Bahria Journal of Professional Psychology, July 2018, Vol. 17, No.2, 89-103

TREATMENT OF DEPRESSION IN CARDIAC PATIENTS THROUGH INTEGRATION OF SPIRITUALITY AND COGNITIVE BEHAVIOR THERAPY

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Current research is intended to see the efficacy of the integration of spirituality and Cognitive Behavior Therapy (CBT) in reducing depression in patients with cardiac illnesses. The hypothesis under consideration is that there will be a significant differences in the level of depression experienced by patients with cardiac illnesses before and after the integrative treatment of spirituality and Cognitive Behavior Therapy (CBT). This study included (N =05) cardiac patients including females (n = 02) and males (n = 03) from a private hospital in Karachi, Pakistan. The age of patients ranged between 36-59 years (M = 49.00, SD = 9.62). Depression in Chronic Illnesses Scale (Yaseen, 2014) was used in the pre-and-post intervention stages to test the efficacy of the treatment applied. This study utilized a Twelve Sessions (1 session per week) manualized treatment approach that focuses on spiritual growth and decreasing depression through a Spiritually Informed Cognitive Behavioral Therapy (CBT; Good, 2010) for the treatment of depression in patients with cardiac illnesses. Results of the paired sample t-test revealed significantly large differences in pre-post assessment(t=3.82). Patients in post-test significantly exhibited lower level of depression as compared to the pre-test results. In conclusion, this study can provide guidelines to mental health practitioners to decrease or prevent depression among cardiac patients. Furthermore, awareness programs can be started to educate patients about depression at the very initial stages of diagnosis of medical illness.

Keywords: Spirituality, Cognitive Behavior Therapy (CBT), depression, cardiac illness, Spiritually Informed Cognitive Behavioral Therapy (SICBT)

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Becker (2001) defines spirituality as those parts of the human's self that are intangible such as our soul and mind. In the same manner, O'Reilly (2004) identified that spirituality is an countenance of the fulfilling ways where human potential reaches its fullest form to the bloom. Spirituality can also be connected to words such as meaning, harmony, hope, transcendence etc.

Mohr (2006) entailed that spirituality as an individual's strife for looking for meaning and purpose in life and the struggle that we make within ourselves to connect to a higher being to fulfil the void that lies within us which longs for a connection with a being that we can surrender to. Religion, divinity, and faith are three interchangeable words that are usually used to define spirituality. Worthington and Sandage (2001) define religion as a search that we make for something divine and sacred that can be identified within formal boundaries and places to connect to. Similarly, Becker (2001) stated that religion is a set of beliefs that is defined by surrendering to a higher power of being and authority. Shafranske and Sperry (1990) explianed religion as a formal membership to a predefined institution that demands for certain rituals and certain acts to be performed in order to be a part of that group and to belong to those set of people who identify themselves to be belonging to that religious sector. These three definitions have their differences along the lines of how they are defining and identifying areas of spirituality but it seems that the main difference that exists between these definitions is that religion gives a formal outlook that has to be followed in order to be a part of that particular group as it is a formal institution that has to be abided by in order for it to classify as religion instead of just spirituality which gives a sense of belonging and surrendering to a higher being (Mohr, 2006).

It still holds importance to understand how different individuals identify with these terms and relate to them, dictating how it plays a significant role in their lives. Divinity and faith are two other terms that connect us to the meaning of spirituality. Becker (2001) claims that divinity signifies surrendering and believing in the authority of a supreme power , God, deity and faith is a feeling of trust towards phenomenon unknown and having unconditional acceptance and belief that whatever the supreme authority has decided, holds the best for the individual.

Prayer, meditation, religious readings and guidelines; and surrendering to higher degree of control are the spiritual interventions that had been employed by mental health practitioners during treatment procedures. (Richards & Bergin, 2005). These spiritual interventions are studied in detail to identify how they connect to psychotherapy and can have a positive impact upon fostering efficacy of the therapeutic process.

