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The Effectiveness of Islamic Cognitive-behavioral Therapy Compared With Conventional Cognitive-Behavioral Therapy in Reducing Depression and Increasing Life Satisfaction and Spiritual Health in Patients With Depression

Morteza Abdoljabbari[1], Mahboubeh Dastani[2], Mohammad Ali Jamshidi[3], Mojtaba Farhoush[4], Mohammad Farhoush[5*]

1. Department of Islamic Education, Religion and Health Studies Center, Shahid Beheshti University of Medical Sciences, Tehran, Iran.
2. Department of Psychology, Faculty of Industrial Engineering, Shahab-Danesh University, Qom, Iran.
3. Department of Health Psychology, Faculty of Humanities, Edalat University, Tehran, Iran.
4. Department of Quran and Psychology, Al-Mustafa International University, Qom, Iran.
5. Department of Islamic Education, Religion and Health Studies Center, Shahid Beheshti University of Medical Sciences, Tehran, Iran.

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ABSTRACT

Background and Objectives: Some studies have shown that spirituality and religion are related to more life satisfaction and less depression. The present study examined the effectiveness of Islamic cognitive-behavioral therapy (CBT) compared to conventional CBT in reducing depression and increasing life satisfaction and spiritual health in patients with depression.

Methods: This is a random trial with a pre-test-post-test design. There were 30 participants in this study; 15 participants received conventional CBT and 15 received Islamic CBT. The instruments used for data collection included a semi-structured interview based on diagnostic and statistical manual of mental disorders, 5th edition (DSM-5), Glock and Stark's (1970) Religiosity Scale, Beck's depression inventory, Diner's life satisfaction questionnaire (1985), and Paloutzian's spiritual wellbeing scale, which were filled in before and after the treatment sessions. Each protocol included ten 50-minute sessions. The collected data were finally analyzed using multivariate analysis of covariance (MANCOVA).

Results: Islamic CBT led to a significantly higher level of spiritual health compared to conventional CBT ($P<0.001$). Both methods led to a significant reduction in depression and increased life satisfaction and no significant difference was found between them.

Conclusion: It is suggested that Islamic CBT should be improved in terms of psychological components and techniques combined with spirituality so that its effectiveness in reducing depression and increasing life satisfaction can be improved compared to conventional CBT.

*** Corresponding Author:**
Mohammad Farhoush, ***PhD.***
Address: *Department of Islamic Education, Religion and Health Studies Center, Shahid Beheshti University of Medical Sciences, Tehran, Iran.*
Phone: *+98 (910) 2041853*
E-mail: *Farhoush.mohammad@gmail.com*

Introduction

Depression is a serious problem and challenge for public health. Major depression is a mood disorder that causes a feeling of worthlessness, lack of joy, lack of concentration, and sleep and eating disorders in an individual. These depression-related problems bring about reduced quality of life and life satisfaction [1].

Life satisfaction is a protective factor against slipping back into depression. Life satisfaction is accompanied by positive feelings, such as happiness. Diner defined life satisfaction as an individual's most comprehensive evaluation of his/her quality of life [2]. Therefore, there is a cognitive and subjective dimension to life satisfaction [3]. It seems that an efficient treatment for depressed people is to increase their life satisfaction.

Psychotherapy is beneficial to those with depression [4]. One of the best methods for the treatment of depression is cognitive-behavioral therapy (CBT), which has a special effect on the treatment of depression. Focusing on incompatible thoughts and beliefs, this approach improves the symptoms of depression [5].

Based on the cognitive-behavioral approach, individuals' experience leads to the development of assumptions and schemas of themselves and the world, which are effective in directing their feelings and behavior. Some assumptions are negative, inflexible, and extremist [6]. These inefficient assumptions cause a person not to have a good view of him/herself and others leading them to experience more negative feelings and show inappropriate behaviors. Gradually, the person may be stuck in a vicious circle that causes suffering and disorder in performance [7]. With increased feelings of depression, negative spontaneous thoughts increase and the logical thoughts gradually disappear. This process increasingly causes the scope of the depressed mood to broaden and form a vicious circle of depression [8].

