and cooper smith scale performed best in the factor analysis (Altman &Roth, 2018).

The majority of self-esteem research has focuses on the global level of self-esteem the individual's positive or negative attitudes toward the self as totality. The Rosenberg self-esteem scale is the most widely used measure of global self-esteem. It was used in 25% of the published studies (Abdul-Kalek, 2016). Rosenberg reported that the scale is correlated modestly with mood measures (Ahmad, 2017). Rosenberg scale focuses on people's general feelings toward themselves, without referring to any specific quality or attribute. The scale normally consist of ten-item, half of them are worded in positive direction and the other half are worded in a negative direction, the items scored on a four-pointed response-system that requires participants to indicate their level of agreement with a range of statements about themselves (Gardner,2003). The Rosenberg self-esteem scale translated into more than 20 languages, across the nation's (Schmitt, 2005).

The social behavior traces inventory, (Helmreich & Stamp, 1974). This scale actually measures how comfortable and competent a person feels in social situations. A person can be uncomfortable in social situations and still like himself in general. Alternatively, a person can be relaxed and outgoing with others but not like self in general. For this reason, the Rosenberg is the appropriate one to use for measuring self-esteem (Salgado, 2010). The cooper Smith self-esteem inventories 1967, (CSEI) have two forms. One form for the adult (CSEI-AD) and the other school form (CSEI-SC). The CSEI-AD instrument typically discriminated between subjects with high & low self-esteem. This inventory consist 58 items with two responses "like me" or "unlike me" and measures person's attitude toward oneself in general, and in specific aspects such as peer, parents, school, and personal interest (Dutt and Dani, 2010).

Another self-report measure developed by O'Brien and Epstein,1983.This is multidimensional self-esteem inventory assess the global and situational self-esteem, it is based on a coherent model of self-concept and self-esteem, measures global self in eight components: competence, lovability, likability, personal power, self-control, moral self-approval, body appearance and body functioning (Epstein,2012).

2.3.8 Low self-esteem: in nursing process

Self-esteem derived from self and others. Low self-esteem disturbance, described as negative feelings about the self, including the loss of confidence, sense of failure to reach the desire, self-criticism, reduced productivity, feeling of inadequacy, irritable and withdrawn socially. (Fortinash & Worret, 2012). Greif is the painful psychological and physiological response to loss. Although it is most commonly associated with death of loved one, grief occurs when there is any significant loss, including loss of self-esteem; identity, dignity or sense of worth (Boyd,

2008). Greif an accompanied by guilt about sustained loss of self-esteem and ambivalence about living is an indication that suicide risk increased and help is needed for such people. Low self-esteem is primarily common among major depression disorder (Ahmad, 2017).

The nursing diagnosis for low self-esteem as identified by North American Nursing Diagnostic Association (NANDA, 2012):-

4. Risk for social isolation: withdrawing behavior associated with low self-esteem.
5. Self-concept Disturbance: low self-esteem associated with dysfunctional grieving.

- Goal: client can build trusting relationship with others
- Nursing interventions:

- Construct a trusting relationship and create safe and peaceful environment.
- Give client the opportunity to express feelings.
- Listen to the client
- Tell the client that he/she is someone who is valuable and responsible and able to help themselves
- Discuss meaning of loss or change
- Identity and build on client's strength
- Give positive reinforcement on reality (NANDA, 2012).

- In mental health setting, caregivers assist client in building self-esteem needs through acceptance, expectations and involvement (Morrison-Valfree, 2005):-

a- Acceptance means that caregivers acknowledge clients as human beings worthy of respect and dignity. Although clients may behave in maladaptive or unacceptable way they are still worthy of respect. Correcting or refocusing the behavior instead of the person spares self-esteem.

b- Expectations play a role in the development of client's abilities to meet self-esteem needs. Assume that clients are capable of achieving success, but assessments based on reality.

c- Involvement is the process of activity interacting with the environment and those people within it. When clients are involved, they are actively sharing. These experiences foster ego strength and feelings of worth and importance. Involvement offers opportunities to modify ineffective behaviors and try out new ones. Therapeutic settings that focus on involvement use cooperation, compromise, and confrontation to bring about behavioral control, effective social interactions and a sense of self-esteem worth in clients.

Hope and hopelessness

2.4.1 Hope: conceptualization

Various conceptualization of hope given by different authors, each gave a different definition in their word. Hearth (2000) defined hope as a motivational and cognitive attribute that is theoretically necessary to initiate and sustain action toward goal attainment. Peterson and Seligman (2004) defined hope as a cognitive, emotional and motivational stance towards the future. In regard to Snayder and Lopez (2005) hope includes a belief that one knows how to reach one's goals (pathways) and a belief that one has the motivation to use those pathways, to reach one's goals (agency).

Narula (2017) conclude that hope has the ability to not just reflect optimism and positivity in the coming times but also absorbs one in deep sanguinity in the present future. She added that we have no guarantee about future, but we exist in the hope of something better.

2.4.2 Hope: theories

- **Cognitive hope theory (Snayder theory of hope)**

Snyder's hope theory: Have two cognitive competent pathways which are ways power and willpower to goal achievement (Huen, 2016). The way power is a process that involves identifying goals, and finding way to achieve goals despite obstacles. Willpower involves a general belief in one's own ability to achieve goals (agency beliefs). Hope inhibits handicapping and self-deprecatory thoughts, as well as negative emotions (Narula, 2017).

Everyone has the right to life, liberty and pursuit of happiness (White, 2013). Snayder and Lopez (2005) noted that happiness as a positive emotional state that is subjectively defined by each person. It encompasses living a meaningful life, utilizing gifts and time, living with thought and purpose (flora, 2016).

- **The broader-build theory**

It suggests hopeful people might begin to harness the beneficial effects of positive emotions to optimize their own well-being by regularly finding positive meaning within the daily ups and downs of life (Nourula, 2017). The PERMA model based on this theory includes positive emotions, engagement, relationship, meaning and achievement/accomplishment. These expectations facilitated by focusing on their strength and using an optimism mind set (Peterson &Seligman, 2004).

1.4.3 Hope: components

Snyder and Lopez (2005) subdivided hope into four categories

- Goals: it is the anchors of hope as they provide direction and endpoint for hopeful thinking

- Pathways-thought: refer to the routs individuals take to achieve the desired goals and the individuals perceived ability to produce these routs
- Agency thought: refers to the motivation individuals have to undertake the routs toward the goals.
- Barrier: block the attainment of individual's goals and in the event as a barrier one can either give up or can use pathway thoughts to create new routes.

Goal attainment has been found to be associated with positive emotion whereas goal blockages are related to negative emotions (Flora, 2016).

2.4.4 Hope: measurements

Researchers have developed measurement tools that assess levels of hope as well as agency and pathway thoughts, the purposes of such assessments for those who are low in hope in an educational setting, and individuals seeking psychological treatment for war veterans who suffer from post-traumatic stress disorder (Lopez et al, 2000).

The Adult state hope scale Lopez et al (2000) which assess goal directed thinking in any given moment or situation . This scale measuring state hope rather than trait hope. Other measures created the children's hope scale by McDermott (1997).

There are several criticisms of hope theory and it's measurement that can be applied to all of the questionnaires assessed so far. First, it may be that hope levels remain the same no matter what situation an individual is in, rather the goals one's aim for differ. Second older adults may face many barriers to hope such as declining physical health or the loss of significant others. However some older people may be able to continue hopeful thinking in the face of these barriers (Chang and Banks, 2007). In conclusion hope can be measured using quantitative measures that cover

the main types of hope; the quantitative measures are less developed (Hanson, 2009; Chang and Banks, 2007).

In a study conducted by Arnau (2007) tested the prospective effects of hope on depression and anxiety and found that no unique effects of the pathways components of hope on depression and anxiety. In other study carried by Thimm et al (2013) to explore hope and unrealistic optimism in clinically depressed individuals using Snyder hope scale, 1991, the results suggested that recovery from depression is not necessarily accompanied by the restoration of normal levels of hope. Clinically depressed individuals are being more hopeless and having less positive and more negative expectation for the future. Never the less it makes an important contribution to understand the hopelessness in depression rather than from preconceived theoretical position of hope and depression (Alarcon et al, 2013).

2.4.5 Hopelessness: conceptualization

Hopeless means feeling or causing of despair (Cambridge English Dictionary, 2018). Having no expectation of good or success (Merriam-Webster Dictionary, 2018) or feeling causing despair very bad or incompetent (English Oxford Dictionary, 2018). Hopelessness means a feeling or state of despair or lack of hope (Zhi, 2004).

Hopelessness can be defined as a manner of thinking and feeling which frames life with negative perceptions of the present and bleak expectations about the future (Baptists et al, 2014). It is a subjective emotion which has a negative view of point for the future, one of losing control, confidence, courage and energy to reach one's goal (Marcus, 2010).

Huen et al (2016) defined hopelessness that is a powerful emotion that often contributes to low mood and may adversely affect the way one perceives the self, others, circumstances and even the world.

Hopelessness can have a significant influence on human behavior as it may reflect an individual's negative of the future. Feeling of hopelessness can often lead an individual to lose interest in important objects, activities, events, or people someone who has become helpless may no longer value things that were once important (Sandler, 2012).

Hopelessness may be a symptom of a variety of mental health conditions, hopelessness closely highly related to depression, hopelessness without depression means despair and negativity (Liu et al, 2015; Downman, 2008). Hopelessness can threaten patient's physical and psychological well-being and affect the process of recovery and rehabilitation (Shi et al 2011).

2.4.6 Hopelessness theories

Hopelessness can be interpreted through Abramson's and Beck's theories of depression:-

1. Abramson's theory

   The hopelessness theory attributes depression to a pattern of negative thinking in which people blame themselves for negative life events, view causes of those events as permanent and overgeneralized specific weakness to many areas of their life (Liu et al 2015).

   Hopelessness theory predicted also that the interaction between negative cognitive styles and negative life events engender a sense of hopelessness. This hopelessness in turn was hypothesized to be sufficient by itself to bring about depression (Fortinash & Worry, 2012).

In this Regard Liu et al (2015) noted that helplessness is viewed as one component of hopelessness perceived lack of control over events assumes a less central role symptom of depression relating to a apathy and luck of motivation, sad affect, negative outcome expectancy and believed to flow from this condition of hopelessness.

2. Beck's cognitive theory:

This theory is based on cognitive perceptions and basically hopelessness is interpreting on a negative trial that involves a negative view of itself, personal world and future (Fortinash and Worret, 2012).

This theory basically stated that depression prone individuals have a negative view of themselves, seeing themselves as worthless, unlovable and deficient, they have a negative view of their environment, seeing it as overwhelming, filled with obstacles and failure; and they have a negative view of their future seeing it as hopeless and believing that no effort will change their lives. These three factors were called the cognitive triad. The negative way of thinking guides one's perceptions, interpretation, and memory for personally relevant experience, there by resulting in negative based worldview and leading to depression (Liu et al, 2015, Downman, 2008; Allen, 2003).

2.4.7 Hopelessness measurements

Hopelessness may represent a temporary response (state) or a chronic outlook (trait). The common hopelessness measures are:-

The Beck hopelessness scale, 1974 is a widely used questionnaire in psychology and health care research. The Beck hopelessness scale (BHS) is a 20 items true/false scale that is based on three dimensions of

hopelessness (a) affective (b) motivational (c) cognitive expectations (Dunn et al, 2014).

Although the BHS is commonly used, much of hopelessness research has used subscale of other psychological measures. Kangelaris et al (2010) used a two-item hopelessness scale. Other state-trait hopelessness scale (STIHS) is a measure use in clinical setting and research (Dunn et al, 2014).

2.4.8 Hopelessness and depression:

A person experiencing feeling of hopelessness generally anticipates that there is no way for life to improve; upholding the belief that individual is powerless in effecting any positive change (Baptista et al, 2014). According to the Abramson's hopelessness theory of depression, hopelessness is a proximal and sufficient cause of a specific subtype of depression. Hopelessness is viewed as the expectation that highly desirable outcomes will not occur or that highly aversive events will occur, and hopelessness mediates the relation between the negative cognitive style (the tendency to attribute negative events to stable, global causes) and increases in stress-related depressive symptoms (Downman,2008).

Several studies have supported the general association between hopelessness and depression, as well as the prediction that the attributional style-depression relation is mediated, at least in part by hopelessness (Joiner, Metal Sky , 1995). Hammen (2005) stated that depressed people, at least in part, generate their own negative life stress.

Hopelessness in the depressed patient is extremely dangerous as the hopeless person is not only expressing depressed mood and behavior but perseverates on the pessimistic view that life is unbearable and positive change is unfathomable (Barker 2009).

In examining personality traits and disorders related to suicidality, four aspects of personality most closely associated with increased risk of suicide are: hostility, impulsivity, depression, and hopelessness (Skinner, 2012). Various studies consistently reported that hopelessness as a key variable in linking depression to suicidal behavior (Huen et al,2016) Britton et al (2008) pointed that hopelessness is found to correlated better with suicidal ideation than depression and is more precise than depression in predicting eventual suicide. A person whose thoughts are hopeless and rigid may conclude that suicide is the only choice. The hopeless person may view death as a mean to an end, an opportunity to escape the pain experienced in life.

In addition the impact of hopelessness leads to a lack of adequate coping skills. A person who is experiencing the conceptual feeling of hopelessness tends to think in extremely narrow term. This range of understanding of situations and potential choices that may be available for problem resolution. Maladaptive coping skills most certainly correlated with increased feeling of hopelessness in depressed patients with suicidal ideation (Kaviani et al, 2011). Some patients may deny feeling of hopelessness or depression and focus on identification of various somatic complaints as physical symptoms are more socially acceptable than those of psychological nature (Flora, 2016).

2.4.9 Hopelessness and self-esteem

Self-esteem has been implicated as a vulnerability factor in onset of depression in number of theoretical models e.g. Beck, 1996. The psychosocial model of Brown and Harris's, 1978 stated that low self-esteem will increase the chance of general appraisal of hopelessness. This

common pathway of hopelessness is the key factor in the genesis of clinical depression (Brown et al, 1986).

