Original Article

Controlled randomized clinical trial of spirituality integrated psychotherapy, cognitive-behavioral therapy and medication intervention on depressive symptoms and dysfunctional attitudes in patients with dysthymic disorder

Amrollah Ebrahimi, Hamid Taher Neshatdoost[1], Seyed Ghafur Mousavi[2], Ghorban Ali Asadollahi[2], Hamid Nasiri[3]

Department of Psychiatry, Psychosomatic Research Center, School of Medicine, [3]Psychosomatic Research Center, [2]Department of Psychiatry, Behavioral Sciences Research Center, School of Medicine, Isfahan University of Medical Sciences (IUMS), [1]Department of Psychology, University of Isfahan, Isfahan, Iran

Abstract

Background: Due to the controversy over efficacy of cognitive-behavioral therapy for chronic depression, recently, there has been an increasingly tendency toward therapeutic methods based on the cultural and spiritual approaches. The aim of this research was to compare efficacy of spiritual integrated psychotherapy (SIPT) and cognitive-behavioral therapy (CBT) on the intensity of depression symptoms and dysfunctional attitudes of patients with dysthymic disorder.

Materials and Methods: This study had a mixed qualitative and quantitative design. In the first phase, SIPT model was prepared and, in the second phase, a double-blind random clinical trial was performed. Sixty-two patients with dysthymic disorder were selected from several centers include Nour and Alzahra Medical Center, Counseling Centers of Isfahan University of Medical Sciences and Goldis in Isfahan. The participants were randomly assigned to three experimental groups and one control group. The first group received 8 sessions treatment of SIPT, second groups also had 8 sessions of cognitive-behavioral therapy, which was specific to dysthymic disorder and third group were under antidepressant treatment. Beck depression inventory and dysfunctional attitudes scale were used to evaluate all the participants in four measurement stages. The data were analyzed using MANCOVA repeated measure method.

Results: The results revealed that SIPT had more efficacy than medication based on both scales ($P < 0.01$); however, it was not different from CBT. SIPT was more effective on the modification of dysfunctional attitudes compared with CBT and medication ($P < 0.05$).

Conclusion: These findings supported the efficacy of psychotherapy enriched with cultural capacities and religious teachings.

Key Words: Cognitive-behavior therapy, depression, dysthymic disorder, medication, psychotherapy, religious, spiritual

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Address for correspondence:
Dr. Amrollah Ebrahimi, Psychosomatic Research Center, Isfahan University of Medical Sciences, Isfahan, Iran.
E-mail: a_ebrahimi@med.mui.ac.ir
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INTRODUCTION

Dysthymic disorder is a chronic state of depression which leads to progressive debilitation of social, educational and occupational functions of patients and is not mostly diagnosed; therefore, most of those who suffer from that are not diagnosed and cured. Recent evidence of epidemiology studies has shown the necessity for diagnosing and curing these patients.[1,2] Dysthymic disorder is a prevalent disorder with the estimated prevalence rate of between 3% and 6%. Thirty-six percent of the psychiatric outpatients suffer from dysthymic disorder and a considerable number of those who refer to primary healthcare centers suffer from this disorder. Thus, annual costs of these patients are higher than those who do not have comorbidity with dysthymia disorder.[3] Inefficiency of medications or controversy over their efficiency for curing mild and chronic depressions[4,5] have led to the application of non-medication treatments for these patients.[4]

Cognitive-behavioral therapies have been introduced as one of the most effective therapies for severe depression disorder and dysthymia.[6,7] However, some studies have questioned its efficiency for curing dysthymia and some others have considered it the same as placebo.[6]

Although, cognitive-behavioral therapies have been known as one of the effective therapies for clinically depressed patients,[7,8] cognitive-behavioral therapies may not have equal effects for the patients with different cultural and religious backgrounds.[9,10] Almost all authorities agree that cultural variables are important for the diagnosis and treatment of mood problems. In fact, the ignorance of cultural differences in clinical studies not only is mismanagement in research policy but also results in serious misinterpretations of the findings of clinical trials.[11]