The main coping strategy that has been identified as being used by spiritual individuals is prayer. The main thing that is lacking by individuals suffering from depression is a sense of meaning and purpose in life. That is a void that is filled through spirituality (Gallagher, Wadsworth, & Stratton, 2002). Even for caregivers, the main coping strategy that has been identified is prayer. (Hebert, Dang & Schulz, 2007). Women who are taking measures to combat depression have also been identified to be using prayer as their form of coping successfully (Mirola, 1999). Research suggests that prayer fosters positivity which is over all needed to foster emotional well-being of a person (Hagerty, 2009).

Muelder (1957) noted that there are ten psychological benefits that prayer is serving namely: being aware of one's needs and realities, confession and adjustment to one's life in a balanced way, relaxation and trust, getting clarification of thought and a perspective on life. Prayer also serves to increase decision making and dedication of an individual along with fostering emotional energy of a person. Social responsiveness can be integrated in the personalities of individuals through relaxation, perseverance, gratitude, loyalty and joy. All of these phenomenon are fostered through spirituality. Other than these psychological benefits, he suggested that prayer helps people to have a taste of what love and forgiveness actually feel like. It allows for a person to experience inner peace and consequently, an individual becomes more self-aware and makes peace with the world. Prayer helps an individual to experience relaxation which improves a person's mood and on the whole subjective well-being is improved. The individual experiences a state of peace and calm (Christiansen, 2008; Farah, 2008; Peloquin, 2008; Smith, 2008).

Mindfulness and meditation exercises are another form of spiritual intervention that are widely used with clients in therapy

settings. Mindfulness means being completely aware of the complete range of experiences that the person can attend to in here and now. Mindful awareness focuses on just being aware, without making any judgments. Meditation is also identified as a technique which fosters relaxation to develop physical, psychological and spiritual wellbeing (Marlatt & Kristeller, 1999).

A number of psychologists have focused on to combine spirituality and cognitive approach to the area of psychotherapy. The main purpose that spiritually modified cognitive therapy serves is personal and spiritual growth and wellbeing of a person (Sperry, 2005). Hodge (2006) proposed that spiritually modified cognitive therapy serves to help clients be aware of and point out unproductive thoughts and how they lead towards a number of underlying problem areas that the person is experiencing. Once these troublesome thought patterns have been identified, the clinician helps the individual to alternate these troublesome and faulty thoughts with more productive and useful thoughts which are used in the form of functional self-statements. Specifically, the clinician uses spiritual concepts in these interventions which hold significant value to the client's individual spiritual reality.

Spiritually modified cognitive therapy makes use of scripts, images pertaining to religious beliefs and scriptures and reference material pertaining to a number of religious views according to the individual's religious views, to help the individual combat his irrational thoughts that are disruptive (Richards & Bergin, 2005). In doing so, the client gets an idea to know the ways which he can spiritually use to combat his irrational and disruptive thoughts that serve as a barrier towards productive thinking process. By following this procedure, spirituality of an individual is fostered while he is going through the process of emotional wellbeing as well.

This approach has several advantages over traditional Cognitive-Behavioral Therapy (CBT) that is usually employed in therapy. The most evident advantage is that spiritual areas are employed in treatment during this procedure. CBT traditionally does not focus on these concerns. As a result, the individual may get an idea that all his concerns are not being addressed and a void might be experienced by the individual on the whole. Spiritually-

modified Cognitive-Behavioral Therapy (CBT) acknowledges this area and is open to spiritual concerns that the individual experiences and uses them as treatment procedure for therapy (Hodge, 2006). Due to this process, therapeutic alliance that is formed is more closely bonded pertaining to the understanding and consensus that is reached pertaining to minute concerns of the individual being addressed. In addition, the person's spiritual identity fosters on the whole as well.

In the light of above mentioned literature it can be stated that a lot of importance is being given to rapid increase in depression and chronic diseases still, these interrelationship needs to explored as individuals who have experienced a Myocardial Infarction (MI) shows symptoms of major depression, while majority of them suffer from significant depressive symptoms (Ziegelstein, 2001). Furthermore, indigenous literature tends to have limited findings in this regard which also highlights the need of current study to fill the literature gap.