Cognitive-behavioral treatment seeks an individual's cognitive reconstruction to help him/her replace illogical, negative, and inefficient thoughts with logical, positive, and efficient ones [9]. Many religious patients prefer to receive psychological treatments along with their religious beliefs [10].

It seems that by using religious beliefs an individual can focus on spiritual goals and reinforce the feeling of spiritual sense [11]. As a result, the individual's attention is diverted away from the thoughts related to lack and loss and reduces excessive attention to internal thoughts and feelings [12]. Mojahed (2009) also showed that although Islamic CBT, similar to conventional CBT, is effective in improving mental health and reducing inefficient attitudes, Islamic therapy is not more effective than conventional therapy [13]. In addition, Khoshbooii et al. (2021) found that both religious and conventional approaches are effective in reducing depression with both showing a significant reduction in depression compared to the control group, but the difference between the two experimental groups was not significant [14].

Despite these findings, theoretically, Islamic CBT is expected to be more effective than conventional therapy. In Islam, issues, such as gratitude, altruism, and generosity have been emphasized as they reduce grief and sadness [15]. Additionally, religious beliefs create a positive and optimistic attitude toward life and its events by reinforcing the meaning of life and changing an individual's interpretation of events. Therefore, they help the individual deal with negative behaviors and cognitions [13]. Many life events evaluated as negative in one's initial evaluation are, in fact, evaluated as positive in secondary evaluation originating from spiritual views. Generally, positive spiritual attitudes increase the individual's resilience in facing problems [16]. Some studies have reported more effectiveness for Islamic therapy [17].

It is expected that therapy combined with Islamic beliefs increases an individual's spiritual health. Johnson et al. (2016) found that nursing students with daily spiritual experiences describe their health as good or excellent while those with lower daily experience report higher levels of depression [18]. Spiritual health includes enjoying a sense of acceptance, positive feelings, and the feeling of a positive mutual relationship with a dominant and superior holy power. Spiritual health is one of the important dimensions of health and causes an individual's adaptability to tensions and crises. It increases positivism and flexibility in an individual. Spiritual health includes two components: Religious health and existential health [19]. The religious dimension shows a relationship with a superior power, i.e. God, and the existential dimension shows an individual's feeling toward the meaning and purpose of life.

Although conventional CBT is effective in reducing stress, many Iranian patients are Muslims and have strong religious beliefs, and tend to see their Islamic beliefs in an integrated structure with treatment [20]. Koenig et al. (2015) designed religious CBT plans for different religions and implemented them for the treatment of depression in some groups. Their findings revealed

no significant difference between religious and conventional CBT [21]. However, in their study, the treatment was provided remotely and by phone, and the effects of the treatment on the spiritual health of people were not assessed. Therefore, the present study was done to replicate the study by Koenig et al (2015) with the difference that the treatment was provided face-to-face and individually, and the effectiveness of the treatment, in addition to depression, was assessed on life satisfaction and spiritual health as well. The main research question is whether Islamic CBT is more effective than conventional CBT in reducing depression and increasing spiritual health and life satisfaction.

Methods

Statistical population

The statistical population of the study included all the individuals with major depression, who had been referred to the counseling center in Qom, Iran; they were informed via telephone or in person about the study. Some of the experts in the counseling center, who specialized in depression treatment, were briefed and asked to invite their patients to participate in our study. Overall, 50 patients volunteered to participate in the study. The participants were briefed on the purpose of the study and their depression levels were assessed with structured interviews (SCID-5-cv) by a psychologist. To prevent participant dropout, in the initial interviews, the participants' conditions were examined in terms of their distance from the center and their motivation for treatment. The sample size was calculated as 30 people by considering covariance analysis statistics, using G*Power software, version 3.1.9.2. A confidence level of 0.95, the number of groups of two, 3 variables, and the effect size of 0.3. Thus, 30 patients were included in the study. They were randomized by stratified randomization method and randomly assigned into two groups of 15 based on their gender, age, and education level to cancel out the effect of demographic variables. As religious CBT was going to be compared with conventional CBT and conventional CBT is a standard therapy for major depression, there was no need for a further control group. However, it was also ethically inappropriate to assign a person diagnosed with major depression to a control group and deprive him/her of therapy for three months.