Hopelessness has also been purported to mediate the relation between life stress and depression in the hopelessness theory of depression by Abramson, Metalsky & Alloy, 1989 (Fortinash & Worret, 2012). In this regard the findings by Franck et al (2007), and Simpson et al (2012) revealed that low self-esteem on its own dose not predict future depressive episodes. Nevertheless, it may do so in interaction with other factors such as severe stress (Brown et al, 1986), loneliness (Savikko et al, 2005) and hopelessness (Britton, Duber Stein and Conwell, 2008).

2.4.10 Hopelessness and spirituality:

There is growing awareness that spirituality and religion can contribute to a person s sense of well-being (Myers, 2000). Researchers exploring how spirituality and religion aid in coping with stressful life events (Lorenz et al, 2019) studies have shown that those who attend worship frequently are less depressed than those who rarely attend (Koenig et al, 1997; Nolen-Hocksema and Larson, 1999). An interaction of religious and spiritual practices and negative life events points to the mobilization of these practices as a way of coping (Ellison, 1991).

Theories of depression have described hopelessness as one of its major characteristics in clinical depression (Sandler, 2012). In a sample of persons with clinical depression, Young et al (2007) found that, when not depressed, those who were more religious and spirituality practices involved were less hopeless. Other study suggested that religion and spirituality can be strength resources or a burden for those with depression (Philip Larkin and Pargament, 2002).

One of the primary goal of spiritual strategies used to hold on to hope. Keeping hope alive were through spiritual rituals, May lead to identified the positive outcomes of seemingly negative life events and may improve hopelessness and depression (Mortis et al, 2011).

2.4.11 Hopelessness nursing process

Hopelessness within the nursing process should be multifaceted innovative and detail in order to address all causal factors associated with client's diagnosis (Lynda, 2008).

A through comprehension of all aspects of hopelessness is necessary in determining the most effective treatment modalities based on the clients individual's needs (Morrison-Valfree, 2005).

The planning and implementation of nursing intervention surrounding the concept of hopelessness first beings with formation of a therapeutic relationship between the nurse and client in which trust, respect, honesty, acceptance and effective communication are para amount (Fortinash and Worret,2012).

The nursing intervention of hopelessness

Let the client to: -

- Understanding hopelessness, recognize hopeless thought and statement.
- Identity where the feelings of hopelessness are coming from (Loneliness, low self-esteem, feeling discouraged, dissatisfied, distressed or experiencing negative of events)
- Find something to appreciate, change to improve life.
- Adjust the view of happiness (inner happiness can't come from outer sources).

- Set achievable goals (breakdown the big goal into smaller sub goal so process can more easily observed.
- Get social support, Exercise, nutrient diet and consult therapist.
- Practice being mindful by focusing here and now technique. Don't judge self about failure (Miller, 2017).

In conclusion, both hopefulness and hopelessness represent opposite expectations. Whereas there is a foresight in hopefulness where the planes to reach the goal will be achieved, a presupposition of failure is present in hopelessness. These two extreme expectations vary from person to person or situations to situation according to when and how the anticipate situation will come about (Sandler, 2012; Huen et al, 2016).

2.5 Previous studies:-

1. Yousafzai and Siddiqi, (2007) carried out air study entitled "Association of lower self-esteem with Depression: A case control study "in Pakistan. The objectives to estimate the level of low-self-esteem in index depressed patients and compare them with their first degree relatives to determine low self-esteem as a risk factor for depression. The case control study (150 cases and 150 controls) was conducted on adult depressed patients (cases) and their healthy first degree relatives (controls) attending psychiatric outpatients clinic of the Aga Khan university hospital, used convenient method of sampling from April 1,2005 to September 1, 2005. Self-esteem was measured by Urdu version of Rosenberg self-esteem scale. Logistic regression was applied for multivariate analysis. Results out of 300 (169 males 131 females) participants, 216 (75%) were married. Cases and controls were fairly matched on socio demographic variables except on marital status, educational level and monthly income that showed significant difference. Main logistic regression shows that depressed

patients had significantly lower self-esteem than non-depressed population (p= 0.001) male gender had lower self-esteem. Self-esteem increased with advancing age, age group (55-65) had the highest level of self-esteem (p=0.005). Undergraduate had significantly lower level of self-esteem (p=0.005). Depressed patients, having the illness for more than one year, were (2.75) times likely to have lower self-esteem (p=0.001). The researchers concluded that the assassination of depression and low self-esteem as a state was replicated. Duration of illness and male gender were significantly associated with low self-esteem.

2. Moritz and others (2011) conducted out a study entitled "A spirituality teaching program for depression qualitative findings on cognitive and emotional change "in Canada. A total of (15) interviews were purposefully sampled from trial population. The intervention consists of audio CDs for home- based use that delivered lectures about spirituality, suggested behavioral applications and included relaxation practices. Results indicated that participants described an expanded spiritual awareness, characterized by a sense of connection with self, others, the world and universal energy. The primary influences participants reported occurred as a result of practicing forgiveness, compassion, gratitude and acceptance in their daily lives and included reduce negative thinking patterns, being less judgmental, reduced ego-centricity, and improved self-esteem, improved mood characterized by reduced anxiety and \or depression, mental clarity, calmness and improved relationship.

3. Uba and others handled a study in 2012 entitled "Dose self-esteem mediate the relationship between loneliness and depression "among Malaysian teenagers. The participants of the study were 242 subjects (119 males and 123 females). Depression was measured using children depression inventory, loneliness was measured using UCLA loneliness

scale and self-esteem was measured using the Rosenberg self-esteem scale. The study discovered that self-esteem had negative and medium correlation with loneliness crops=-. 380, p <. 01) And depression (r=. 493, p <. 01). Self-esteem was found to be both the unique predictor of depression and a partial mediator of the relationship between loneliness and depression.

4. Avila MF, in 2014 carried out a research entitled "self-esteem, spirituality and acculturation and their relationship with depression in Latinos" in university of Denver, Colorado. Adult sample of participants was solicited from the community and included (110) Latino participants from various ancestries of origin. Acculturation was measured by the Bidimensional Acculturation scale for Hispanics, self-esteem by the Rosenberg self-esteem scale and spirituality by the Brief multidimensional measure of Religiousness\spirituality scale. The outcome variable, depression was measured by the center for Epidemiological studies depression scale. Statistical hierarchal multiple regression was used the results showed that participants who endorsed lower levels of self-esteem tended to endorse higher rates of depression (p<0.01). Further participants who endorsed lower levels of spirituality, specifically in forgiveness, predicted higher level of depression (p<0.01). Lower socio-economic status was found to be associated with higher depression scores. The relationship between acculturation and depression was non-significant (p >. 05). The researchers recommended that the clinical implication of the study include adding to the understanding of factors that affect depression in Latinos and the importance of cultural competence when working with such type of population.

5. Baptist, Carneiro and Cadoso carried out a study in 2014 titled "Depression, family support and hopelessness: a correlated study in Brazil. The Beck hopelessness scale, support family scale, Baptista depression

Adult scale and sociodemographic questionnaire on a sample of (198) undergraduate of pharmacy and psychology courses of Sao Paulo university with mean age of (23-44)years, SD ± 6.8 and with a prevalence of women (80.7%). Results showed a significant and positive correlation between depression and hopelessness, (p>0.01), and significance negative correlations between depression, hopelessness with social support indicating that the higher perception of family support the fewer depressive symptoms and hopelessness (p>0.01).

6. Wittink and others, 2009 directed their study entitled "Losing faith and using faith: older African American's discuss spirituality, religions activities, and depression ", aimed to understand how spirituality may play a role in the way they conceptualize and deal with depression. The design was cross- sectional qualitative interview study, sample size (47) older African American patients required from primary care practices in the Baltimore, MD area. The measurements used semi-structured interviews lasting approximately 60 minutes. Interviews were transcribed and themes related to spirituality in the context of discussing depression were identified using a grounded- theory approach. The main results were participants in a study held a faith-based explanatory model of depression with a particular emphasis on the cause of depression and what it do about it. Specially, participants described depression as being due to a "loss of faith and spirituality/ religious activities were thought to be empowering in the way they can work together with medical treatments to provide the strength for healing to occur. The researchers concluded that the participants of the study described an intrinsically spiritual explanatory model of depression. Addressing spirituality in the clinical encounter may lead to improved detection of depression and treatments that are more congruent with patient's belief and values.

7. Mihaljevic and others 2015 conducted their study entitled "spirituality and its relationship with personality in depressed people: preliminary finding ", in Croatia. The sample consisted of (85) consecutive outpatients treated for depression. The measurements used were: Beck Depression inventory, WHO-quality of life-spiritual, Religious, personal Beliefs, and treatment and character inventory. The results have shown that higher harm avoidance, the lower self-directness and lower cooperativeness are personality dimensions associated with depression. The spiritual QoL has showed to play a significant ($p \leq 0.05$) role in depression, Just as it has proved to be a unique predictor of lower depressive symptoms, adjusted for personality dimensions. The study suggested a more comprehensive understanding of depression, spirituality and personalit

Chapter Three
Methodology

CHAPTER THREE

Methods and patients

This chapter describes the patient and methods that was used to achieve objectives of this study. Chapter three presents the design, administrative arrangements, the setting and the sample of the study, questionnaire development, validity, pilot study and reliability of the questionnaire. This chapter also includes the procedure of data collection and data analysis.

3.1. Design of the study

A quantitative-descriptive design was used in order to achieve the aim of the study by using assessment technique to describe the studied variables which includes spirituality, self-esteem and hope on community Patient with major depressive disorder. The study was carried out from December, 10th, 2017 to October, 1st, 2019.

3.2 Administrative Arrangement

An official permission is obtained from Ministry of Health/Directorate of health (DOH) in Sulaimani to Ali Kamal consultation center to get their help & cooperation for the researcher to conduct this study (Appendix A).

The Director of psychiatric clinic in Ali Kamal consultation center was informed about this study and permission has been granted to interview patients for data collection. Also, ethical approval for the use of the questionnaire of this study has issued by research ethical committee of the college of medicine/university of Sulaimani (Appendix B).

Verbal informed consent was taken from patients and relatives before patients participating and interviewing by the researcher for data collection.

3.3 Setting of the study

This study carried out at Psychiatric clinic in Ali Kamal medical Consultation Center which is affiliated to the Teaching Hospital in Sulaimani City.

The psychiatric clinic is the only consultation clinic that provides outpatient mental health services in Sulaimani city.

Around 30-35 patients attending the department daily for diagnosis, follow up treatment or referral to Mental Health Center if needed. Most patients are previously diagnosed by the consultant psychiatrists working in the clinic. The clinic includes three rooms, one room for the nurse and administrative staff, one room for the consultant psychiatrist, and the other room for the doctors.

3.4. Sample of the study

3.4.1. Sample size estimation

This is confirmed by a power analysis conducted out by using G-power correlation model and the approximate sample size was calculated to be at least (130) patients are needed with medium effect sizes of 0.5 - 0.8 power, with 95% confidence interval, and level of significant (p-value) of 0.05.

3.4.2. The sample of the study

A non-probability, convenience sample of 150 patients previously diagnosed with major depressive disorder were recruited from consecutively attended the psychiatric department during the period from January 28th, 2018 to May, 1st, 2018. The sample was selected according to following criteria.

Including criteria

- Patient who have a diagnosis of major depressive disorder, non-psychotic as assessed by the consultant psychiatrist.
- Patients, males and females, who their age 18 years and above.
- Patients who were on regular treatment.
- Patients and relative accepted to participate in this study and informed consent obtained by them.

Exclusion criteria

- Patient who have a diagnosis of major depressive disorder with any co-morbid psychiatric or medical illness.

3.5 The study instruments

A questionnaire was developed by the researcher of this study to measure the variables underlying the present study mainly to assess spirituality, self-esteem and hopelessness among patients diagnosed with major depressive disorder.

The development of the questionnaire is based on the following resources:

- Extensive review of available literature, related previous studies and measurement tools.
- The use of the following standardized scales used in previous studies:
- Spiritual well-being scale (SWBS) (Elison- Paluzian, 1982)

The researcher of this study obtained the author's permission to utilize the SWBS. The SWBS used in clinical and health care studies (Carter L, 2015, Peterman et al, 2002, Genia 2001, Fehrin et al, 1997).

- **Rosenberg Self-Esteem Scale (RSES).**
- This scale most widely used measure in psychosocial and nursing studies (Ahmad D., 2017, Gradi, 2009, Schitt and Allik, 2005).

- **Beck Hopelessness Scale** (BHS)

The BHS measures the extent of negative attitude or pessimism features and used primarily with adult depressed, drug abuse and suicidal patient in clinical and research purpose (Fraser et al, 2017, Dunn et al, 2006, Velting, 1999).

The questionnaire consists of five parts

Part one: Patients Socio-demographic characteristics

This part includes age, gender, marital status, educational level, occupation, residual area and economic status.

Prat two: Patients Psychiatric history

This part includes duration of illness, number of hospitalization, suicidal attempts and family history of mental illness.

Part three: Spiritual Well-being scale (SWB)

This is a list of 20 items scale composed of two 10-item subscales; religious well-being (RWB) and existential well-being (EWB).