The treatment of depression has been evidently shown that depression have significant effects upon the cardiac illnesses. Despite of the effectiveness of antidepressants; negative side-effects of the drug profiles and drug-drug interactions can be ignored and hence the role of psychotherapeutic approaches becomes vital as they tend to be more effective treatment strategies and prognosis. Of these, interactions suggest a role for psychotherapeutic approaches, and CBT showed real promise (Chilcot, Wellsted & Farrington, 2010).

The cognitive-behavioral approach has extended and incorporated spirituality in it. As per this approach, the therapist tends to utilize the basic therapeutic techniques of CBT and combine them with spiritual beliefs and values of the client for the treatment (Beitel, et al., 2007).

The prior research has evidenced the significance and efficacy of CBT in reducing the depressive symptoms of depression and treating their thought and behavioral issues (Beck,

1995).Moreover some of the studies have suggested that some components of spirituality can also facilitate in decreasing the symptoms of depression (Blazer, 2007 a & b). Hence, it can be concluded that the integration of CBT and spirituality may facilitate in decreasing the depressive symptoms that are being faced by the client. The therapeutic procedure incorporates not only the emotional, social, physical, but spiritual facets as well. Through this holistic approach the needs of the clients are being addressed and their issues are being resolved. Therefore, the aim of the current study is to see the efficacy of integration of spirituality and Cognitive-Behavioral Therapy (CBT) in reducing depression in patients with cardiac illnesses. For this, a hypothesis was generated that there will be a significant difference in the level of depression experienced by patients with cardiac illnesses before and after exposure to the integrative treatment of spirituality and Cognitive-Behavioral Therapy (CBT).

Method

Research Design

A pre-post quantitative quasi-experimental design was used in the current study in which a pre-test was done followed by a 12-week session plan after which a post-test was conducted.

Participants

For the current study, N=05 (*Male* n=3 & *Female* n=2) participants were included who had cardiac illnesses with moderate levels of depression. They were approached while using purposive sampling from a private hospital in Karachi, Pakistan. The inclusion criteria for the participants included that they were suffering from a cardiac illness (had gone through by-pass surgery or angioplasty) for at least one year but not more than six years. The age range of the participants was between 36 to 59 years. All the participants were suffering from cardiac illnesses almost from 1.5 years.

Measures

The following measures were used in the current study:

Demographic Information Form. The form consists of items related to demographic information, socio-economic background, and the history of their particular medical condition. The form also included questions related to the exclusion and inclusion criteria.

Semi-Structured Interview Form. The form consists of questions related to different areas of life; items covered the history related to these significant areas of life, i.e. history related to cardiac or any other medical issue, friendship, family, work/occupation, etc.

Depression in Chronic Illness Scale (DCIS). The Depression in Chronic Illness Scale (DCIS) is a culturally-receptive scale to measure depression in chronically ill patients. It is an 18 item-Likert scale and each item is scored from 0 to 3 (strongly agree=3, agree=2, disagree=1, strongly disagree=0) with the total score ranges from 0 to 54. The classificatory indices are 0-16, indicating no and/or minimal depression, 17-25, indicating mild depression, 26-33, indicating moderate depression, and more than 33 indicating severe level of depression (Yaseen, 2014).

Procedure

Upon approval from the Ethical Review Committee, the study was set in motion. In the first phase of the study, permission was sought from the relevant authorities of the locations from where participants were recruited. The relevant Head of the Department (Cardiology) was then contacted, so that suitable scheduling and arrangements could be made. Potential participants were then screened for the inclusion and exclusion criteria, and final recruitment was conducted upon which 05 suitable consenting participants agreed to participate. The participants were informed about the voluntary nature of their participation and their right of

withdrawal, along with the purpose of the study, and maintenance of confidentiality and anonymity. All of the participants were presented with the pre-intervention measures, including the demographic information form, semi-structured interview form, and the Depression in Chronic Illness Scale (DCIS).

The participants were then subjected to 12 sessions over the course of 12 weeks, each lasting for 60-minutes, according to the Spiritually-Informed Cognitive-Behavioral Therapy Treatment by Jennifer J. Good (2010). The spiritual techniques in therapeutic plan were based on the Bible, which were replaced with *Surah-e-Rehman* as the current study was conducted in Pakistan and majority of the population is of Muslims and they follow the Holy Quran. The intervention was conducted by the researcher, who is a trained professional Clinical Psychologist. Upon completion of the intervention, post-intervention measure, the DCIS, was administered on participants. The results were statistically analyzed through Statistical Package for the Social Sciences, 22nd version.