The inclusion criteria included: 1) Diagnosis of major depression by a psychologist, 2) Having at least a score of 20 on the inventory of depression, 3) The age of 20-50 years, 4) Being religious (the criterion for being religious included obtaining a score of 26 or higher on the Glock and Stark's religiosity scale), and 5) No symptoms of psychotic disorder, bipolar disorder, PTSD, and personality disorder assessed by a psychologist, 6) No symptoms of drug abuse, and 7) Consent to participation in the study and signing a written consent form. The exclusion criteria also included 1) Having an active plan for committing suicide, 2) Personal cancellation, and 3) Being absent for more than two treatment sessions.

Research instruments

The instruments used in the present study included the structured clinical interview for DSM-5, Glock and Stark's religiosity scale, Beck's depression inventory, Diner's life satisfaction questionnaire, Paloutzian's spiritual wellbeing scale, the conventional CBT protocol, and Islamic CBT protocol. Each of these instruments is elaborated on in this section.

Structured clinical interview for DSM-5: Structured clinical interview for DSM-5 is a semi-structured interview for the diagnosis of disorders based on DSM-5. Clinical validity is a positive agreement between the interview and clinical diagnoses in a range between 73% and 97%. Also, the diagnostic sensitivity/specificity was more than 0.70 [22]. In a study in Iran, the internal consistency (Cronbach's α) of all diagnoses was in the range of 0.95 to 0.99, which indicates excellent internal reliability. In addition, composite reliability for all diagnoses was very acceptable (Cronbach's α: 0.99). Test retest reliability for all diagnoses was in the range of 0.60 to 0.79, which indicates good reliability [23].

Glock and Stark's religiosity scale: The religiosity questionnaire was developed by Glock and Stark (1970) to measure religious attitudes and beliefs and an individual's religiosity [24] and has been matched with the religion of Islam (31). The Cronbach's α value was 0.81 for the belief dimension, 0.75 for the emotional dimension, 0.72 for the consequential dimension, and 0.83 for the ritual dimension [25]. This questionnaire was used to measure the participants' religiosity, which was the inclusion criterion for entering the study. A religious person is someone who obtains a score higher than 26. The reliability of this questionnaire in this study was 0.88.

Beck's depression inventory: The Beck depression inventory-II (BDI-II) is a 21-item questionnaire (Beck, Steer, and Brown, 1996) and the revised version of Beck's depression inventory. It measures the symptoms of depression and their severity in individuals. Test retest reliability of this inventory with a one-week interval was obtained to be 0.91. Its internal consistency was

also reported to be 0.91 [26]. Its internal consistency was 0.91 and its reliability was 0.94 [27]. In the present study, this inventory was used to measure the severity of depression. The reliability of this questionnaire in this study was 0.53.

Diner's life satisfaction questionnaire (SWLS): SWLS was developed by Diener et al. [2]. It evaluates to what extent individuals are satisfied with their life. Its test retest coefficient is 0.82 and its internal consistency is 0.87 [2]. Cronbach's α coefficient of the Persian version was 0.83 and its reliability coefficient was 0.75 [28]. The reliability of this questionnaire in this study was 0.65.

Paloutzian's spiritual wellbeing scale, Paloutzian and Ellison's inventory was introduced as the spiritual health scale in 1982. This questionnaire has two factors and 20 items. Its reliability and validity were reported to be good by its developers [19]. The reliability of the Persian version was found to be 0.82 [29]. The reliability of this questionnaire in this study was 0.71.

The present study sought to implement Koenig et al.'s (2015) treatment plan for those with depression and examine its effectiveness. For this purpose, their designed treatment plan was translated for religious CBT and conventional CBT and confirmed by two experts in the field. The protocols consisted of ten sessions. The conventional CBT developed by Koenig includes ten sessions. Its contents include 1) Assessment and introducing conventional CBT, 2) Behavioral activation, 3) Identifying and challenging unhelpful thoughts, 4) Challenging unhelpful thoughts, 5) Dealing with loss, 6) Coping with negative emotions, 7) Gratitude, 8) Altruism and generosity, 9) Stress-related growth, and 10) Hope and relapse prevention.