Increasing studies of psychiatry, spirituality and religion deal with the necessity of mixing original religious teachings and cultural beliefs and convictions related to health in psychotherapeutic strategies.[12-15] On this basis, different psychotherapeutic models have been created in different cultures by integrating psychotherapy and religious teachings. Some examples of these approaches include religious cognitive-behavioral therapy model for curing depression disorder,[9] spiritually focused therapy,[16] religious psychotherapist plan for depression and anxiety[17] and spiritually augmented cognitive behavioral therapy.[12] Strengthening effectiveness of conventional psychotherapies with spiritual teaching is increasingly considered in eastern and Islamic countries. One can name mixed cultural-religious psychotherapy model for curing depression and anxiety.[18-20] Controlled clinical trials of efficacy and their better adequacy compared to similar non-religious therapies have been demonstrated for the Muslim population.

Many systematic review studies have been conducted to study the point whether religious psychotherapy reduces depression and anxiety in patients with religious backgrounds and how consistent its effects can be. In this systematic review, random and semi-random controlled clinical studied were entered. The results showed that: Religious psychotherapy (RPT) was a reliable approach for psychotherapy and its effectiveness in the treatment of depression and anxiety was comparable to other therapies.[19] Religious psychotherapy accelerated improvement of depression and anxiety symptoms and reduced psychological problems of psychosomatic patients.[21] This model had more effectiveness in terms of reducing symptoms and preventing from the relapse of depression periods.[9,11] Nevertheless, some studies have shown that this psychotherapy model has not been different from other therapies during the 6 months follow-up stages.[19] This clinical trial was conducted considering the current challenge in terms of the adequacy of cognitive-behavioral therapies for curing dysthymic patients and the necessity of strengthening psychotherapy with cultural and spiritual backgrounds on the one hand and the ambiguity in its stable effects and adequacy in different cultures. Thus, in order to answer these controversy, the aim of this study was to compare efficacy of spiritual (Islamic approach) integrated psychotherapy (SIPT) and cognitive-behavioral therapy (CBT) on the intensity of depression symptoms and dysfunctional attitudes of patients with dysthymic disorder.

MATERIALS AND METHODS

The research method was a mixed method design with two qualitative and quantitative phases. In the first phase and using the qualitative method model, grounded theory of spirituality integrated psychotherapy model was formulated. The second phase was a double-blind randomized clinical trial with a control group (waiting list). The participants (people with dysthymic disorder) were included in the study from different ways of requesting from general practitioners, psychiatrists, calling through notification in health centers (Noor and Alzahra Medical Centers), dormitories and faculties of Isfahan University of Medical Sciences and Isfahan Goldis Psychological Services Center. Initial screening was done through a clinical interview and structured clinical interview for DSM-IV Axis I Disorders

(SCID-I).[22] Positive cases who were qualified for entering the study were randomly assigned to one of the experimental conditions (experimental groups) or waiting list. The experimental and control groups were evaluated by Beck depression inventory (BDI-II) and dysfunctional attitude scale (DAS-26) in 4 sessions during the study (before the intervention, 4 weeks after starting, after ending the therapy and three months later). Inclusion criteria included dysthymic disorder diagnosis according to DSM-IV-TR, age between 20 and 65 years old, minimum literacy, no consumption of any psychiatrist medicine in the past 3 months and lack of participation in psychotherapy sessions in the past 6 months, Persian language, being Muslim and consent to the participation in this project. Exclusion criteria included suffering from one of the severe physical diseases, serious neurology, mental retardation, psychosis disorders or symptoms, bipolar disorder, depression disorders resulting from drug and alcohol abuse and other psychiatric disorders with depression as their secondary symptoms, reluctance of the patient to continue the therapy, serious suicide ideation and risk of suicide, which require emergency intervention. After performing the pretest by a doctor of clinical psychology, the intervention started by therapists. The raters and therapists were not aware of each others' work.