Details of the Twelve-Week Manualized Spiritually-Informed Cognitive-Behavioral Treatment are given below in the table 1.

Table 1

Twelve-Week Manualized Spiritually-Informed Cognitive-Behavioral Treatment

Sessions	Aims and Objective	Outcome
1	Assessment Introduction of Depression Introduction of CBT	Awareness about symptoms of Depression
2	Introduction of therapeutic approach Review of previous content Incorporation of *Surah-e-Rehman*	Awareness of therapeutic approach
3	Introduction of behavioral strategies	Increase those behaviors that promote pleasure Decrease those behaviors that feed into the depression
4	Techniques for doing more Incorporation of various strategies	To adopt the new behavioral patterns

Sessions	Aims and Objective	Outcome
5	Review of Cognitive Behavioral Model. Examine ways in which different spiritual on interventions can be utilized in conjunction with the cognitive behavioral model.	To educate regarding the impact of cognition on depression
6	Examine the cognitive distortions To discuss spiritually-informed dysfunctional thought record.	Recognition of ways through which these interventions can be utilized outside the therapy session.
7	Focus on ways that Quranic guidelines can be used to challenge irrational cognitions.	To challenge irrational cognitions
8	To examine the belief of the client in regards to the cognitive quadrant.	To identify the roots of belief system
9	Focus on the elements of surrender and control. Beliefs about God and spirituality	Increase in beliefs about God and spirituality
10	Guided imagery exercise Explanation of significance of meditation	Teaching of meditative processes
11	To teach progressive muscle relaxation exercises To discuss the value of *Surah-e-Rehman* in relaxation process.	Learning of relaxation techniques
12	Examine the goals that were set initially Set goals for the future Discuss relapse prevention Listening to *Surah-e-Rehman*	Review ways the client changed throughout treatment. Termination of therapy

The above mentioned table provides a detailed overview of the 12-weeks sessions plan with respective aims and objectives and expected outcomes.

Results

The results of current study were analyzed through SPSS 22 Version. Descriptive Analysis and Paired Sample T-Test was performed to obtain the results.

Table 2

Descriptive Statistics for the Depression in Chronic Illness Scale (DCIS; N=05)

	No. of Items	*M*	*SD*	*SK*	*K*	Range	
						Actual	Potential
Pre-test	18	31.40	2.30	-0.60	0.27	28-34	0-54
Post-test	18	17.00	4.84	0.95	-0.53	12-24	0-54

The above mentioned table shows the values Mean, Standard Deviation, Skewness and Kurtosis, which shows that the data of the current study is normally distributed.

Table 3

Pre-Post Paired Sample t-test Comparison of the Level of Depression of the Participants (N=05)

Pre-test		*Post-test*		*t*	*df*	*p*	*95% CI*		
M	*SD*	*M*	*SD*				*LL*	*UL*	*r*
31.40	2.30	17.0	4.84	6.40	05	0.01	8.15	20.64	3.82

Note. CI = confidence interval, LL = lower limit, UL = upper limit, *r*= Hedges's *g*

The finding of above-mentioned table shows large differences the pre and post scores of levels of depression of the patients with cardiac illnesses.

Discussion

The hypothesis tended to test the level of depression experienced by patients with cardiac illnesses before and after the integrative treatment of spirituality and Cognitive-Behavioral Therapy. Results showed significantly large differences in the levels of depression. This indicated that the treatment procedure is significantly effective in decreasing level of depression of the participants. The current findings were supported by Paukert et al. (2009) which stated that the spiritual coping strategy, i.e. religion holds a vital importance for older adults, and the findings have

shown that mental health is positively associated with religious beliefs. Among psychotherapies that are being used for the treatment of depression and anxiety, Cognitive-Behavioral Therapy (CBT) holds strong evidence based support. Incorporation of CBT with religious practices may alleviate its acceptability and effectiveness for such problems. According to their research, they have studied the effects of combination religion and CBT for anxiety and depression; which showed an immense improvement in decreasing the depressive and anxiety symptoms.