The Islamic CBT protocol, which was designed by Koenig, also includes ten sessions. Its contents include 1) Evaluating and introducing religious CBT, 2) Behavioral activation: Walking with faith, 3) Identifying and challenging inefficient behaviors: The battlefield of the mind, 4) Challenging inefficient behaviors, 5) Facing the losses, 6) Dealing with negative emotions and spiritual conflicts, 7) Thanksgiving, 8) Altruism and generosity, 9) Stress-related spiritual growth, and 10) Hope and preventing relapse.

Structure of the sessions: In both protocols, each session has 60 minutes and its structure consists of reviewing the tasks of the previous session and solving possible obstacles and problems, reviewing the purpose of the session and its importance in increasing vitality and reducing depression, providing techniques to achieve the purpose of the meeting, presentation of exercises in the meeting and homework, and summary.

The collected data were finally analyzed using multivariate analysis of covariance (MANCOVA) by SPSS software, version 23. The significance level was P<0.01.

Results

Each group consisted of six male and nine female participants. Their age ranged from 21 to 43 years and their mean age was 29 years. The mean age showed no significant difference between the two groups. Their educational degree included a diploma, BS, or MS and 60% of the participants were married. The two groups were homogeneous in terms of gender, age, education level, and marital status. All participants took a depression test and obtained a score of 26 or higher on the religiosity test. The mean score related to the religiosity of the participants was 65. The participants' pre-test and post-test scores of the research variables are presented in Table 1.

As shown in Table 1, the mean scores related to the variables of depression, satisfaction with life, spiritual health, and its components in the post-test (after implementing the conventional and Islamic CBT) improved in both groups. The results of Levene's test confirmed the assumption of equality of variance of the scores (P<0.05). In addition, the results of Box's M test (homogeneity of variance-covariance matrices) confirmed the assumption of equality of covariance matrices in all analyses. For checking the homogeneity of the regression slope assumption, we examined the interaction between the dependent and moderator variables. The results confirmed the assumption of MANCOVA. Therefore, MANCOVA was run (Table 2).

As presented in Table 2, there was an overall significant difference between the two experimental groups in depression, satisfaction with life, and spiritual health. In other words, there was a significant difference between the participants who received Islamic CBT and those receiving conventional CBT at least regarding one of the dependent variables.

The results presented in Table 3 showed no significant difference between the adjusted means in the variables of depression and satisfaction with life; although the post-test scores showed a considerable improvement compared to the pre-test scores. However, regarding the scores related to spiritual health and its components, there was a significant difference between the two groups with

Table 1. Mean±SD of the research variables

Variables	Groups	Mean±SD	
		Pre-test	Post-test
Depression	Conventional	42.1±1.81	22.1±10.5
	Islamic	41.0±1.7	23.5±7.7
Satisfaction with life	Conventional	12.5±1.6	22.7±3.3
	Islamic	12.2±2.2	24.9±3.4
Total spiritual health	Conventional	42.7±7.0	73.9±11.6
	Islamic	43.1±7.7	91.2±9.6
Religious health	Conventional	21.5±4.0	37.7±6.1
	Islamic	21.7±4.5	46.5±5.4
Existential health	Conventional	21.1±3.3	36.3±5.7
	Islamic	21.4±3.8	44.7±4.8

the Islamic CBT group showing more improvement in spiritual health and the existential and religious components than the conventional CBT. The effect of Islamic CBT on increasing spiritual health was 41%, 38% on religious health, and 41% on existential health (P<0.001).

Discussion

The findings of the present study showed that Islamic CBT led to reduced depression and increased satisfaction with life comparable to conventional CBT. Islamic CBT was not more effective than conventional therapy. However, based on the findings, Islamic CBT was more effective in increasing spiritual health and its components.