INTERVENTION DESCRIPTION

Spirituality integrated psychotherapy

The content and process of spirituality integrated psychotherapeutic intervention included theoretical model, intervention strategies and implementation guideline, which was extracted from religious (Islamic) sources in the first phase of the study and using grounded theory and was prepared in 8 sessions. This phase of the study lasted for 18 months. Based on the grounded theory,[23] the data paths were gathered and analyzed in different ways. First, religious and psychology experts were interviewed in Iran and their viewpoints were collected until data saturation, and followed by their analysis and conceptualization. In the next phase, religious sources including written and electronic sources were searched with regard to questions and goals and under the supervision of experts of religious sciences considering the interview data. Then the data were classified and analyzed in terms of content. Content of therapeutic protocol included religious theoretical viewpoint for explaining the formation of depression disorders and therapeutic methods including cognitive, behavioral, emotional-spiritual methods with religious content and behavioral recommendations in Islamic sources. Therefore, 8 weekly sessions of 45 min were held for each individual.

Medication

Medication was prescribed by a psychiatrist and using standard medication protocol for patients suffering from dysthymia according to comprehensive textbook of psychiatry[24] and considering the medications available in Iran. Type of medicine, starting, continuing and ending dose were selected by and at discretion of the psychiatrist and suitable medicines were prescribed in a standard but flexible design depending on disease symptoms and conditions. The sheets for evaluating symptoms and prescribing medicines, which were completed by the psychiatrist were revised and confirmed by an assistant psychiatrist (professor of psychiatry) twice.

3-6-2-Cognitive-behavioral therapy

Cognitive-behavioral therapeutic protocol which was used in this study was a standard copy of cognitive-behavioral therapeutic design for chronic depression and dysthymia, which was prepared by Moor and Garland.[25] The mentioned therapeutic design was prepared in 8 weekly sessions. Each session lasted for 45 min and was held for each individual.

Measurement tool included

1-structured clinical interview for DSM-IV Axis I Disorders (SCID-I), which is a tool for diagnosis on the basis of DSM-IV criteria. Inter-rater reliability was reported acceptable on the basis of kappa coefficient index (0.7);[22] 2-Beck Depression Inventory (second edition (BDI-II)) for measuring symptoms and intensity of depression which includes 21 items. Each item has a score between 0 and 3 and it is one of the valid depression measurement scales in clinical trial.[26]

3-Dysfunctional attitude scale has been made to measure underlying attitudes of cognitive content of depression symptoms on the basis of Beck theory.[26] Its original form contains 40 statements and scoring is done on a 7-level Lickert scale. Its short form (DAS-26), which was used in this study was made of its original form during a psychometric study in Iran. Its reliability was calculated by Cronbach's alpha method (92%) and its validity was reported through correlation with depressive disorders as diagnosed by the psychiatrist (0.55) with the total score of GHQ-28 (0.56).[28]

Data analysis method

SPSS-16 software was used for analysis and MANCOVA method with repeated measures was applied. Pretest scores of DAS-26 and BDI-II scales and age were controlled as covariate variables.

Table 1: Mean and standard deviation of Beck depressive inventory (BDI-II) and dysfunctional attitude scale (DAS-26) in pretest, one month after starting, posttest and follow-up stages

Groups	Indices	Pretest		One month after starting		Post-test		Follow-up	
		M	Sd	M	Sd	M	Sd	M	Sd
Medical intervention *N*=15	BDI-II Scores	30.2	1.53	2.93	7.14	15.2	8.68	19.13	8.9
	DAS-26 Scores	112.66	26.19	102.4	31.153	92.6	17.4	89.8	27.8
cognitive behavioral therapy (CBT) *N*=16	BDI-II Scores	29.06	9.9	17.37	6.97	8.7	3.84	10.25	4.61
	DAS-26 Scores	109.18	24.15	95.62	25.54	72.6	26.7	65.3	21.3
Spirituality integrated psychotherapy (SIPT) *n*=16	BDI-II Scores	28.35	7.98	16.75	5.61	7.3	4.9	8.13	5.11
	DAS-26 Scores	115.25	27.45	86.75	31.83	65.5	23.1	55.7	20.6
Control group (waiting list) *N*=15	BDI-II Scores	29.6	8.37	27.46	10.16	28.6	8.3	27.13	8.13
	DAS-26 Scores	110.4	26.35	107.4	24.88	109.2	25.5	113.3	24.6