Even number items are part of the EWB subscale and an odd number items comprise the RWB subscale. The SWB scale items are scored on a 6-point modified Likert style scale with responses ranging from strongly agree to strongly disagree. Higher number represent greater spiritual well-being. Eleven items of the SWB Scale are phrased in positive wording (item No. 3,4,7,8,10,11,14,15,17,19 and 20) which are rated as (strongly agree=6, moderately agree=5, agree=4, disagree=3 moderately disagree=2, strongly disagree=1) with the nine negative wording items (items NO.,1,2,5,6,9,12,13,16 and 18) which are being rated in reverse score (strongly disagree=6, moderately disagree=5, disagree=4, agree=3, moderately agree = 2, strongly agree = 1). Total SWB score range from 20 -120, and scores categorize as:

Scoring

20 - 40 low spiritual wellbeing

41 - 99 moderate spiritual wellbeing

100 - 120 high spiritual wellbeing

Part four: Self-esteem scale

This part includes 10- statements which are scored on a four-point rating type scale ranging from strongly agree to strongly disagree, it is a self-evaluation of individual self-esteem. Five statements of SES (NO. 1,2,4,6and 7) are rated in positively framed direction and as (strongly agree=3, agree=2, disagree=1, and strongly disagree=0) with the five statements (NO. 3,5,8,9 and 10) are rated in reversed in valence as strongly agree=0, agree=1, disagree=2 and strongly disagree=3. The scores range from 0-30, the higher score, the higher the self-esteem.

SES-SCORING

0-14 low self-esteem.

15-24 moderate self-esteem.

25-30 high self-esteem.

Part five: Hopelessness scale

This part includes a list of 20 true – false items with total score ranging from 0-20. The responses are compared with scoring template. It is designed to measure the extent of the respondent's negative attitudes about the future in three major aspects of hopelessness; feeling about the future, loss of motivation and expectation.

Scoring Template:

No. of Item	Response	No. of Item	Response	No. of Item	Response	No. of Item	Response
1	False	6	False	11	True	16	True
2	True	7	True	12	True	17	True
3	False	8	False	13	False	18	True
4	True	9	True	14	True	19	False
5	False	10	False	15	False	20	True

Scoring	**Interpretation**
0-3	minimal hopelessness
4-8	mild hopelessness
9-14	moderate hopelessness
15-20	sever hopelessness

- Scores above 9 considered to be a clinical cut-off. Implying this client is greater risk for suicide.

The questionnaire (Appendix C) was translated into Kurdish language (Appendix D). The forward-backward procedure was applied to translate from English into Kurdish, and then translated back into English language by two bilingual experts in the department of English language in the college of languages, University of Sulaimani.

3.6. Validity of the questionnaire

Face validity is used to ensure that the measure is actually measure what it is intended to measure (Johanson and Kuby, 2007).

The face validity of the present study questionnaire was determined through a panel of 19 experts (Appendix E) used to investigate the items of the

questionnaire for clarity and adequacy in order to achieve the objectives of this study.

The preliminary questionnaire form was presented to each expert for the determination the scope of the content clarity, relevancy and adequacy in order to achieve the present study objectives. These experts were from different faculty members of the following universities: -

- Six experts from University of Sulaimani.
- Four experts from Tehran University of Medical Science
- Four experts from Erbil Medical University.
- Two experts from Baghdad University.
- Two expert from Kirkuk University.
- One expert from Karbala University.

And one consultant psychiatric nurse from Ministry of Health-Baghdad.

The vast majority of the experts had agreed that the questionnaire was appropriately designed and developed to measure the phenomenon underling the present study.

3.7 Pilot study:

A pilot study conducted in December 2017 on ten patients with major depressive disorder was selected from Ali Kamal consultation center/Psychiatric clinic; the setting of this study: The pilot study attempted to reach the following purposes:

- To enhance the reliability of the questionnaire.
- To confirm the clarity of the questionnaire.
- To estimate the average time required for the data collection of each participants.

The result of the pilot study shows that:

- The items of the questionnaire were clear, understood and applicable.
- The time required for each interview ranged from 40 to 50 minutes for each patient.

The sample of pilot study excluded from the original study sample.

3.8. Reliability of the questionnaire

Questionnaire reliability generally refers to the consistency of a measure (Johanson and Kuby, 2007). The internal consistency of the questionnaire was determined through the computation of Alpha correlation coefficient (Cronbach's Alpha). The Cronbach's Alpha was applied by application of statistical package for social science (SPSS) version 22. The result of reliability was (0.744) for the spiritual well-being scale, and (0.843) for the self-esteem scale and (0.863) for the hopelessness scale. Such results were statistically acceptable and good which mean that the questionnaire had adequate level of initial consistency and equivalent measurability.

Data collection procedure

First, the researcher has met the consultant psychiatrist working in the psychiatric department at Ali Kamal consultation center for the purpose of explaining the aim of this study, to make arrangement for data collection, and to take their permission to refer patients with major depressive disorder non-psychotic feature who were attending the psychiatric clinic for treatment and follow up.

Second all the referred patients who fulfill the inclusion and exclusion criteria during the period of data collection were included as sample of this study. The patient and relative were assured that their responses would be kept confidential and would be used for research purpose only. After gaining approval to participate in this study and verbal informed consent was obtained, each patient sample of current study was interviewed by the researcher to fill the Kurdish

version of questionnaire. The researcher was conducting the interview with the patient in the nurse room in psychiatric clinic Ali Kamal center. Interviewing each patient and filling the questionnaire took approximately 50-60 minutes. The data were collected from January 28th, 2018 to May 1st, 2018.

Before starting data collection for the current study, the researcher has completed a course in professional therapeutic counselling, the researcher gets a certification from Tehran University of Medical Science (Appendix F).

Statistical Method

Statistical package for social science (SPSS) version 22 is used for data analysis. Data are analyzed through the application of the approaches:

A. Descriptive Statistical Data Analysis:

This approach was performed through computation of frequencies (f) percentage (%) mean (X) and standard deviation (sd) as follow: -

- Percentage= % 100
- Mean = X
- Standard deviation = $\mp$ SD

B. Inferential Statistical Data Analysis:

This approach was employed through the following:

1. Cronbach's Alpha (coefficient Alpha):

It is used to measure the reliability of the questionnaire by estimating the internal consistency of such psychometric instrument (Johanson & Kuby, 2007).

2. t – test

Is used for determine the differences for comparing two means of the study variables.

3. Analysis of variance (ANOVA):

One- way analysis of variance was used to assess global comparative differences among more than two means of studied variables.

Fixing the threshold of significance at 5% for significant result, the p-value indicates the degree of significance as follow: -

Non-significance $P > 0.05$

Significance $P \leq 0.05$

Highly significance $P < 0.01$

Delimitation of the study:

The study should be seen in light of the following limitations:

1. The study limited only to the community patients previously diagnosed with major depressive disorder attending outpatient psychiatric clinic at Ali Kamal consultation center for treatment & follow up.

2. The study was limited to the period between, December 21st, 2017 to April 1st, 2018.

3. The daily plan for attending the center limited only to two days per week (Sunday and Wednesday) which it was the only two days of work per week for the center during the period of data collection.

4. The time of data collection was from 8.30 Am to 12.30 Pm.

5. Some patients refuse to share in the study and other refuse to complete the assessment so they were excluded from the study.

6. This study cost more time to be completed because its title is changed, since the administrative approvals need time.

Chapter Four
Results

CHAPTER FOUR

RESULTS

Results

The results of the data analysis are corresponded with the study objectives, and presented systematically in tables and figures in narrative and organized as follows :-

- Distribution of the socio-demographical and psychiatric clinical characteristics of the sample.

- Assessment the levels of the study variables which include spirituality, self-esteem &hopelessness.

- The difference between study variables in regard to sociodemographic and psychiatric history characteristics.

- Association between study variables through the use of correlation.

Throughout this chapter, the results of data analysis were presented systematically in tables and correspondence with objectives of the study and organized as follows:

Table 4.1 Distribution the socio-demographic characteristics of the sample

Sociodemographic Characteristics		Frequency	Percentage
Age group	18-27 year	31	%20.7
	28-37 year	51	%34.0
	38-47 year	40	%26.7
	48-57 year	21	%14.0
	58 Year or more	7	%4.6
	Mean ± SD	37.5 ∓ 11.03	
Gender	Male	99	%66
	Female	51	%34
Marital status	Single	33	%22
	Married	87	%58
	Divorced	24	%16
	Widowed	6	%4
Educational levels	Illiterate	36	%24
	Primary school	39	%26
	Intermediate school	24	%16
	Secondary school	21	%14
	Institute or university	30	%20
Occupation status	Employed	51	%34
	Unemployed	99	%66
Residential areas	Urban	117	%78
	Sub urban	24	%16
	Rural	9	%6
Economic status	Sufficient	24	%16
	Somehow sufficient	78	%52
	Insufficient	48	%32
Religious-status	practice	111	%74
	Partial practice	21	%14
	Non practice	18	%12
Total		150	%100

This table shows that approximately one third of the sample (34.0%) are in the age group (28-37) years, and only (4.6%) of them are in age group more than (58) years. The mean age was (37.5 ± 11.3). Most of them male (66%) and married (58%). According to their educational level, the high percentage of the sample 26% has primary school, and 24% of them illiterate, while 20% of them graduated from college or institute. Approximately two third (66%) of the study sample are not employed, more than half of them with barely sufficient economic status (52%) and the majority of them from urban area (78%) and only (6%) of them from rural area in regard to religious status, the table shows that the majority of the participants (111, 74%) religious practice and the least of them (12%) non- religious practice.

Table 4.2 Distribution of the sample according to their psychiatric history characteristics

Psychiatric history	Clinical characteristics	Frequency	Percentage
Duration of illness	1-5 years	87	%58
	6-10 years	36	%24
	11-15 years	12	%8
	16-20 years	6	%4
	21-25 years	9	%6
Number of hospitalization	Non	111	%74
	1 time	15	%10
	2 times	12	%8
	3 times	6	%4
	4 times and more	6	%4
Suicidal attempt	No	102	%68
	Yes	48	%32
Number of Suicidal attempt	No attempt	102	%68
	1 attempt	9	%6
	2 attempt	9	%6
	3 attempt	12	%8
	4 attempt and more	18	%12
Family history of mental illness	No	96	%64
	Yes	54	%36
Family member with mental illness	Non	96	%64
	First degree	9	%6
	Second degree	36	%24
	Third degree	9	%6
Total		150	%100

Table (2) shows that more than half of the study sample of depressed patients are their duration of illness ranged from (1-5) years (58%), and least percentage

was from (21-25) years (6%), the mean duration of illness is (6.14) years, SD ± 6.3. Also this table appear that the majority of the study sample (74%) have no admission to mental hospital, only (10%) of them attended hospital once and those who attended two or three times their percentage was equal which is 4%. The table shows that two third of the sample (68%) have no suicidal attempt while (32%) of them have suicidal attempt and (12%) of them attempted more than four attempts. The table appear that around two third of the study sample (64%) have no family history of mental illness, while (36%) have family history of mental illness among them (24%) related second degree of kinship while only (6%) related to first degree of kinship.

Table 4.3 the significant difference between calculated mean and theoretical mean in spirituality measures for the study sample, using t-test

Variable	Sample	Calculated mean	standard deviation	theoretical mean	$t-$ value	Level of significance
Spirituality	150	72.626	11.398	60	13.567	0.001

Table (3) shows statistically significant difference was found between calculated mean ($\overline{x}$ = 72.626) and theoretical mean (x=60) (t-test = 13.567, SD ± 11.398) at p<0.001 in spirituality measure. The results in this table indicate that the difference was in favour of calculated mean which means that the level of spirituality, in general is high among study sample for patients with major depressive disorder.

Table 4.4 Distribution of sample according to the levels of spirituality

Statistical Indicator	Level of spirituality			Total
	Low level (20-40)	Medium level (41-99)	High level (100-120)	
Frequency	3	45	102	150
Percentage	%2	%30	%68	%100

Table (4) appears the distribution of the patients according spirituality- well-being scale index. The table reveals that highest percentage (68%) of the total patients was high level of spiritual well-being and the mean score ranged from (100-120), and the lowest percentage (2%) of the total patients were low level of spiritual well-being, the mean score ranged from (20-40).

Table 4.5 the significant difference between calculated mean and theoretical mean in self-esteem measure, using t-test

Variable	Sample	Calculative mean	standard deviation	theoretical mean	$t-$ value	Level of significance
Self-esteem	150	14.380	4.097	15	1.853	Nonsignific ant

Table (5) appears that statistically no significant difference was found between calculated mean ($\overline{x}$ 14.380) and theoretical mean (x=15), (t-test = 1.853, SD ± 4.097) at p>0.05 level in self-esteem measure. In this table, the results revealed that the level of self-esteem, In general was moderate among study sample patients with major depressive disorder.

Table 4.6 Distribution of the sample according to the self-esteem levels

Statistical Indicator	Level of self-esteem			Total
	Low level (0-14)	Medium level (15-24)	High level (25-30)	
Frequency	78	69	3	150
Percentage	%52	%46	%2	%100

The table shows the distribution of the patients according to self-esteem scale index. The table indicates that the highest percentage (52%) of the total patients was low level of self-esteem and the mean score ranged from (0-14), and the lowest percentage (2%) of the total patients was high level of self-esteem and the mean score ranged from (25-30).

Table 4.7 the significant difference between calculated mean and theoretical mean in hopelessness measures for the sample using *t*-test

Variable	Sample	Calculative mean	standard deviation	theoretical mean	$t-$ value	Level of significance
hopelessness	150	9.860	4.676	10	0.367	Nonsignificant

The table shows statistically non-significant difference between calculated mean ($\bar{x}$ =9.860) and theoretical mean (×=10) (t-test =0.367 SD ± 4.676) at p> 0.05 level. The results indicate that the level of hopelessness in general, was moderate among study sample of patients with major depressive disorder.

Table 4.8 Distribution of the sample according to the level of hopelessness

Statistical Indicator	Level of hopelessness				Total
	Minimal Score 0-3	Mild Score 4-8	Moderate Score 9-14	Sever Score 15+	
Frequency	18	45	60	27	150
Percentage	%12	%30	%40	%18	%100

Table (8) shows that the distribution of the patients according to the hopelessness scale index. The table appears that the highest percentage (40%) of the total patients was moderate level of hopelessness and the mean score ranged from (9-14), and lowest percentage (12%) of the total sample were minimal level of hopelessness and the mean score ranged from (0-3).