Table 2. The results of MANCOVA

Test	Values	F	Hypothesis df	Error df	P	η^2
Pillai's trace	0.516	3.014	6.000	52.000	0.01	0.258
Wilks' lambda	0.484	3.643	6.000	50.000	0.00	0.304
Hotelling's trace	1.065	4.260	6.000	48.000	0.00	0.347
Roy's largest root	1.084	9.225	3.000	28.000	<0.001	0.518

Table 3. The results of univariate ANCOVA

Dependent Variables	Sum of squares	df	Mean Square	F	P	η^2
Depression	18.577	1	18.577	0.234	0.63	0.009
Satisfaction with life	38.351	1	38.351	3.400	0.08	0.112
Spiritual health	2233.472	1	2233.472	18.992	<0.001	0.413
Religious health	580.052	1	580.052	16.831	<0.001	0.384
Existential health	538.732	1	538.732	19.020	<0.001	0.413

In terms of the similar effectiveness of conventional and Islamic CBT in reducing depression, the results of the present study are consistent with the findings of other international studies, including that of Koenig et al. (2015) [21] and some domestic studies, including that of Khoshbooii et al. (2021) [14] and Mojahed (2009) [13].

Our findings are, however, inconsistent with the results of some studies, in which conventional CBT was more effective than religious CBT and spiritual treatment [30]. The results are also not matched with the study by Azhar and Verma who showed religious CBT is more effective than conventional therapy [17]. The findings of the present study, in terms of the higher effectiveness of Islamic CBT in promoting spiritual health, are consistent, with those of Johnson et al. (2016) [18].

In explaining the findings of the research, it can be said that depressed people have ineffective thoughts, such as extreme generalization, catastrophizing, and mental filters. These thoughts make a person interpret events more negatively. Also, withdrawal from effective social relationships and effective work is common in depressed people, and the person feels lonely, helpless, and finally feels worthless [31]. In Islamic CBT, a person is first informed about the role of thoughts in feelings and behaviors, then he/she is challenged with his ineffective thoughts, and effective thoughts replace ineffective thoughts. Also, the gratitude technique strengthens his positivity [32]. Altruism and generosity improve interpersonal relationships [33]. In the spiritual development related to stress, the secondary positive evaluation of spirituality is strengthened in the person and he/she finds a more positive view of the problems. Also, by trusting in God, hope is strengthened in a person [34].

The researchers expected Islamic CBT to be more effective than conventional CBT. However, the results were against our expectations. Therefore, we looked for intervening and mediating variables and consulted experts on CBT. The results revealed the following intervening and mediating variables:

1) Therapist's capability: With regard to the lower effectiveness of Islamic CBT compared to conventional CBT, some researchers found that the conventional therapist was more capable than the Islamic therapist [30]. It is suggested that future studies use one therapist for both protocols or that the ability and expertise of the therapists be taken into consideration and homogenized for both groups.

2) Gender similarity: In the present study, all participants were of an equally high level of religiosity. In both groups, when the therapist and the patient were of the same gender, a better medical relationship was established between them and the therapy was more effective. In the present study, gender similarity was more effective in conventional therapy. Future studies need to examine the role of gender in this respect.

3) Weak treatment plan: The Islamic CBT used in the present study was developed by Koenig et al. In our consultation with the CBT experts with an Islamic approach, we found that many of the Islamic teachings are effective in the treatment of depression and are good for integration into CBT. However, they have not been applied in Koenig's protocol (2015). We recommend that future studies design the CBT using an Islamic approach in the framework of teamwork with local specialists. The most important spiritual dimensions suggested include giving a spiritual sense, spiritual hope, spiritual resilience, thanksgiving, attention to spiritual growth during problems, attention to encouraging Quranic verses, attention to God's help, determining spiritual goals, attention to spiritual sources, gaining the social support of friends and believers, praying to God, attending religious centers, and contributing to charity events.