RESULTS

Mean age of the participants in medication, cognitive-behavioral and religious cognitive-behavioral psychotherapy experiment groups and control group was 32.26 ± 10.36, 31.25 ± 8.82, 31.81 ± 10.31 and 29.06 ± 9.5, respectively. Fifty-five percent were female and 45% were male. Scores of depression and dysfunctional attitudes of the experiment and control groups were reported in four experimental phases in Table 1.

Depression scores of groups were analyzed through MANCOVA with repeated measures. Before the analysis, the presumptions required for MANCOVA analysis were studied. Levin test confirmed homogeneity of variances ($P > 0.05$ and $f = 0.94$). M-Box test did not confirm homogeneity of co-variances but MANCOVA analysis was possible due to the equality of groups and application of Wilks' lambda conservative test. Pretest and the age scores were taken as covariate and their effect on the dependent variable was controlled. Table 2 shows the results of MANCOVA analysis with repeated measures of the groups' depression scores in four experiment stages.

Table 2 shows the effect of treatment on the groups, depression scores in 4 stages (pretest, one month after starting, and the end of intervention and 3-month follow-up period). The findings indicated that therapy was effective in general ($P < 0.0001$) and time effect was also significant (the difference of different stages) ($P < 0.01$) and type of therapy had a significant relationship with measurement stages (time) ($P < 0.01$).

Paired comparisons showed that all three therapeutic groups (medication, cognitive-behavioral and spirituality integrated psychotherapy) were significantly different from the control group ($P < 0.01$). Spirituality integrated psychotherapy group was significantly different from medication group ($P < 0.05$); however, spirituality integrated psychotherapy group was not significantly different from cognitive-behavioral group. Also, cognitive-behavioral group was not significantly different from medication group ($P > 0.05$).

Figure 1 shows changing situation of BDI-II scores in four groups in four stages of measurement

Another dependent variable of this study was dysfunctional attitudes. Table 3 shows results of MANCOVA analysis with repeated measures for the scores of dysfunctional attitudes test (DAS-26). Equality assumption of the variance of DAS-26 scores was confirmed by Levin test in all four measurement stages ($P > 0.05$). Equality assumption of covariance of dependent variable scores was not confirmed in four stages of measurement but it is possible to use this method later with regard to equal samples sizes and application of Wilks' lambda conservative test. Effects of pretest and age scores were controlled as covariate.

MANCOVA analysis with repeated measures showed that therapeutic intervention effect was considerable on the reduction of DAS-26 scores ($P < 0.01$), time effect (difference of different stages) was also significant ($P < 0.01$) and the interaction between type of therapy and stages was also significant ($P < 0.001$).

Paired comparison of the mean of groups by *post hoc* tests showed that experiment groups except medication group were significantly different from the control group ($P < 0.05$). Spirituality integrated psychotherapy group had more efficacy than medication and cognitive-behavioral group ($P < 0.05$) but there was not differences between cognitive-behavioral and medication group. Figure 2 shows mean DAS-26 scores of groups in four experiment stages.

As shown in the above figure, spirituality integrated psychotherapy group had a considerable effect on dysfunctional attitudes over time and medicine had no considerable effect on attitudes.

Table 2: MANCOVA analysis with repeated measure of depression scores (BDI-II) in experiment and control groups in four stages

Effect rate	Df	F	Sig	Test power
Intervention effect	57.3	16.11	0.0001	1
Time effect	55.3	5.85	0.002	1
Interactional effects of time and intervention	134.9	7.60	0.001	0.94