Table 4.9 the analysis of the variance, ANOVA, of spirituality, self-esteem, hopelessness in regard to age factor among sample

Variables	Variance type	Sum of squared differences	Degrees of Freedom Df	Mean square	F value	Level of significant
Spirituality	Between groups	213.77	4	532.94	4.486	0.01
	Within groups	17227.32	145	118.80		
Self-esteem	Between groups	113.99	4	28.49	1.731	Nonsignificant
	Within groups	2387.34	145	118.80		
Hopelessness	Between groups	238.74	4	59.68	2.866	0.05
	Within groups	3019.32	145	20.82		

The results in table 9 indicate that there were statistically high significant difference in the scores of spirituality (f=4.486, at p<0.01) and hopelessness (f=2.866 at p<0.05) while no statistically significant differences between mean score of self-esteem in compare to patients age because p-value was greater than the common alpha 0.05 (t=1.731 at p>0.05). The table reveals that age is impact factor affecting spirituality and hopelessness and not affected self-esteem.

Table 4.10 the significant difference of spirituality, self-esteem, hopelessness in regard to patient's gender factor among sample

Variables	Group	Number	Mean score	Standard Deviation	$t-$ value	Level of significant
Spirituality	Males	99	73.64	8.81	1.534	Nonsignificant
	Females	51	70.64	15.12		
Self-esteem	Males	99	14.45	3.81	0.310	Nonsignificant
	Females	51	14.23	4.62		
Hopelessness	Males	99	9.54	4.43	1.149	Nonsignificant
	Females	51	10.47	5.10		

The table appears that there were statistically non-significant difference between mean score of spirituality , self-esteem, and hopelessness in compare to patients gender because p- value was greater than common alpha 0.05 for all study variable (t- test = 1.535, 0.310, 1.149) respectively. The table reveals that gender factors is not impact factor affecting the spirituality, self-esteem and hopelessness in major depressive disorder among study patients.

Table 4.11 the analysis of variance ANOVA of spirituality, self-esteem, hopelessness in regard to patient's marital status factor in sample.

Variables	variance type	Sum of squares	Degrees of Freedom Df	Mean squares	F value	Level of significant
Spirituality	Between groups	1922.69	3	640.89	5.366	0.01
	Within groups	17436.40	146	119.42		
Self-esteem	Between groups	2405.02	146	16.47	1.949	Nonsignificant
Hopelessness	Between groups	628.01	3	209.33	11.621	0.001
	Within group	2630.05	146	18.01		

The results in table (11) indicates that there were statistically high significant difference between mean score of hopelessness (f=11.621 at p<0.001)., and spirituality in regard to patients marital factor (f= 5.366 at p<0.01), while the table shows that there were statistically non-significant difference between mean score of self-esteem in regard to patients marital status (f=1.949 at p>0.05). The table reveals that the marital status is impact factor highly affecting the hopelessness and the spirituality levels in major depressive disorder among study sample.

Table 4.12 the analysis of the variance, ANOVA of spirituality, self-esteem, hopelessness in regard to educational status factor among patients

Variables	variance type	Sum of squares	Degrees of Freedom Df	Mean squares	F value	Level of significant
Spirituality	Between groups	3970.1	4	992.52	9.352	0.001
	Within groups	15388.98	145	106.48		
Self-esteem	Between groups	245.94	4	61.48	3.953	0.01
	Within groups	2255.39	145	15.55		
Hopelessness	Between groups	152.92	4	38.23	1.785	Nonsignificant
	Within groups	3105.13	145	21.41		

The results in table (12) show that there were statistically high significant difference between mean score of spirituality (f=9.352 at p<0.001), and self-esteem (f=3.953 at p<0.01) in regard to patients educational levels, while the table shows that there were statistically non-significant difference between mean score of hopelessness in compare to patients educational levels (f=1.785 at p>0.05). The table indicates that educational status is highly impact factor affecting spirituality and self-esteem levels in major depressive disorder among study patients.

Table 4.13 the significant difference between spirituality, self-esteem and hopelessness in regard to occupational factor among patients

Variables	Group	Number	Mean score	Standard Deviation	$t-$ value	Level of significant
Spirituality	Employed	51	70.88	13.58	1.349	Nonsignificant
	Non employed	99	73.52	10.04		
Self-esteem	Employed	51	14.76	4.88	0.824	Nonsignificant
	Non employed	99	14.18	3.64		
Hopelessness	Employed	51	10.64	4.35	1.486	Nonsignificant
	Non employed	99	9.54	4.80		

Table 13 indicates that there were statistically non-significant difference between mean score of spirituality, self-esteem and hopelessness in regard to patient's employment because p-value was greater than the common alpha 0.05(t=1.349 at p>0.05) (t=0.824 at p>0.05) (t=1.486 at p>0.05) respectively for study variables. The tables reveals that the occupation is not impact factor affecting the study variables in major depressive disorder among sample.

Table 4.14 the analysis of the variance ANOVA of spirituality, self-esteem, hopelessness in regard residency factor among patients

Variables	variance type	Sum of squares	Degrees of Freedom Df	Mean squares	F value	Level of significant
Spirituality	Between groups	956.30	2	478.15	3.819	0.05
	Within groups	18402.78	147	125.18		
Self-esteem	Between groups	86.07	2	43.03	2.619	Nonsignificant
	Within groups	2415.26	147	16.43		
Hopelessness	Between groups	340.48	2	170.24	8.577	0.001
	Within groups	2917.57	147	19.84		

Table 14 appears that there were statistically high significant difference between mean score of hopelessness (f=8.577 at p<0.001) and spirituality in regard to patients residence areas (f=3.819 at p<0.05), while no statistically significant difference between mean score level of self-esteem in regard to patients residence area become p-value was greater than the common alpha 0.05. The table indicates that the residency factor is highly impact factor affecting hopelessness, and spirituality levels in major depressive disorder among patients.

Table 4.15 the analysis of the variance ANOVA of spirituality, self-esteem, hopelessness in regard to economic status factor

Variables	variance type	Sum of square	Degrees of Freedom Df	Mean squares	F value	Level of significant
Spirituality	Between groups	617.94	2	308.97	2.423	Nonsignificant
	Within groups	18741.14	147	127.49		
Self-esteem	Between groups	418.48	2	209.24	14.768	0.001
	Within groups	2082.85	147	14.169		
Hopelessness	Between groups	196.58	2	98.29	4.720	0.01
	Within groups	3061.47	147	20.82		

The table appears that there were statistically highly significant difference between mean score of self-esteem (f=14.768 at p<0.001) and hopelessness with patients economic status factor (f=4.720 at p<0.01) while no significant difference between mean score of spirituality in regard to patients economic status because p-value was greater than the common alpha 0.05 (f=2.423 at p>0.05). The table reveals that economic status is highly impact factor affecting self-esteem, and the hopelessness levels in major depressive disorder among the patients.

Table 4.16 the analysis of the variance ANOVA of spirituality, self-esteem, hopelessness in regard the religious status factor of the sample

Variables	variance type	Sum of square	Degrees of Freedom Df	Mean squares	F value	Level of significant
Spirituality	Between groups	6665.78	2	3332.89	38.598	0.001
	Within groups	12693.30	147	86.34		
Self-esteem	Between groups	480.52	2	240.26	17.478	0.001
	Within groups	2020.81	147	13.74		
Hopelessness	Between groups	655.94	2	327.97	18.528	0.001
	Within groups	2602.11	147	17.70		

Table 16 appears statistically high significant difference in the mean score of spirituality, self-esteem and hopelessness patients religious status (f=38.598 at p<0.001) (f = 17.478, at p<0.001) and (f= 18.528 at p<0.001) respectively. This table revealed that the religious status is highly impact factor affecting all study variables, spirituality self-esteem and hopelessness level in major depressive patients.

Table 4.17 the analysis of the variance ANOVA of spirituality, self-esteem, hopelessness in regard to patient's duration of illness

Variables	variance type	Sum of squares	Degrees of Freedom Df	Mean squares	F value	Level of significant
Spirituality	Between groups	4395.99	4	1098.99	10.650	0.001
	Within groups	14963.10	145	103.19		
Self-esteem	Between groups	284.48	4	71.12	4.652	0.001
	Within groups	2216.85	145	15.28		
Hopelessness	Between groups	328.71	4	82.17	4.068	0.01
	Within groups	2929.34	145	20.20		

The table indicates that there were statistically highly significant differences between the mean score of spirituality (f=10.650, at p<0.001) self-esteem (f= 4.652 at p<0.001), and hopelessness (f=4.068 at p<0.01) in regard to patients duration of illness factor. This table reveals that duration of illness factor is highly impact factor affecting all study variables, spirituality, self-esteem and hopelessness levels in major depressive disorder among sample.

Table 4.18 the analysis of the variance ANOVA of spirituality, self-esteem, hopelessness in regard to number of hospitalization factor among sample

Variables	variance type	Sum of square	Degrees of Freedom Df	Mean squares	F value	Level of significant
Spirituality	Between groups	1016.41	5	203.28	1.596	Nonsignificant
	Within groups	18342.67	144	127.28		
Self-esteem	Between groups	479.28	5	95.85	6.826	0.001
	Within groups	2022.05	144	14.02		
Hopelessness	Between groups	410.51	5	82.10	4.152	0.001
	Within groups	3847.54	144	19775		

Table 18 shows that there were statistically non-significant difference between mean score of spirituality with number of hospitalization (f=1.596, at p>0.05), while the table shows that statistically highly significant differences between the levels of spirituality and hopelessness with number of hospitalizations factor (f=6.826, at p<0.001) (f= 4.152 at p<0.001) consequently. The table indicates that the number of hospitalization is highly impact factor affecting self-esteem and hopelessness levels in major depressive disorder among patients.

Table 4.19 the significance differences of mean score of spirituality, self-esteem, hopelessness in regard to suicide attempt factor among patients

Variables	Suicide attempt	Number	Mean score	Standard Deviation	$t-$ value	Level of significant
Spirituality	No	102	73.83	12.11	1.907	Nonsignificant
	Yes	48	70.06	9.29		
Self-esteem	No	102	15.47	3.90	5.142	0.001
	Yes	48	12.06	3.52		
Hopelessness	No	102	8.41	3.96	6.181	0.001
	Yes	48	12.93	4.60		

The table shows that there were statistically highly significant differences between mean score of self-esteem (t-test =5.142 at p<0.001) and hopelessness (t-test =6.181 at p<0.001) in regard to patients attempted suicide while the table appears that there were statistically non-significant difference between mean score of spirituality in compare to patients non suicidal and suicidal attempt, because p-value was greater than the common alpha 0.05(t=1.907, at p>0.05). Table 19 reveals that the suicidal attempt is highly an impact factor affecting self-esteem and hopelessness in major depressive disorder and not affecting spirituality, which reveals that spirituality, is self-coping against suicide attempts.

Table 4.20 the analysis of the variance ANOVA of spirituality, self-esteem, hopelessness in regard to number of suicidal attempts factors among patients

Variables	variance type	Sum of square	Degrees of Freedom Df	Mean squares	F value	Level of significant
Spirituality	Between groups	1623.67	7	231.95	1.857	Nonsignificant
	Within groups	17735.41	142	124.89		
Self-esteem	Between groups	682.42	7	97.49	7.611	0.001
	Within groups	1818.91	142	12.80		
Hopelessness	Between groups	928.85	7	132.69	8.090	0.001
	Within groups	2329.20	142	16.403		

This table appears that there were statistically highly significant differences between mean score of self-esteem and hopelessness in regard to patients number of suicidal attempts (f=7.611, at p<0.001) (f=8.090 at p<0.001) respectively. While the table reveals that there were statistically no significant differences between mean score of spirituality in compare to the same factor (f=1.857 at p>0.05). Table 20 reveals that the number of suicidal attempt is a highly impact factor affecting self-esteem and hopelessness levels and not affecting spirituality level in major depressive disorder among patients.

Table 4.21 the significance differences between spirituality, self-esteem and hopelessness in regard to family history of mental illness factor, among patients

Variables	Family mental illness	Number	Mean score	Standard Deviation	$t-$ value	Level of significant
Spirituality	No	96	72.88	13.18	0.370	Nonsignificant
	Yes	54	72.16	7.30		
Self-esteem	No	96	14.87	3.98	1.992	0.05
	Yes	54	13.50	4.17		
Hopelessness	No	96	9.12	4.47	2.617	0.01
	Yes	54	11.16	4.48		

The table shows that there were statistically high significant difference between the mean score of hopelessness (f=2.617 at p<0.01) and the self-esteem (f=1.992 at p<0.05) in regard to patients family history of mental illness. The table also appears that there were statistically no significant differences between spirituality in regard to the same factor (f=0.370, p>0.05).The result in this table reveals that patients with no family history of mental illness had higher self-esteem ($\overline{x}$ =14.87, SD ± 3.98) and lower hopelessness ($\overline{x}$ = 9.12, SD ± 4.47) than patient with family history of mental illness in self-esteem ($\overline{x}$ =13.50, SD ± 4.17) and hopelessness ($\overline{x}$ =11.16, SD ± 4.78). The table appears that family history of mental illness is impact factor affecting hopelessness and self-esteem levels in major depressive disorder among patients.

Table 4.22 the analysis of the variance ANOVA of spirituality, self-esteem, hopelessness in regard to patient's family relatives with mental illness

Variables	variance type	Sum of square	Degrees of Freedom Df	Mean squares	F value	Level of significant
Spirituality	Between groups	218.60	3	72.86	0.556	Nonsignificant
	Within groups	19140.49	146	131.09		
Self-esteem	Between groups	252.09	3	84.03	5.454	0.001
	Within groups	2249.25	146	15.40		
Hopelessness	Between groups	484.56	3	161.52	8.503	0.001
	Within groups	2773.50	146	18.99		

The table appears that there were statistically highly significant differences between mean score of self-esteem and hopelessness in compare to patients family relatives with mental illness (f= 5.454 at p<0.001) (f=8.503 at p<0.001). Also, this table shows that there were statistically no significant differences between mean score of spirituality in regard to patients family relative with mental illness (f=0.556, at p>0.05). This table reveals that family kinship with mental illness is highly impact factor affecting self-esteem and hopelessness levels in major depressive disorder among study patients.