Present research results also indicated that, integrating spirituality and Cognitive-Behavioral Therapy helped cardiac patients to alter their cognitive distortions and employing the clients own religious beliefs to be identified and be replace with the sustainable depressive thoughts and to highlight that religious practices and beliefs can be utilized as an agent to alleviate depressive symptoms and inculcate positive emotions. These results were also supported by past intervention based research conducted by Pearce et al. (2015), which showed that integrating clients' spiritual and religious beliefs in therapy is as or more effective in reducing depression than secular treatments for religious clients. Some of the major tools of such therapeutic approaches which were also part of the current therapeutic plan, included scripture memorization to renew one's mind, contemplative prayer, challenging thoughts using religious teachings, engaging in religious practices (e.g., gratitude, altruism, forgiveness), and involvement in a religious community. Helping clients to integrate their own religious beliefs, behaviors, and resources in skillful and appropriate ways is the heart and soul of this integrative therapeutic plan.

A study was conducted by Murphy and Fitchett (2009), in which they mentioned that the integrative approach helps to promote well-being through believing in a loving and caring God. Furthermore, it plays a role in the reduction of symptoms for depressed individuals. The participants utilized their religious convictions to foster positive religious coping behaviors.

Affirmative religious coping styles are associated with enhanced positive effects (Powers, Cramer, & Grubka, 2007; Hebert, Dang, & Schulz, 2007). All these strategies were also utilized in the current research, as in Pakistan, spirituality including religious coping strategies are significant part of individuals' lives.

Results of the study conducted by Jennifer J. Good (2010) also showed significant changes in the level of depression of the participants. These studies reinforce the idea of the present study that has been conducted, integrating spirituality with Cognitive-Behavioral Therapy.

Conclusion

Pakistan is very different from the Western world in terms of standards of life, religion, and culture. The research conducted in this area was an effort to add to the existing body of therapies of an integrative approach which can be widely used among our masses, keeping the religious roots in mind. Results of the current study revealed that, integration of spirituality and Cognitive-Behavioral Therapy is effective for reducing the level of depression in patients with cardiac illnesses. Future researches are recommended in this area which could integrate spirituality with other forms of therapy.

References

Beck, J. S. (1995). *Cognitive therapy: Basics and beyond.* New York: Guilford Press.

Becker, D. M. (2001). Integrating behavioral and social sciences with public health. In N. Schneiderman, M. A. Speers, J. M. Silvia, H. Tomes & J. H. Gentry (Eds.), *Public Health and Religion,* 351- 368. Washington, DC: American Psychological Association.

Beitel, M., Genova, M., Schuman-Olivier, Z., Arnold, R., Avants, K. S., & Margolin, A. (2007). Reflections by inner-city drug users on a Buddhist-based spirituality focused therapy: A qualitative study. *American Psychological Association, 77*(1), 1-9.

Blazer, D. G. (2007a). Section introduction: Spirituality, depression and suicide. *Southern Medical Association, 100*(7), 733-734.

Blazer, D. (2007b). Spirituality, depression and suicide: A cross-cultural perspective. *Southern Medical Association, 100*(7), 735-736.

Chilcot, J., Wellsted, D., & Farrington, K. (2010, January). Depression in end-stage renal disease: current advances and research. In *Seminars in dialysis* (Vol. 23, No. 1, pp. 74-82). Oxford, UK: Blackwell Publishing Ltd.

Christiansen, C. H. (2008). The dangers of thin air: A commentary on exploring prayer as a spiritual modality. *Canadian Journal of Occupational Therapy, 75* (1), 12-15.

Farah, J., & McColl, M. A. (2008). Exploring prayer as a spiritual modality. *Canadian Journal of Occupational Therapy, 75*(1), 5-17.

Gallagher, E. B., Wadsworth, A. L., & Stratton, T. D. (2002). Religion, spirituality and mental Health. *Journal of Nervous and Mental Disease, 190*(10), 697-704.

Good, J. J. (2010). *Integration of spirituality and cognitive-behavioral therapy for the treatment of depression.* Philadelphia College of Osteopathic Medicine.