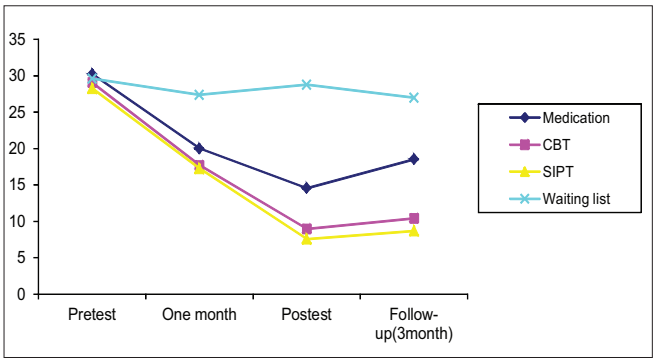

Figure 1: Profile of mean changes of Beck depression scores of the groups in four experiment stages

DISCUSSION

The results showed that spirituality integrated psychotherapy had more efficacy on the reduction of depression symptoms among the patients suffering from dysthymia compared with the control and medication groups in post-test and follow-up stages ($P < 0.05$), but it was not significantly different from the cognitive-behavioral group. Also, spirituality integrated psychotherapy had more efficacy on the reduction of dysfunctional attitudes compared with the medication and cognitive-behavioral groups in post-test and follow-up stages ($P < 0.05$). Medication had no significant effect on the reduction of dysfunctional attitudes. Thus, it can be inferred that spirituality integrated psychotherapy, which was prepared as a qualitative study (grounded theory) can be effective in the reduction of depression symptoms and cognitive vulnerability of the patients suffering from dysthymia.

The findings of this part of the research supported this viewpoint that different dimensions of religion play a major role in the treatment of hopelessness considering cognitive, behavioral, emotional and existentialism components[12] and spirituality based therapies, which concentrate on the components of control, meaning finding, identity and communication can strengthen the efficacy of therapy in terms of reducing depression symptoms, especially chronic depression, whether in combination with conventional psychotherapies or by themselves.

Table 3: MANCOVA analysis with repeated measures of DAS-26 scores of experiment and control groups

Effect	Df	F	Sig	Test power
Intervention effect	57.3	5.12	0.003	0.90
Time effect	55.3	5.73	0.001	0.96
Interactional effects of intervention and time	134.9	8.55	0.001	1

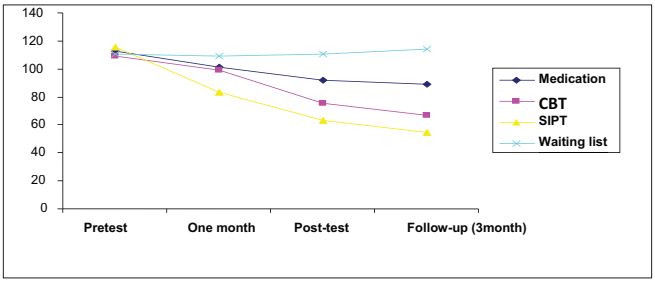

Figure 2: Mean scores of DAS-26 in experiment and control groups in four experiment stages (before, one month after starting, end of therapy and 3 months after ending)

The findings of this research were in line with a part of research results given by Azhar and Warma.[19] In their study, spirituality focused psychotherapy was more effective than the therapy in the waiting list and medication groups at the end of intervention but it was not different from that of the medication group in the follow-up stage. The present research findings supported the findings of Propest *et al*.[9] In the above mentioned research, the patients showed more improvement at the end of the intervention period under cognitive-behavioral religious therapy (0.845 improvements). Findings of the current research were similar to those of some studies in this field.[11,13,29-31] Probably, effectiveness capability of combining spirituality focused intervention with psychotherapy is related to the fact that semantic-religious teachings for life provide feeling of orientation for life, support and optimism for the clients.[32] Moreover, when therapy is coordinated with cultural structures, spiritual needs and content of religious thought of the patients, response to and acceptance of the therapy are improved.[13,33]

On the other hand, findings of this research on the efficacy of sprituality integrated psychotherapy were not parallel with some findings of Azhar and Warma.[34] The groups did not have significant difference one month after starting the intervention and after ending the intervention but the effect of spiritually focused cognitive therapy was more consistent in the follow-up phase. Probably, lack of coordination between the mentioned findings and those of this research was resulted from the nature of this disorder (grief reaction in the mentioned study and dysthymic disorder in the present work). The findings of this research

regarding the effectiveness of spirituality integrated psychotherapy supported Bartoli's approach[35] about the necessity of incorporating religious components in the intervention designs of dysthymic disorder.