Table (23) Correlation analysis between spirituality, self-esteem and hopelessness

Correlation items	Correlation	Overall Self-esteem	Overall Hopelessness	Overall Spirituality
Overall Self-esteem	Person Correlation	1	-487	-366
	Sig.(2-tailed)		0.001	0.001
	N	150	150	150
Overall Hopelessness	Person Correlation	-457	1	550
	Sig.(2-tailed)	0.001		0.001
	N	150	150	150
Overall Spirituality	Person Correlation	-366	550	1
	Sig.(2-tailed)	0	0	
	N	150	150	150
Correlation is significant at 0.001 level (2 tailed)				

In this table bivariate person's correlation show that a significant negative correlation are displayed between self-esteem and hopelessness ($p<0.001$) while no significant correlation between spirituality with self-esteem and hopelessness ($p>0.05$).

Chapter Five
Discussion

CHAPTER FIVE

DISCUSSION

Discussion

5.1 patient's socio-demographic characteristics:-

The result in this study shows that one third of the sample is within age group 23-37 years old and mean age 37.5 +_ 11.3 this results are slightly consistent with the study conducted by Yousafzai and Sidiqi (2007) who found that approximately one third of 150 depressive outpatients of convenient sampling their age ranged from 24-34 years old, in Pakistan. Also the results of this study are similar to the findings of Darwish (2016) who found that more than one third of depressive outpatients their age 28-37 years old in Sulaimani city.

Fortinash and Worret (2012) and Boyd (2008) confirmed the results of this study and mentioned that the average of age of onset for major depression has been consider the middle thirties. There is some evidence that onset is occurring in younger age (Ahmad, 2017). Although the most frequent age of onset for depression may range 25 to 44 years old age group, people in younger age group have an ever increasing risk of developing depression (Yaacob et al, 2009). Some data indicate that the onset of depression at on early adolescents age (Cuba et al, 2012) or at age 55years or more (Ahmad, Altaf and Jan, 2016) such data predicts a more protracted, recurrent and chronic courses of major depressive disorder.

In this study the results revealed that the predominant gender were males (66%).This results are almost similar with the findings of Ahmad, Altaf and Jan (2016) who found that males (57%) more than females (43%) of depressive outpatients in Kashmir/ India, also Yousafzai and Sidiqi (2007) found that the predominance males gender more than females among outpatients in Pakistan. On the other hand this results are inconsistent with Uba et al (2012) in Malaysia, Baptista (2014) in Brazil, who found that the predominance gender were females among depressed patients. Literatures noted that gender roles continue to linger and contribute to high rates of depression among women (Boyd, 2014 and Fontaine,1997). The findings of this study is that male-female ratio could be explained as females psychiatric patients were less frequently brought to psychiatric governmental clinics due to the feeling of shame and public stigma and self-stigma (Vass et al, 2015) . Vass et al (2015) stated that such stigmatizing attitude create a vicious circle of disability and disadvantages through diminishing equality of life, preventing help-seeking and engagement with mental health services and treatment . Or the results of present study be considered that during the period of data collection of current study that the chance of being male patients are more than females. More than half (58%) of the sample their marital status is married and (22%) single. This results goes with the findings of Mortiz et al (2011) in Canada, and also similar to results of Lasgaard, Goossens and Elklit (2011) and Mohammad, T. (2012) found that approximately more than half of study depressed patients were married. The finding of the present study may be explained by the late onset or recovery from acute onset among the sample of this study and fortunately such patients tend to have less difficulties in maintaining their daily life and exhibiting social roles and social integration (Vass et al, 2015).

About half of the studied depressed patients were low educational level, primary school (26%) and illiterate (24%) and two thirds of them were unemployed.

This results similar to the findings of Satija, Advani and Nathawat (1998) who found that more than one third of depressed patient. With low educational level, while they found that more than half of their sample were employed which are inconsistent to the results of this study. In regard to economic status the results in table 4.1 revealed 52% of depressed patients have partly sufficient economic status and majority of them were living in urban area. This results close to the results of Ahmad, Altaf and Jan (2016) in Kashmir/India.

Concerning religious status, the majority of the study depressed patients (74%) practice religion activities and only 12% were non-practice religion activities. This result goes with the findings of Philips, Lakin and Paragment (2002) who found that half of the participants with serious mental illness (major depression and schizophrenia) identified themselves as very religious and moderately spiritual. The results of this study were confirmed by Joshanloo and Daemi (2015). They reported that the religious resources and coping methods have been associated. A person may use religion resources as defense factor to increasing sense of worth which may in turn leads to increase emotional well-being.

5.2 patient's clinical characteristics

The main characteristics of depressed patients have shown in table 2 that their duration of illness was 1-5 years (58%). This results is consistent with findings of Ahmad, Altaf and Jan (2016), Salih (2016) and Mohammad (2012). The finding of the present study predicts that the study patient's condition may have reached a chronic limit or in remission. Torpey (2008) confirm the result of this study and stated that acute episodes of major depression last a limited amount of time. The DSM-V specifies that symptoms last at least two weeks, and median duration about 20 weeks. But some patients, the condition becomes chronic with symptom lasting at least two years. The difference between episodic and

chronic depression encompass more than just duration, studies show that, compared with episodic major depression, chronic depression is continually met the full DSM-V criteria for major depressive episode and have more functional impairment , increases risk of suicide and is more likely to occur in conjunction with other psychiatric disorders. The Harvard medical school (2009) reported about 20% of patients who develop major depression have not recovered in two years while 12% have not recovered after five years.

Most of the study sample are not admitted to psychiatric hospital (74%) they treated in outpatient's psychiatric clinics. This results are in agreement of the findings by Mortiz et al (2011) in Canada and Ahmad, Altaf and Jan (2016) in India, found that most study depressed subjects were treated in homes. Today the emphasis in psychiatric care treatment is on outpatients or community-based interventions that address the treatment needs of psychiatric clients striving to maintain a position within the community. This began the de-institutionalization movement over 30years ago. The increased investment in community care, de institutionalization was highly influenced by psychotropic medications leading to rapid discharge from hospital or to provide care to clients in homes, thus discouraging unnecessary hospitalization (Boyd, 2014 and Fortinash & Worret, 2012). The current study showed that one third of the depressed participants were attempted suicide and 18% of them have more than four attempts. The findings of Ribeiro et al (2018) , Lasgaard, Goossens and Elklit (2011) and Kaviani et al (2011) confirmed the results of this study and mentioned that depression is one of the factors confirm risk for suicide ideation, attempts and death. The finding of this study is consistent with the constructs accessibility to negative constructs and give rise to inadequacy for providing effective problem solution then probably resulting hopelessness and therefore may lead to suicidal ideation or attempts.

The psychiatric family history was present among 36% of depressed patients in this study, among them 6% with first degree and 24% second degree. This is in line with the evidence suggests by Fontain (2003). Fontain, stated that inheritability of major depression is 40 to 50 percent. The general population rate of current depression is 8 percent. Children of depressed parents have twice the risk or about 16% over a lifetime. If both parents have depression the risk rises to 75%. First degree relatives of depressed children also have a twofold greater risk of depression.

5.3 Spirituality factors

The results of the present study showed that the observed (calculated) mean score (72.626) of spirituality was significantly ($p<0.001$) higher than the theoretical mean score (60)$\pm$ 11.398 and the majority of the study depressed patients (68%) have high spiritual level in comparison to the standards scoring (70-100) of spirituality scale and only few of them (2%) with low level of spirituality (Table 3, 4). The frequent finding of high spirituality level among depressed patients in the current study was similar to the findings from another study carried out by Joshanloo and Daemi (2014) study in Iran and Avila (2014) study in USA. They found that spirituality level was significantly high among patients with major depressive disorder.

Although the results of this study pointed a significant high spirituality level among depressed patients, yet the causal direction between higher spirituality level and depression is not studied in this research, however Koenig (2012) and Mortiz et al (2011) support the results of this study. Koenig 2010 noted that the general population and those with medical illness use spiritual beliefs and practices to cope, and those with mental illness also often rely heavily on spiritual resources to cope, while Mortiz et al 2011 were pointed that spirituality may address the struggles of depressed patients feeling separated from their

surrounding world as well as from inner self, and proposed that a sense of the spiritual is central to their existence propelling a quest for meaning and counteracting feeling of boredom and emptiness, and they found that the influences participants in spirituality program , occurred as a result of practicing forgiveness, compassion, gratitude and acceptance reduced negative thinking pattern, being less judgmental, reduced ego centricity , improved self-esteem, concurrent with these shifts participants experienced an improved mood characterized by reduce depression.

The possible explanation of the result of this study that the collaborative relationship that depressed patients have with God may counteract the culture belief of fatalism (Avila, 2014), and the effect to be especially strong in stressed population Smith et al (2003) stated that it is an important consideration is how patient define spirituality, among patients an overlap occurs between spirituality and religiousness, however literature show negative association of religiousness on depressive symptoms.

The findings of this study therefore add evidence that high spirituality level common state experience by the study patient, with major depressive disorder living in the community.

5.3.1 Spirituality and Socio-demographic characteristics:-

The findings in the current study showed that patients age , marital status, educational level, residential area and religious status are significant factors effecting the differences in spirituality score ($p<0.05$) while gender, occupational status and economic status are non-significant factors ($p>0.05$). Similarly to this results Stanely et al (2011) found that the differences in spirituality levels related to educational levels, Avila (2014) showed that gender

and economic status were non-significant impact factors effecting the differences in spirituality score levels.

In contrast to the results of this study Joshanloo and Daemi (2014) identified that the gender as a factor effecting spirituality levels, and Cheadle and Schetter (2018) showed that the low socio-economic status factors effecting the differences in spirituality levels.

5.3.2 Spirituality and psychiatric history characteristics

In this study all the studied clinical characteristics of depressed patients including number of hospitalizations, suicidal attempt and family history of mental illness were non-significant factors effecting the differences in spirituality levels ($p>0.05$) except the characteristics duration of the illness was significant factor related to the differences in spirituality level ($p<0.001$). This is in agreement with the study by Tuck (2012) who reported the mechanism for spirituality remains unclear as to whether those are direct or indirect effects, Also Gall et al (2009) found that no support for Pargament's spiritual mobilization hypothesis during illness or that spirituality/ religious served as protective factor. Gall et al (2009) found that distress increases over time and proposed that the strength of religion/ spirituality beliefs prior to the illness and the mobilization of these beliefs in absence of illness a strong base during the crises promoted distress Instead.

5.4 Self-esteem factors

The results showed that the depressed participants observed (calculated) mean score of self-esteem (14.580+_ 4.676) were non – significantly difference with theoretical mean score (15+_ 4.676) of Rosenberg self-esteem scale ($p>0.05$, table 5). The distribution of studied sample revealed 52% low self-esteem level,

46% moderate self-esteem only 2% with high self-esteem. This findings similar to the findings by Yousafzai and Sidiqi (2007) study in Pakistan. Who found that the main logistic regression results indicate that depressed patients had lower self-esteem than non-depressed population Also, Yacoob et al (2009) study in Malaysia found that depressed mood and low self-esteem occur with disproportionately high prevalence among adults, And also in adolescents (Uba et al, 2012) .

Recently emerging studies suggest that low self-esteem contributes to the development of depression (Tripkovic et al, 2015). In contrary, Kenis (2006) reported that there is a reciprocal relationship between self-esteem and depression, yet the causal direction of this association is not establish and noted that self-esteem can both lead to and result from clinical depression and suggested that the self-esteem fluctuation is a factor in a etiology and maintenance of depression. Yacoob et al (2009) determined that self-esteem emerged as the strongest predictor of depression, in contrast Simpson et al (2012) revealed that low self-esteem and its own does not predict future depressive episodes, nonetheless, it may do so interaction with other factors. Such factors hopelessness (Ribeiro et al, 2018). Vass et al (2015) study in UK found that low self-esteem mediate the effect of stigma on passive social withdrawal.

This findings of the current study point out that low self-esteem is a state dependent on depressed mood and acts as a vulnerability factor for the development of major depression among study patients.

5.4.1 Self-esteem and sociodemographic characteristics

In this study, the findings showed that the education levels, economic status and religious status are highly significant ($p<0.001$) factors effecting self-

esteem levels , while other socio-demographical characteristics including age, gender, marital status, and residential area are not significant factors effecting self-esteem levels ($p>0.05$) . These findings are supported by the Yousafzai and Sidiqi (2007) found that educational level and income significantly affected the differences in self-esteem score, Cheadle and Schetter (2018) found that religiosity status effected self-esteem score yet

the findings of this study are inconsistent with the results of Tripkovic et al (2015) and Yacoob et al (2009) found that self-esteem score significantly affected by gender, and also by age (Ahmad and Altaf and Jan, 2016).

5.4.2 Self-esteem and psychiatric history characteristics

This study found that in general all, clinical characteristics including of illness, number of hospitalizations, suicidal attempts and family history of psychiatric illness are highly significant factors effecting patients self-esteem levels ($p<0.001$). This findings are consistent with the findings of previous studies (Lasgaard et al 2011) noted that lowest self-esteem increase the risk of suicide attempts in depressed patients. Yousafzai and Sidiqi (2007) determined that depressed patients having the illness for more than one year were 2.75 times more likely to have lower self-esteem (p-value 0.001) family history and stigma cause's losses of self-esteem (Vass et al, 2015). Low self-esteem acts as vulnerability factor for development or variation of major depression (Uba, 2012; Yousafzai and Sidiqi, 2007).

These findings tend to indicate that treatment directed at self-esteem enhancement and stimulation of positive things can decrease the risk of chronic psychosocial damage among depressed patients (Tripkovic et al, 2015).