Grabovac, A., Clark, N., & McKenna, M. (2008). Pilot study and evaluation of postgraduate course on the interface between spirituality, religion and psychiatry. *Academic Psychiatry, 32*(4), 332-337.

Hebert, R. S., Dang, Q., & Schulz, R. (2007). Religious beliefs and practices are associated with better mental health in family caregivers of patients with dementia: Findings from the REACH study. *American Journal of Geriatric Psychiatry, 15*(4), 292-300.

Hodge, D. R. (2006). Spiritually modified cognitive therapy: A review of the literature. *Social Work, 51*(2), 157-166.

Marlatt, G. A., & Kristeller, J. L. (1999). Mindfulness and meditation. In W. R. Miller (Ed.), *Integrating spirituality into treatment: Resources for practitioners* (pp. 67-84). Washington, DC, US: American Psychological Association.

Mirola, W. A. (1999). A refuge for some: gender differences in the relationship between religious involvement and depression. *Sociology of Religion, 60,* 419-437.

Muelder, W. G. (1957). The efficacy of prayer. In S. Doniger (Ed.), Healing: Human and divine: Man's search for health and wholeness through science, faith, and prayer (pp. 131-143). New York: Association Press.

Mohr, W. K. (2006). Spiritual issues in psychiatric care. *Perspectives in Psychiatric Care*, *42*(3), 174-183.

Murphy, P. E., & Fitchett, G. (2009). Belief in a concerned God predicts response to treatment for adults with chronic depression. *Journal of Clinical Psychology, 65,* 1000-1008.

O'reilly, M. L. (2004). Spirituality and mental health clients. *Journal of Psychosocial Nursing & Mental Health Services*, *42*(7), 44-53.

Paukert, A. L., Phillips, L., Cully, J. A., Loboprabhu, S. M. Lomax, J. W. & Stanley, M. A., (2009). Integration of Religion into Cognitive-behavioral Therapy for Geriatric Anxiety and Depression. *Journal of Psychiatric Practice*, *15*(2), 103-112.

Pearce, J. M., Koenig, G. H., Robins, J. C., Nelson, B., Shaw, F. S., Cohen, J. H. & King, B. M. (2015).Religiously Integrated Cognitive Behavioral Therapy: A New Method of Treatment for Major Depression in Patients with Chronic Medical Illness. *Psychotherapy Chicago Journal, 52(1), 56-66.*

Peloquin, S.M. (2008). Mortality preempts modality: A commentary on exploring prayer as a spiritual modality. *Canadian Journal of Occupational Therapy, 75* (1), 15-16.

Powers, D. V., Cramer, R. J., & Grubka, J. M. (2007). Spirituality, life stress, and affective well-being. *Journal of Psychology and Theology*, *35*(3), 235-243.

Richards, P. S., & Bergin, A. E. (2005). Religious and spiritual assessment. *A Spiritual Strategy for Counseling & Psychotherapy*, 219-249.

Shafranske, E. P., & Sperry, L. (2005). Addressing the spiritual dimension in psychotherapy: Introduction and overview. In L. Sperry & E. P. Shafrankske (Eds.), *Spiritually-oriented psychotherapy* (pp. 11-29). Washington, DC: American Psychological Association.

Smith, S. (2008). Considering ideology, context and client-centered language: A commentary on exploring prayer as a spiritual modality. *Canadian Journal of Occupational Therapy, 75* (1), 16-17.

Sperry, L. (2005). Integrative spirituality oriented psychotherapy. In L. Sperry & E. P. Shafrankske (Eds.), *Spiritually-oriented Psychotherapy* (pp. 141-152). Washington, DC: American Psychological Association.

Worthington, E. L., & Sandage, S. J. (2001). Religion and spirituality. *Psychotherapy, 38*(4), 473-478.

Yaseen, A. (2014). *Development and Validation of Depression in Chronic Illnesses Scale*. Pakistan: Institute of Clinical Psychology, University of Karachi.

Ziegelstein, R. C. (2001). Depression in patients recovering from a myocardial infarction. *Journal of American Medical Association, 286,* (13), 621-627.