Another important finding of this study was the confirmation of CBT effectiveness in terms of the symptoms of the patients suffering from dysthymia. These findings were in line with broad meta-analysis results of Wampold *et al*.[6] and Chen *et al*.[36] with regard to CBT effectiveness on dysthymic disorders. The mentioned studies showed that effectiveness of CBT therapy was significantly different from that of the waiting list and pseudo-therapy conditions in all the stages. There was another similarity between this finding and meta-analysis results of National Health Institute, Research Cooperation Plan for Depression Therapy,[8] which showed the equal effect of medication and CBT.

Another result of this clinical trial was the efficacy of medication on dysthymic symptoms. This part of the study was in line with the findings of Lima and Hatf,[37] which is one of the largest systematic reviews of medication therapy for dysthymic disorder. One of the similarities of this study to the studies which were entered into the mentioned review was the evaluation tool for determining medication effectiveness, which is usually SSRTs. Their general results demonstrated that antidepressants are adequate and effective for curing dysthymic disorder in comparison with placebos and the difference of different medicines is mostly found in their complication profile and loss of patients during the therapy. Adequacy evidence is stronger for SSRTs and TCAs group.[37] In the present study, SSRTs were prescribed in more than 90% of the cases and the difference of this research from the findings of other studies was that the present work did not compare the complications of drugs.

Confirming the efficacy of spirituality integrated psychotherapy and its probable preference over the consistency of the effect of therapy and correction of dysfunctional attitudes supports this model's theoretical bases and shows the coordination between theoretical framework and therapeutic solutions. It seems that performing cognitive, behavioral, ontological and spiritual strategies extracted from religious sources such as viewpoints of Imam Ali based on the creation of realistic attitude and adjustment of expectations with the current realities,[38] strategy of Imam Sadegh for creating and practicing a positive attitude toward future and searching for positive points in past experiences to change the present mood[39] and recommendations of Imam Bagher in terms of searching for meaning in hardship and positive and divine interpretation of incidents[40] along with the application of other believing-behavioral skills such as meditation, prayer and involvement with enjoyable spiritual activities have caused changes in the mood and behavior. Since the efficiency and acceptance of any type of psychotherapy depend on the adjustment of its content with cultural backgrounds and values of the people, spirituality integrated psychotherapy (SIPT) is more suitable for Muslims and these people will be better candidates for such a therapy.

On the other hand, effectiveness of spirituality integrated psychotherapy (SIPT) and its relative preference over biological and cognitive-behavioral therapies result from the nature of dysthymic disorder and multi-component nature of spirituality integrated psychotherapy. Dysthymic disorder has turned into an established lifestyle due to its chronic nature and this therapy tries to change life quality by targeting at cognitive, emotional, behavioral and spiritual components. The present authors agree with Peterson and Seligman[32] that spirituality and religion with the mechanisms and interfaces such as the effect on personal coping processes, problem solving skill, increase of self-esteem, hope, sincerity, control, comfort, emotional support, spiritual support and integrated (monotheistic) interpretation of the world, are effective on the individual solidarity and well-being and increase intra-psychological abilities to change lifestyle.

CONCLUSION

The results of this randomized clinical trial revealed that because of their religious background, in Iranian patents with dysthymic disorder spiritually augmented psychotherapy is more effective than medication and cognitive behavioral therapy to modify dysfunctional attitudes. However, there is not difference between SIPT and CBT to reduce severity of depressive symptoms.

One of the limitations of this study was its short follow-up period (three months) and it is necessary to have a longer follow-up period in future studies. The second limitation was about the effectiveness index of test scores and statistical differences. It is suggested for future studies to include percentage of the improved patients and clinical significance as the criteria. Another limitation was that medical intervention of this study which was compared with other methods was not a specified medicine with definite dosage but the medicines were those prescribed by the psychiatrist but on the basis of the standard protocol.

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