5.5 Hopelessness factor

The findings showed that both the observed (calculated) mean score 9.860 ∓ 4.676 and theoretical mean score 10.0 ∓ 4.676 have statistically non-significant differences ($p>0.05$) (table 7) which means that high distribution of the study sample are in moderate level of hopelessness (40%, table, 8). This findings consistent with results of Ribeiro et al (2018) study in USA and Vass et al (2015) study in UK. Hopelessness is the subjective appraisal of negative expectations about the occurrence of highly valued outcomes coupled with the sense that one lacks control over desired to event in the future (Fraser, 2017)

Hopelessness has been related to the onset or development of depression (Pomplim, 2010). In a systematic review study carried by Soundy et al (2015) identified hopelessness is a major barrier to recovery from depression. Other study found that hopelessness has been identified as responses to public stigma and which is important element of depressed patients pessimism about their own illness (Pitt et al, 2007) , recent study noted that hopelessness is a powerful emotion that often contributes to low mood and can play mediating role to effects symptoms and subjective recovery (Huen et al, 2016).

Although, the results of this study revealed a moderate (40%) to severe (18%) level of hopelessness among study patients, yet the mechanism of hopelessness in depression is not an objective of this study, however Fortinash and Worret (2012) stated , unfortunately the specific mechanisms of hopelessness is converted into the specific symptom pattern of depression and hopelessness condition remains elusive.

It is evident based on the results of present study that patients with major depressive disorder clearly experience a condition of hopelessness may be a symptom of depression or risk factor predicts to depressive episode.

5.5.1 Hopelessness and Socio-demographic characteristics

The results of this study appeared that patients age , marital status, residential area, economic status and religious status are significant factors affecting the differences in hopelessness levels ($p<0.001$) while the gender, educational levels and occupation are non-significant factors affecting depression.

This is consistent with study by Bener and Alsulaiman (2017) determined that marital status and age contributing factors effecting hopelessness levels, also Utku UZ (2016) found gender did not show significant differences in hopelessness score while, the result of the present study is inconsistent with study by Ribeiro et al (2018).

The present study findings revealed the coexistence and association of the socio-demographical factors related to the hopelessness' level of patients with major depressive disorder.

5.5.2 Hopelessness and psychiatric history characteristics

In this study all patients psychiatric history characteristics including duration of illness, number of hospitalizations, suicidal attempts and history of mental illness in the family are significant factors effecting hopelessness level ($p <0.001$). This results are consistent with the study by Pomplim (2010), Kaviani et al (2011) and Ribeiro et al (2018) determined that hopelessness has been related to the onset or development of depression and associated with suicidal ideation and is recognized as better predictor for suicidal intent than depression. In the line with Fortinash and Worret (2012) reported that suicide behaviors are symptoms of depressive episodes, other symptoms of depression relating to a apathy, luck of motivation, sad affect as well as other symptoms of depression are believed to flow from the condition of hopelessness. The hopelessness effects on suicidal attempts appeared stronger among gender relative to clinical

and self-injurious sample (Bentley et al, 2016) Kessler et al (2002) determined that advancing prediction accuracy of suicidal behaviors will likely require simultaneous consideration of many risk factors and the complex relationships between those factors, thus when considered in combination with many other factors in an optimal fashion, depression and hopelessness may be very important predictors of suicidal behavior. This view has been supported by Abu Talib et al (2017) who examined the association between hopelessness and depression, spirituality and suicidal behavior in Malaysia students, their findings indicated that participants high in hopelessness and depression also high in spirituality less suicidal than others, they recommended that spirituality act as a protective factor against hopelessness, depression and suicidal behavior.

In this study, male are almost twice the number of females (table 1) , this may be seen as a matter of concern suggesting that it would make a difference as male seem to be more susceptible to get into risky behavior such suicide attempt.

5.6 The association between spirituality, self-esteem and hopelessness:-

It is evident from the results of this study (table 23) that self-esteem and hopelessness highly significantly associated between each other, more hopelessness highly associated with lowest self-esteem ($p<0.001$), however neither self-esteem nor hopelessness appeared non-significant associated with persisting spirituality score among depressive patients. These findings are consistent with previous studies, which suggest that low self-esteem and more hopelessness are state and more prevalent among depressed patients (Yousafzai and Sidiqi, 2007; Uba et al, 2012; Ribeiro et al, 2018). The identification of such association are very useful in the management of depression.

However in this table showed that neither self-esteem nor hopelessness appeared non-significantly associated with persisting spirituality level among

study depressed patients. This results goes with the study by Mihaljevic et al (2015) found that spiritual- QoL has shown to play a significant role in depression, just as it has proved to be a unique predictor of lower symptoms adjusted for personality dimensions, which include lower self-directness, higher harm avoidance and lower cooperativeness. In the same line Wittink et al (2009) reported that spirituality as important factor in depression intervention, and sought to understand how spirituality may play a role in order to inform possible intervention aimed to improving the acceptability and effectiveness of depression treatment.

Chapter Six Conclusions and Recommendations

CHAPTER SIX

Conclusions & Recommendations

Based on the discussion and interpretations of the study results, conclusion and recommendations are set forth:

6.1 conclusions:-

6.1.1 Most of patients were male, unemployed, living in urban areas, practicing religious activities and their mean of age 37.5 years

6.1.2 Most of the patients were less admitting to hospital although the long duration of illness ranged from 1-25 years.

6.1.3 The patients experience high level spirituality value, low self-esteem level and moderate level of hopelessness.

6.1.4 The level of spirituality value effected by age, marital status, level of education, residential area, religious status and duration of illness.

6.1.5 The self-esteem level effected by educational level, economic status, religious status , duration of illness, suicide attempt, number of attempts, family history of psychiatric illness and degree of kinship.

6.1.6 Hopelessness level effected by age, marital status, residential area, economic status, religious status, and all clinical characteristics which include duration of illness, number of hospital admission, suicidal attempt, number of attempts, family history of psychiatric illness and degree of kinship.

6.1.7 Hopelessness level affected by more number of socio-demographical and clinical characteristics compared to spirituality and self-esteem variables.

6.1.8 Patients gender and occupation are not a significant factors effecting the differences in spirituality, self-esteem and hopelessness level.

6.1.9 Patients religious status are significant factors effecting the variation of all studied variables; spirituality, self-esteem and hopelessness.

6.1.10 patients suicide attempt and number of attempts are not associated with the spirituality value.

6.1.11 there are high significant association between self-esteem and hopelessness mean scores, that low self-esteem possibly lead to increase hopelessness and hopelessness is a risk factor to lower self-esteem among patients.

6.1.12 there are no significant association between spirituality value with both self-esteem and hopelessness mean scores among patients.

6.1.13 Hopelessness and low self-esteem are state of emotional distress dependent on depressed mood and they are possible gateway to depression.

6.1.14 High spirituality value on its own the strongest significant factors may represents emotional source and possibly used to handle or self-cope with depressed mood by the patients.

6.2 Recommendations

Based on the conclusions of this study the researcher recommended the followings:-

1. Cognitive behavior therapy which utilize a group therapy may be successful at reducing internalized stigma, improving self-esteem and reduction feeling of hopelessness.
2. Mental health services need to consider practical ways to minimizing social-occupational excursion for people with mental disorder by employing occupational advisors.
3. Greater importance should be given to the self-esteem and hopelessness during nursing assessment of depression, therefore it's beneficial to employ the assessment tools used in this study by the nurses working in psychiatric department in Alikamal consultation Center to achieve this issue.
4. Carful conceptualization and measurement of spirituality in culturally resonant way will be critically important for future investigations and interventions in depressed people.
5. Importance of assessing hopelessness in patients with major depressive disorder and provide critical evidence of the need for nurses, clinicians to encourage patients to participate in social and recreational activities particularly to the outpatients.
6. Depressed people relatively have broader range of spiritual preference, thus effective nursing intervention that aim to improve patients interpersonal skill, problem solving and coping skill would be another source to defense against existential emotional distress in depression is needed.
7. Primary emphasis need to be placed upon assessment and alleviation of suicidal behaviors for the sake of patient's safety.
8. Establish community psychiatric mental health services including educational programs, and home visits to engage the clients in treatment,

assess the client and to teach communication and social skill for persons with persistent depression disorder.

6.3 suggestions

1. Future investigations are required to clarify the probable cause or effect roles of studied variables with the levels of depression to draw a more detailed picture of the complexity of study factors.
2. Another investigations are suggested to assess factors that interfere with the development of positive self-esteem and decrease hopelessness among depressed patients.

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Appendices

Appendix A

هەرێمی کوردستان – عێراق
نەنجومەنی وەزیران
وەزارەتی تەندروستی
بەڕێوەبەرایەتی گشتی تەندروستی سلێمانی
- کاروباری هونەری -

Kurdistan Regional Government
Council of Ministers
Ministry of Health

اقليم كوردستان – العراق
مجلس الوزراء
وزارة الصحة
المديرية العامة لصحة السليمانية
- الامور الفنيه -

ژمارە : ٢٥٢٢
بەروار/ ٢٠١٧/١٠/٢٣
بەروار/ // گەڵاوێژان /٢٧١٧

No
Date

(لە سایەی بەرخۆدان و قوربانیدانی پێشمەرگە سەقامگیری و ئاسایشی وولاتمان پارێزراوە)

بۆ / کلینکی ڕاوێژکاری علی کمال

ب// هاوکاری

ئاماژە بە نووسراوی کۆلێژی پەرستاری / زانکۆی سلێمانی ژمارە (١٥٨٦) لە (٢٠١٧/١٠/٢٣) هاوکاری خوێندکاری باڵای دکتۆرا (طه احمد فرج) بکەن لە کاتی سەردان کردنی بە مەبەستی کۆکردنەوەی داتا و وەرگرتنی زانیاری بۆ توێژینەوەکەی لە ژێر ناونیشانی (Assessment of spirituality , self-esteem and hope among outpatients with major depressive disorder in Ali Kamal Hospital in Sulaimani City) ..

د. میران محمد عباس
بەڕێوەبەری گشتی
/ ٢٠١٧/١٠

وێنەیەك بۆ//

زانکۆی سلێمانی / کۆلێژی پەرستاری / بۆ ئاگاداریتان

کاروباری هونەری / کامل /لە گەڵ بە رایە کانی

دۆسیە ی تایبە ت

سۆزان //

کاروباری هونەری/

Email :dohsuli@yahoo

Appendix A

هەرێمی کوردستان – عێراق
نەنجومەنی وەزیران
وەزارەتی تەندروستی
بەڕێوەبەرایەتی گشتی تەندروستی سلێمانی
- کاروباری هونەری -

اقليم كوردستان – العراق
مجلس الوزراء
وزارة الصحة
المديرية العامة لصحة السليمانية
- الامور الفنيه -

ژمارە/
بەروار: ۱۲ /۱۰/ ۲۰۱۷
بەروار : / ڕەزبەر / ۲۷۱۷ کوردی

NO:
Date:

(پێشمەرگە پاڵەوانی ئاشتی یە لە سایەی پێشمەرگە دا ئارامە کوردستان)

بۆ / سەنتەری چارەسەر کردنی نەخۆشیە دەرونیەکان

ب// هاوکاری

ئاماژە بە نووسراوی کۆلێژی پەرستاری / زانکۆی سلێمانی ژمارە (۱۵۰۲)لە (۲۰۱۷/۱۰/۹)
هاوکاری خوێندکاری باڵای (دکتورا) (طه احمد فرج)بکەن بەمەبەستی ئەنجامدانی توێژینەوەکەی لەژێرناونیشانی
Effectiveness of spiritual psycho-education program on self-worth, self-esteem and hope among patients with major depressive disorder in Mental Health Center/ Sulaimani Teaching Hospital

د. میـــران محمـد عباس
بەڕێوەبەری گشتی
۲۰۱۷/۱۰/

وێنەیەك بۆ

- کاروباری هونەری/ کامل / لە گەڵ بەراییەکان
- دۆسیە ی تایبە ت

نزیرە //

کاروباری هونەری / کامل

Appendix B

The ethical committee of the faculty of medical sciences should fill this field.

Ethical committee of the faculty of medical sciences has met to assess the plan and suggestions of the postgraduate and scientific committees regarding the research project Ph.D student:

Taha Ahmad Faraj

Entitled :

Effectiveness of spiritual psycho-educational program on self-worth, self-esteems and hope among patients with major depressive disorder attending Mental Health Treatment Center in Sulaimani Teaching Hospital

in the field of (Nursing) in the specification of (Psychiatric Mental Health Nursing) and a fine

specification of (Psychiatric Mental Health Nursing)

under supervision of :

1- Professor Dr. Salwa Shakir Muhsin

As a result, the committee has decided to approve the PhD project.

Members of Ethical committee of the faculty of medical sciences

No : 44

Date : 30/1/2017

Ass.Prof. Dr.Bakhtiar Mohammed Mahmoud
Head of the committee

Ass.Prof.Dr. Saeed. A.latteef A.kareem
Member

Ass. Prof. Farhad .M.Abdulkarim
Member

Anwer Aboubaker kareem
Member

Ass.Prof Dr. Sardar Rashid hama Salih
Member

Dr. Tavga Ahmed Aziz
Member

Dr. Dyary Hiewa Othman
Member

Dr.Fatah Hama Raheem
Member

Ass.Prof . Dr. Mohamad Rasheed Ameen
Member

Mr. Borhan Abdulla Shamorad
Member

UNIVERSITY OF SULAIMANI
COLLEGE OF MEDICINE
ETHIC COMMITTEE

UNIVERSITY OF SULAIMANI
COLLEGE OF MEDICINE
ETHIC COMMITTEE

Appendix B

The faculty council should fill this field.

In view of resolutions of the scientific committee meeting of the faculty of medical sciences regarding to the enhancement of the research project of the Ph.D student Taha Ahmad Faraj

in the field of Nursing in the specification of Psychiatric Mental Health Nursing

and a fine specification of Psychiatric Mental Health Nursing

The faculty council in his meeting on.....14/2/2017.....**decided that:**

Protocol accepted ☑

Day put to start the work.....