4) Lack of structure and organization in the religious and spiritual dimensions of health: Cognitive-behavioral therapists case formulate and case conceptualize based on the goals of therapy in each session. In other words, they show the patients where the problem lies. For example, they show how cognitive distortions cause negative feelings and behaviors. As a result, a need is created in the patients for correcting the cognitive distortions and moving step by step with the therapist using the Socratic method. However, in the religious and spiritual dimensions of therapy, this process is not followed and the patient does not understand the role of religious belief or concept in reducing his/her anxiety. It seems that there is a need for case formulation in religious and spiritual dimensions according to the goals of each session to make the patient move toward the specified goal step by step using the Socratic method and reinforce a particular attitude or skill in the patient. Overall, it appears that structured therapies are better than unstructured ones. For instance, Yousefi (2012) showed that Islamic CBT is more efficient than meaning therapy [35].

5) Easy access to religious and spiritual coping strategies: This study was carried out in Qom, Iran, and the patients were religious. Therefore, it seems that the participants in the Islamic cognitive-behavioral group also

combined the techniques with spirituality and used religious coping strategies. Accordingly, the difference between the two groups was not significant. Other studies have also referred to this point with regard to the religious patients residing in Qom [34].

Although Islamic CBT was as highly effective as the conventional method, the researchers observed that the religious patients in the present study have a high motivation for therapy combined with spirituality and do their assignments better. In line with this, there are studies show that religious individuals who received CBT combined with religion and spirituality have a higher motivation for and commitment to treatment [21]. Studies have also confirmed the positive role of Islamic teachings in the development of positive attitudes by Muslim patients and, consequently, increased efficiency of psychotherapy [36]. On this basis, future studies need to design CBT with an Islamic approach and evaluate its effectiveness.

Conclusion

Although religious cognitive-behavioral therapy leads to individuals' improvement in the religious and spiritual dimensions, it should be improved in terms of psychological components and techniques combined with spirituality so that its effectiveness in reducing depression and increasing life satisfaction is promoted.

Limitations of the study

Among the limitations of the study was the small number of participants. Furthermore, this study was conducted in Qom, where people have easy access to religious and spiritual coping strategies, which may decrease the difference between the groups. Other limitations of the study were the lack of a follow-up and delayed post-test. However, we tried to administer a post-test, but only half of the participants attended the post-test. Therefore, the results were not reported. Finally, the intervening variables were not controlled in terms of gender similarity and the specialty of the therapist.

Suggestions for further research

Future studies are suggested to eliminate the limitations and shortcomings of the present study. Besides, workshops can be held for the therapists based on a cognitive-behavioral approach to familiarize them with the spiritual dimensions of Islam so that they can combine them with their therapy. In addition, there is a need to hold workshops for therapists based on a religious and spiritual approach to increase their ability in psychological analysis of the patient's problems and case formulation so that they can use more effective techniques and combine them with Islamic and spiritual teachings.

Many studies have combined Islamic concepts with CBT. For example, Asghar et al. (2021) in Pakistan presented the cognitive-behavioral protocol with an Islamic approach [37]. A review study is needed to collect and classify the components and techniques of these protocols. Further, a meta-analytical study can compare the effectiveness of these protocols and introduce more efficient protocols explaining the reasons for their effectiveness. Subhas et al. (2021) in Malaysia designed a CBT with an Islamic approach and showed its effectiveness in reducing the symptoms of agoraphobia [38].

Ethical Considerations

Compliance with ethical guidelines

The Committee of Ethics in Biomedical Research at Shahid Beheshti University of Medical Sciences approved this study (Code: IR.SBMU.RETECH.REC.1396.740). For ethical considerations, the ethics codes presented by the American Psychiatric Association (2000) were taken into consideration and the following items were given full consideration with regard to the patients: 1) Respecting the confidentiality of the participants' information, 2) Briefing them on how the study was going to be implemented, 3) Obtaining written consent for participating in the treatment, 4) Continuing the treatment even after the study if required, 5) Leaving the participants free to leave the study until the final treatment sessions, and 6) Not imposing any additional costs for participating in the study.

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Authors' contributions

Holding treatment sessions and data collection: Mahboubeh Dastani, Mohammad Farhoush and Mohammad Ali Jamshidi; Statistical analysis: Mohammad Farhoush; Writing the manuscript: Mojtaba Farhoush and Mohammad Farhoush; Data analysis and interpretation: Morteza Abdoljabbari; Final approval: All authors.

Conflict of interest

The authors declared no conflict of interest in the present study.

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