Day expected to finish the work.....

Dean

Name : ..D.r. Isra M.A.I.....
Signature : .....
Date : .....14.2.2017.....

Approval of Vice – President of Sulaimani University for Scientific Affairs and Postgraduate Studies:

Approved

Signature : K/Rashid
Name : Dr.Khasraw Abdulla Rashid
Scientific degree:Professor
Date : / / 2016
28/2/2017

Questionnaire

"Assessment the levels of spirituality, self-esteem and hope among patients with major depressive disorder in Ali Kamal Consultation Center in Sulaimani City"

Patient's initial name..... patient's code .....

Do you have any physical illness? .....

Part l: Patient socio-demographic characteristics

Age: ☐ Years

Gender: Female ☐ Male ☐

Marital status: Single ☐ Married ☐ Divorced ☐ Widow ☐

Separated ☐

Educational level: Illiterate ☐ Primary school ☐

Intermediate school ☐ Secondary school ☐ Higher education ☐

Occupation: ☐

Residential area: Urban ☐ Suburban ☐ Rural ☐

Economic status: Sufficient ☐ Barely sufficient ☐ Insufficient ☐

Religious status: Practice ☐ Partial practice ☐ Non-practice ☐

Part ll: Patient's psychiatric history:

Duration of illness: ☐ **Years**

No. of hospitalization: ☐ **Times**

Suicidal attempts: No ☐ Yes ☐ If yes, how many attempts ☐

Family history of mental illness ☐ ☐ ☐

Appendix C

1- Spiritual Well-Being (Ellison- Paluzian SWB Scale)

For each of the following statements circle the choice that best indicates the extent of your agreement or disagreement as it describes your personal experience:

No.	Statements	Strongly Agree	Moderately Agree	Agree	Disagree	Moderately disagree	Strongly disagree
1	I don't find much satisfaction in private prayer with God.	SA	MA	A	D	MD	SD
2	I don't know who I am, where I came from, or where I'm going.	SA	MA	A	D	MD	SD
3	I believe that God loves me and cares about me.	SA	MA	A	D	MD	SD
4	I feel that life is a positive experience	SA	MA	A	D	MD	SD
5	I believe that God is impersonal and not interested in my daily situation.	SA	MA	A	D	MD	SD
6	I feel unsettled about my future.	SA	MA	A	D	MD	SD
7	I have a personally meaningful relationship with God.	SA	MA	A	D	MD	SD
8	I feel very fulfilled and satisfied with life.	SA	MA	A	D	MD	SD
9	I don't get much personal strength and support from my God	SA	MA	A	D	MD	SD
10	I feel a sense of well-being about the direction my life is headed in.	SA	MA	A	D	MD	SD
11	I believe that God is concerned about my problems.	SA	MA	A	D	MD	SD
12	I don't enjoy much about life	SA	MA	A	D	MD	SD
13	I don't have a personally satisfying relationship with God.	SA	MA	A	D	MD	SD
14	I feel good about my future.	SA	MA	A	D	MD	SD
15	My relationship with God helps me not to feel lonely	SA	MA	A	D	MD	SD
16	I feel that life is full of conflict and unhappiness.	SA	MA	A	D	MD	SD
17	I feel most fulfilled when I'm in close communion with God	SA	MA	A	D	MD	SD
18	Life doesn't have much meaning.	SA	MA	A	D	MD	SD
19	My relation with God contributes to my sense of well-being.	SA	MA	A	D	MD	SD
20	I believe there is some real purpose for my life.	SA	MA	A	D	MD	SD

SA= strongly Agree **MA=** moderately agree **A=**agree **D=** disagree MD=moderately disagree **SD=** strongly disagree

2- Self-esteem: (Rosenberg Self- Esteem)

Instruction: Below is a list of statements dealing with general feelings about itself. If it's strongly agreed, circle SA. If it's Agree with the statement circle A. if it's disagree circle D if it's strongly disagree circle SD

No.	Statements	SA STRONGLY AGREE	A AGREE	D DISAGREE	SD STRONGLY DISAGREE
1.	I feel that I'm a person of worth, at least on an equal plane with others.	3	2	1	0
2.	I feel that I have a number of good qualities.	3	2	1	0
3.	All in all, I am inclined to feel that I am a failure.	0	1	2	3
4.	I am able to do things as well as most other people.	3	2	1	0
5.	I feel I do not have much to be proud of.	0	1	2	3
6.	I take a positive attitude toward myself.	3	2	1	0
7.	On the whole, I am satisfied with myself.	3	2	1	0
8.	I wish I could have more respect for myself.	0	1	2	3
9.	I certainly feel useless at times.	0	1	2	3
10.	At times, I think I am no good at all.	0	1	2	3

Part IV: hopelessness: (Beck Hopelessness Scale)

Instruction: If the statement describes your attitude answer true, If the statement is not described your attitude answer false.

No.	statements	True	False
1	I look forward to the future with hope and enthusiasm.		
2	I might as well give up because there's nothing I can do to make things better for myself.		
3	When things are going badly, I am helped by knowing that they can't stay that way for ever.		
4	I can't imagine what my life would be like in ten years.		
5	I have enough time to accomplish the things I most want to do.		
6	In the future, I expect to succeed in what concerns me most.		
7	My future seems dark to me.		
8	I happen to be particularly lucky and I expect to get more of the good things in life than the average person.		
9	I just don't get the breaks, and there's no reason to believe that I will in the future.		
10	My past experiences have prepared me well for my future		
11	All I can see ahead of me is unpleasantness rather than pleasantness.		
12	I don't expect to get what I really want.		
13	When I look ahead to the future I expect I will be happier than I am now.		
14	Things just won't work out the way I want them to.		
15	I have great faith in the future.		
16	I never get what I want, so it's foolish to want anything.		
17	It is very unlikely that I will get any real satisfaction in the future.		
18	The future seems vague and uncertain to me.		
19	I can look forward to more good times than bad times.		
20	There's no use in really trying to get something I want because I probably won't get it.		

Depression Inventory (MDI) (lCD-10)

The following questions ask about how you have been feeling over the last two weeks. Please put a tick in the box which is closest to how you have been feeling. The Major Depression Inventory (MDI) is a self-report mood questionnaire developed by the World Health Organization's Collaborating Center in Mental Health.

Example: If you have felt in low spirits or sad slightly more than half of the time during the last two weeks put a "tick" in the third box from the left in the first row.

	How much of the time...	All of the time	Most of the time	More than half of the time	Less than half of the time	Some of the time	At no time
1	Have you felt in low spirits or sad?	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0
2	Have you lost interest in your daily activities?	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0
3	Have you felt lacking in energy and strength?	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0
4	Have you felt less self-confident?	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0
5	Have you had a bad conscience or feelings of guilt?	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0
6	Have you felt that life wasn't worth living?	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0
7	Have you had difficulty in concentrating, e.g. when reading the newspaper or watching television?	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0

8a	Have you felt very restless?	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0
8b	Have you felt subdued?	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0
9	Have you had trouble sleeping at night?	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0
10a	Have you suffered from reduced appetite?	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0
10b	Have you suffered from increased appetite?	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0

When using the scale to diagnose depression according to ICD-10, there are the following possibilities:

- **Mild depression**: A score of 4 or 5 in two of the first three items. Plus a score of at least 3 on two or three of the last seven items.
- **Moderate depression**: A score of 4 or 5 in two or three of the first three items. Plus a score of at least 3 on four of the last seven items.
- **Severe depression**: A score of 4 or 5 in all of the first three items. Plus a score of at least 3 on five or more of the last seven items.

Major depression: The number of items is reduced to nine, as Item 4 is part of Item 5. Include whichever of the two items has the highest score (item 4 or 5). A score on at least five items is required, to be scored as follows: the score on the first three items must be at least 4, and on the other items at least 3. Either Item 1 or 2 must have a score of 4 or 5

ڕاوەرگرتن

"کۆکردنەوەی زانیاری دەربارەی ڕۆحانی ، باوەڕبەخۆبوون و هیوا لە نەخۆشی تووش بوو بە نەخۆشی خەمۆکی لە سەنتەری ڕاوێژکاری عەلی کەمال لە شاری سلێمانی"

ناوی نەخۆش : ..... کۆدی نەخۆش: .....

هیچ نەخۆشیەکی جەستەیت هەیە؟ .....

بەشی یەکەم: تایبەتمەندێتی دیمۆگرافی و کۆمەڵایەتی نەخۆش

تەمەن ☐ ساڵ

ڕەگەز: نێر ☐ مێ ☐

باری خێزان: ڕەبەن ☐ خێزاندار ☐ تەڵاق ☐ جیابووەوە ☐ هاوسەر مردو ☐

ئاستی خوێندن: نەخوێندەوار ☐ سەرەتایی ☐ ناوەندی ☐ دواناوەندی ☐ خوێندنی باڵا ☐

پیشە: ☐

شوێنی نیشتەجێبوون: شار ☐ شارۆچکە ☐ گوند ☐

باری دارایی: بەش دەکات ☐ تاڕادەیەک بەش دەکات ☐ بەش ناکات ☐

باری ئاینی: پەیوەست ☐ کەمێک پەیوەست ☐ ناپەیوەست ☐

بەشی دووەم: پێشینەی باری دەروونی نەخۆش:

ماوەی نەخۆشییەکە: ☐ ساڵ

ژ. مانەوە لە نەخۆشخانە: ☐ جار

هەوڵی خۆکوژی: نەخێر ☐ بەڵێ ☐ نەگەر بەڵێ، چەند جار ☐

پێشینەی نەخۆشی دەروونی لە خێزانەکەدا: نەخێر ☐ بەڵێ ☐ نەگەر بەڵێ، کێ ☐

بەشی سێیەم: باوەڕبەخۆبوون (باوەڕبەخۆبوونی ڕۆزنبێرگ)

ڕێنمایی: دەستەواژەکانی خوارەوە پەیوەستن بە هەستی گشتی دەربارەی خۆت. ئەگەر تەواو هاوڕایت (AS) بخەرە نێو بازنەوە بەڵام ئەگەر تەنها هاوڕابویت (A) بخەرە بازنەوە. ئەگەر هاوڕانەبووییت (D) بخەرە ناو بازنە وە ئەگەر تەواو هاوڕانەبووییت (SD) بخەرە ناو بازنەوە.

ژ.	دەستەواژەکان	SA تەواو هاوڕام	A هاوڕام	D هاوڕا نیم	SD تەواو هاوڕانیم
١-	هەستەکەم من کەسێکی بە نرخم، بەلایەنی کەمەوە بەهەمان ئاستی کەسانی تر	٣	٢	١	٠
٢-	هەستەکەم من ژمارەیەک کوالیتی باشم هەیە	٣	٢	١	٠
٣-	بەگشتی هەستەکەم من فاشلم	٠	١	٢	٣
٤-	من توانای کردنی ئەو شتانەم هەیە کە زۆربەی خەلک دەیکەن	٣	٢	١	٠
٥-	من هەست دەکەم من ئەوەندەم نیە کە شانازی پێوە بکەم	٠	١	٢	٣
٦-	من بیرکردنەوەم ئەرێنیە (پۆزەتیفە) دەربارەی خۆم	٣	٢	١	٠
٧-	بە گشتی من ڕازیم لە خۆم	٣	٢	١	٠
٨-	خۆزگە بمتوانیایە ڕێزی زیاترم هەبێت بۆ خۆم	٠	١	٢	٣
٩-	من بەدڵنیایی زۆرکات هەست بە بێ کەڵکیم دەکەم	٠	١	٢	٣
١٠-	زۆرکات من وا بیردەکەمەوە کە من هیچ باش نیم	٠	١	٢	٣

بەشی چوارەم: بێ هیوایی (پێوانەی بێ هیوایی بێک)

ڕێنمایی: ئەگەر دەستەواژەکان هاوتای بیرکردنەوەی تۆ بوو بڵێ (ڕاستە)، ئەگەر دەستەواژەکە پێچەوانەی بیرکردنەوەی تۆ بوو بڵێ (هەڵەیە).

ژ.	دەستەواژەکان	ڕاستە	هەڵەیە
١-	من بە شەوق و هیواوە دەڕوانمە داڕۆژ		
٢-	من لەوانەیە کۆڵ بدەم چونکە هیچ شتێک نیە بتوانم بیکەم تا شتەکان باشترکەم بۆ خۆم		
٣-	کاتێک شتەکان خراپ دەڕۆن، یارمەتیدەرم ئەوەیە کە دەزانم تاسەر هەرگیز ناهێنێتەوە		
٤-	من ناتوان بیهێنمە پێش چاوم کە ژیانم دوای دە ساڵی تر چۆن دەبێت		
٥-	من کاتی پێویستم هەیە بۆ تەواوکردنی ئەو شتانەی کە زۆر خوازیارم بیانکەم		
٦-	لە داهاتودا چاوەڕوان دەکەم کە سەرکەوتووبم لەوانەدا کە زۆر مەراقمە		
٧-	داهاتوم تاریک دێتە پێش چاوم		
٨-	جار جار بەختم هەیە وە چاوەڕوانم زۆر شتی باشتر بێتە ژیانم لە زۆربەی خەڵک		
٩-	من هیچ پشوم نیە ، وە هیچ هۆکارێک نیە کە باوەڕ بێنم لە داهاتودا پشو بدەم		
١٠-	ئەزموونی ڕابردوم بە چاکی ئامادەی کردوم بۆ داهاتوم		
١١-	ئەوەی کە چاوەڕێی دەکەم بێتە پێشم هەر ناخۆشیە نەک خۆشی		
١٢-	من چاوەڕێی ئەوە ناکەم ئەوە بەدەست بهێنم کە بەڕاستی دەمەوێت		
١٣-	کاتێ من لە داهاتو دەڕوانم چاوەڕێ دەکەم دڵخۆشتر بم لە ئێستام		
١٤-	شتەکان بەو ئاراستەیەدا ناڕۆن کە من دەمەوێن		
١٥-	من باوەڕی گەورەم بە داهاتووە		
١٦-	ئەوەی من دەمەوێت هەرگیز دەستم ناکەوێت ، بۆیە شێتی یە کە داواکاریم هەبێت		
١٧-	زۆر چاوەڕوان نەکراوە کە لە داهاتودا بەڕاستی ڕازیبم		
١٨-	داهاتو ئاڵۆز دەبینم و دڵنیایی نیە بۆ من		
١٩-	من ناتوانم چاوەڕوانی کاتی باشی زیاتر بم نەک کاتی خراپ		
٢٠-	بە ڕاستی بێ سوودە هەوڵ بدەم شتێک بەدەست بهێنم کە دەمەوێت چونکە ڕەنگە بەدەستی نەهێنم		

بەشی پێنجەم: ئاسودەیی ڕۆحی (پێوەری ئاسودەیی ڕۆحی ئێلیسۆن- پالوزیان)

بۆ هەر دەستەواژەیەک بازنە بکێشە بەدەوری ئەو وەڵامەی کە دەگونجێت لەگەڵ ڕێژەی هاوڕابوون یان هاوڕانەبوونت بە گوێرەی ئەزمونی خۆت.

ژ.	دەستەواژەکان	بەتەواوی هاوڕا	تەواو هاوڕا	هاوڕا نیە	هاوڕا	تەواو هاوڕا نیە	بەتەواوی هاوڕا نیە
١-	زۆر ڕازی نیم لە نوێژکردنم بۆ خودا	SA	MA	D	A	MD	SD
٢-	من نازانم من کێم، لە کوێوە هاتوم، یان بۆ کوێ دەچم	SA	MA	D	A	MD	SD
٣-	من باوەڕم وایە کە خودا منی خۆش دەوێت و چاوی لێمە	SA	MA	D	A	MD	SD
٤-	هەستەکەم ژیان ئەزمونێکی پۆزەتیفە	SA	MA	D	A	MD	SD
٥-	باوەڕم وایە خودا نادیارەو هیچ گرنگی بەبارودۆخی ڕۆژانەم نادات	SA	MA	D	A	MD	SD
٦-	من هەستەکەم دانەمەزراووم دەربارەی داهاتوو	SA	MA	D	A	MD	SD
٧-	من پەیوەندیەکی پڕمانای خۆمم هەیە لەگەڵ خودا	SA	MA	D	A	MD	SD
٨-	من هەست بە پڕی و ڕازی بوون دەکەم لە ژیان	SA	MA	D	A	MD	SD
٩-	من ئەوەندە هێز و پشتیوانی لە خوداوە وەرناگرم	SA	MA	D	A	MD	SD
١٠-	من هەست بە خۆشگوزەرانی دەکەم دەربارەی ڕەوتی ژیانم	SA	MA	D	A	MD	SD
١١-	هەستەکەم خودا گرنگی بە کێشەکانم دەدات	SA	MA	D	A	MD	SD
١٢-	من زۆر لەزەت لە ژیان ناکەم	SA	MA	D	A	MD	SD
١٣-	من پەیوەندیەکی کەسی ڕەزامەندم نیە لەگەڵ خودادا	SA	MA	D	A	MD	SD
١٤-	من هەستم باشە دەربارەی داهاتووم	SA	MA	D	A	MD	SD
١٥-	پەیوەندیم لەگەڵ خودادا یارمەتیدەرە تا هەست بەتەنهایی نەکەم	SA	MA	D	A	MD	SD
١٦-	هەستەکەم ژیان پڕە لە کێشەو ناخۆشی	SA	MA	D	A	MD	SD
١٧-	هەستەکەم زۆر پڕم کاتێ لە پەیوەندی نزیکدام لەگەڵ خودا	SA	MA	D	A	MD	SD
١٨-	ژیان ئەوەندە مانابەخش نیە	SA	MA	D	A	MD	SD
١٩-	پەیوەندیم لەگەڵ خودادا کۆمەکە بۆ هەستی ئاسودەیی	SA	MA	D	A	MD	SD
٢٠-	باوەڕم وایە کە هەندێ ئامانجی ڕاست هەبێ لە ژیانمدا	SA	MA	D	A	MD	SD

APPENDIX E

List of expertes

1	Professor Dr. Nazar Mohammad Mohammad Amin	College of medicine University of Sulaimani
2	Professor Dr.Rushdi Ali Mirza	College of Education University of Sualimani
3	Professor Dr. Ali Karim Al-Jubouri	College of Nursing Universty of Karbala
4	Professor Dr. Aliraza Nikbakht Nasrabadi	School of Nursing and Midwifery Tehran University of Medical Sciences
5	Professor Dr. Mohammad Ali Cheraghi	School of Nursing and Midwifery Tehran University of Medical Sciences
6	Professor Dr. Saadun Dawd Ahmad	College of Medicine University Kirkuk
7	Assistant Professor Dr. Abdulqadr Hussein Hamad	College of Nursing Hawler Medical University
8	Assistant Professor Dr. Viyan Othman Naqshbandi	College of Nursing Hawler Medical University
9	Assistant Professor Dr. Salih Ahmad Abdulla	College of Nursing Hawler Medical University
10	Assistant Professor Dr. Karim Fatah Aziz	College of Nursing Hawler Medical University
11	Assistant Professor Dr. Hiwa Sittar Salih	College of Nursing Universty of Kirkuk
12	Assistant Professor Dr. Twana Abdlrahman Rahim	College of Medicine University of Sulaimani
13	Consultant Dr. Siham Abdulla Hamoo	Consultant Psychiatric Nurse Ministry of Health Baghdad
14	Assistant Professor Dr. Karim Rashak Sachit	College of Nursing Universty of Baghdad
15	Assistant Professor Dr. Muhammad Rashid Amin	College of Nursing Universty of Sulaimani
16	Assistant Professor Dr. Abolfazl Mohammadi	Department of Psychiatric Tehran University of Medical Sciences
17	Associate Professor Dr. Fatemeh Noughani	School of Nursing and Midwifery Tehran University of Medical Sciences

18	Assistant Professor Dr. Fataneh Ghadirian	School of Nursing and Midwifery Tehran University of Medical Sciences
19	Lecturer Dr. Bahar Nasradin Majeed	College of Nursing Universty of Sulaimani

Appendix F

School of Nursing & Midwifery
Tehran University of Medical sciences

Certificate of Quality

Psychiatric Mental Health Nursing Department

This is to certify that Mr. **Taha Ahmad Faraj** was awarded the following grades:

Subject	Score	Grade
Fundamental of Professional Therapeutic Counseling	100	A
Clinical Counseling	100	A
Counseling in Chronic Health Conditions	100	A

PROF. ALIREZA NIKBAKHT NASRABADI
Dean
Tehran School of Nursing & Midwifery

Tehran University of Medical Sciences
School of Nursing and Midwifery
Vice-Dean for International Affairs

Dr. Fatemeh Noughani
Head of Psychiatric Nursing Department
Tehran School of Nursing & Midwifery

Appendix F

School of Nursing and Midwifery
Tehran University of Medical Sciences

Date:13 Jan, 2018

NO:96/-/250/6061

CERTIFICATE OF COMPLETION

This is to certify that Dr. Taha Ahmad Faraj has successfully completed the following course:

"Professional Therapeutic Counselling"

that was organized and conducted by the Psychiatric Nursing Department of
Tehran School of Nursing and Midwifery from
22 (Dec) 2017, to 22 (Jan) 2018.
With the collaboration of Imam Khomein, Roozbeh, and Shariati Hospitals

DR. FATEMEH NOGHANI
HEAD OF PSYCHIATRIC NURSING DEPARTMENT
SCHOOL OF NURSING & MIDWIFERY

DR. ALIREZA NIKBAKHT NASRABADI
DEAN
SCHOOL OF NURSING & MIDWIFERY

DR. RAMIN KORDI
VICE-CHANCELLOR FOR GLOBAL STRATEGIES
AND INTERNATIONAL AFFAIRS (TUMS)

Tehran University of Medical Sciences
Vice-Chancellor for Global Strategies & International Affairs

Medico-Legal Update
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No6097/MLU/2019 30-11-2019

To,
Taha Ahmad Faraj
Lecturer, College of Nursing/University of Sulaimani

Dear author/s

I have pleasure to inform you that your following Original Article has been accepted for publication in Medico-Legal Update.

Assessment of self-esteem among patients with major depressive disorder in Sulaimani City

Taha Ahmad Faraj [1], Professor Dr. Salwa Shakir Muhsin [2]

[1] Lecturer, College of Nursing/University of Sulaimani

[2] College of Nursing/University of Sulaimani

It will be published in Volume 20, No.1, January – July 2020 issue. It is further mentioned for your information that our journal is a double-blind peer reviewed indexed international journal. It is covered by Index Copernicus (Poland), Indian Citation index, Google Scholar, CINAHL, EBSCOhost (USA), EMBASE (Scopus) and many other international databases. The journal is now part of CSIR, DST and UGC consortia. The Journal is index with Scopus and fulfills MCI Criteria as per MCI circular dated 03/09/2015.

With regards

Yours sincerely

Prof R K Sharma
Editor

حكومة أقليم كوردستان- العراق
وزارة التعليم العالي و البحث العلمي
جامعة هَولير الطبيّة
كليّة التمريض
مجلة أربيل للتمريض و القبالة

حکومەتی هەرێمی کوردستان– عێراق
وەزارەتی خوێندنی باڵا و توێژینەوەی زانستی
زانکۆی هەولێری پزیشکی
کۆلێژی پەرستاری
گۆڤاری ئەربیل بۆ پەرستاری و مامانی

HAWLER MEDICAL UNIVERSITY
کۆلێژی پەرستاری
Iraqi Kurdistan Region
Council of Ministers
Ministry of Higher Education and Scientific Research
Hawler Medical University
College of Nursing

No: ب- ٢- 2133
Date: 27-11-2019

ژمارە: ٤/ ١٣٣٣/ ٢
ڕێکەوت: ٢٧/ ١١/ ٢٠١٩

Acceptance Letter

Dear **Mr. Taha Ahmad Faraj**
Dr. Salwa Shakir Muhsin

We would like to inform you that your submitted manuscript with ID "EJNM-2019-52" entitled **"Hopelessness levels among patients with major depressive disorder in Sulaimaniya City"** is accepted to publish in **Erbil Journal of Nursing and Midwifery, Vol. 3, No. 1, May., 2020**

We are looking forward to having your other valuable works

Assist.Prof.Dr. Vian Affan Naqshbandi
Associate Editor

Hawler Medical University College of Nursing EJNM Erbil Journal of Nursing & Midwifery

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پوختە

پێشینە:-

نەخۆشی خەمۆکی خەڵکانێکی زۆر پێوەی گیرۆدەن و بۆتە هۆی مردنی زۆریشیان زۆرێك لە تۆژەرەکان پەیوەندی نازوون دەبینن لە نێوان نەخۆشی خەمۆکی وئاستی زۆحانی و ئاستی بڕوا بە خۆبوون و بێ هیوای نەخۆش توندی ئاستەکانی ئەم هۆکارانە زۆڵێکی گرنگ دەبینن لە توشبون و چاکبونەوە و دەستنیشان کردنی نەخۆشی خەمۆکی.

ئامانج:-

ئامانجی سەرەکی ئەم تۆژینەوەیە هەڵسەنگاندنی ئاستەکانی زۆحانی بوون و باوەڕ بەخۆبوون و بێهیواییە لەلای نەخۆشی.

میتۆد:-

ئەم تۆژینەوەیە وەسفی چەندێتی زانستی یە. کە ١٥٠ نەخۆشی توشی بوی بە خەمۆکی لە خۆگرتووە کە لە سەنتەری ڕاوێژکاری عەلی کەمال لە شاری سلێمانی بینراون.

ئەنجام:-

ئەنجامەکان دەری دەخەن کە نەخۆشەکانی توش بوو بە خەمۆکی ئاستێکی بەرزی زۆحانی نیشان دەدەن بەڵام باوەڕ بەخۆبوونێکی نزم و ئاستی بێهیوابونیان مام ناوەندە.

دەرئەنجام:-

بە پێی ئەم تۆژینەوەیە بەها زۆحانیە بەرزەکان هۆکارێکی گرنگی بەهێزە کە سەرچاوەیەکەی هەست و سۆزە و ئەکرێت بەکار بهێنرێت بۆ زاڵبوون یاخود ڕاهاتن لەگەڵ هەستی خەمۆکی لای نەخۆش.

پێشنیار:-

پێشنیار ئەوەیە کە چارەسەری هەڵسوکەوت و ژیری کە چارەسەری گروپیش لەخۆدەگرێت ئەکرێت سەرکەوتوانە بەکار بهێنرێت بۆ کەمکردنەوەی خراپ ڕوانین لە خود و بەرز کردنەوەی باوەڕ بەخۆبوون و کەمکردنەوەی هەستکردن بە بێهیوایی.

حکومەتی هەرێمی کوردستان
وەزارەتی خوێندنی باڵاو توێژینەوەی زانستی
زانکۆی سلێمانی
کۆلێژی پزیشکی

هەڵسەنگاندنی ئاستەکانی ڕۆحانی و باوەڕ بەخۆ بوون و بێ هیوا بوون لەلای ئەو نەخۆشانەی کە نەخۆشی خەمۆکیان هەیە لە شاری سلێمانی

ئەم توێژینەوەیە پێشکەشکراوە بە ئەجومەنی کۆلێژی پزیشکی زانکۆی سلێمانی وەک بەشێک لە پێداویستیەکانی بەدەست هێنانی بڕوانامەی دکتۆرا لە زانستی پەرستاریدا

لەلایەن
تەها احمد فرج
ماستەر لە زانستی پەرستاری ۱۹۹۹
زانکۆی ماستریخت\ هۆڵەندا

بەسەرپەرشتی
پرۆفیسۆر
د.سلوی شاکر الکروی