








Effectiveness of An Islamic Approach to Hope Therapy on Hope, Depression, and Anxiety in Comparison with Conventional Hope Therapy in Patients with Coronary Heart Disease

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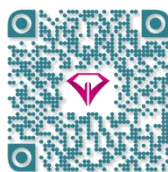
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ABSTRACT

Background & Objective: Hope therapy is an efficient and positive psychology intervention used to treat chronic diseases. The purpose of this study was to investigate the effect of hope therapy on anxiety and depression using an Islamic approach and compare this approach with conventional hope therapy in coronary heart disease (CAD) patients.

Materials & Methods: The study was conducted in the form of a randomized trial with pre- post-test, and control groups. A total of 45 patients with CAD were sampled through convenience sampling from a hospital in Qom city, Iran. Data were collected using Snyder's hope questionnaire, and the Hospital Anxiety and Depression Scale (HADS). After collecting pre-test data, the participants were randomly divided into three groups of peers, and the intervention sessions were performed in eight sessions of 90 minutes each. One experimental group received Islamic hope therapy, and the other experimental group was exposed to conventional hope therapy, while the control group received a stress relief package. All three groups undertook a post-test, the data from which were analyzed by SPSS 22, using Levin, Kolmogorov-Smirnov, and covariance tests.

Results: Islamic and conventional hope therapy both significantly outperformed the stress relief package in terms of increasing hope and decreasing depression. Also, Islamic hope therapy had an especially significant effect on reducing anxiety.

Conclusion: Islamic hope therapy seems similar to conventional hope therapy in its ability to increase hope and reduce depression and is more effective in reducing anxiety. Therefore, it could be helpful in treatment of patients with CAD and other chronic diseases that cause patients a high level of anxiety.

Keywords: Anxiety, Coronary heart disease, Depression, Hope, Hope therapy



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Introduction

Heart diseases are chronic and debilitating, and they lead to many psychological complications, such as exhaustion, anxiety, and depression (1). The American Heart Association declared depression as a risk factor for patients with coronary artery disease (CAD) (2). The results of a previous study indicated that 32.5% of patients with CAD had anxiety symptoms, and 17.5% showed symptoms of depression (3).

On the other hand, research has shown that anxiety, stress, and depression are significant barriers to the rehabilitation of heart patients (4). The coexistence of psychological disorders and heart disease could negatively affect the outcomes of treatments and increase the overall burden of the disease in patients (5).

Exhaustion and reluctance to continue treatment are other consequences of depression and anxiety, as are a reduced quality of life, interpersonal disorders, and some physical symptoms (6). Furthermore, along with cognitive problems (7) increased depression and anxiety scores are associated with the disease duration (8).

In this way, cardiovascular diseases are among the major factors that influence the quality of life. Studies have shown that low quality of life is significantly related to despair, anxiety, and depression (8-10). Therefore, reducing the depression and anxiety of CAD patients is necessary for their treatment. Hope, as a positive psychology construct, protects against

difficulties (12) and has an undeniable effect on personal motivation and behavior (13).

Hope is one's perceived ability to create desirable paths to achieve their goals and to provoke to take these paths (14). The idea of hope-based intervention was first proposed by Schneider *et al.*, who defined hope as a mental status based on a mutual sense of will and plans to achieve one's goals (15). Studies show that people with higher scores on the scale of hope present fewer symptoms of depression and anxiety and have a higher quality of life (16). Moreover, Dorsett (17) revealed an association between hope and the level of life satisfaction, psychological adjustment, and coping in patients. Ho *et al.* (18) considered hope among the ten factors of health improvement and determinants of quality of life.

Based on the above-mentioned works, hope therapy is an efficient, positive psychology intervention used for chronic diseases (19). Whereas traditional psychotherapy focuses on reducing symptoms and lessening harm, positive psychology underscores improving abilities and personal growth (20). Hope therapy aims to help clients formulate goals and construct multiple paths to reach them, provoke themselves to pursue goals, and reframe obstacles as challenges to overcome them and achieve victory (21). A number of studies affirm the effect of hope therapy in reducing anxiety (22) and depression (23).

Though hope-therapy is essentially effective in reducing anxiety and depression, it is necessary to consider the patient's religious and cultural background to increase its effectiveness (24, 25). Since most Iranian patients are Muslims with robust religious beliefs, it is necessary to evaluate and complete hope therapy from a religious perspective (25). The positive impact of Islamic instructions on positive attitudes of Muslim patients and the resultant improved efficiency of psychotherapy have been documented in a number of studies (26).

Meanwhile, studies have revealed the effect of spirituality in increasing hope in patients with chronic diseases (27). Other studies indicate the effect of hope in chronic disease patients' spirituality (28). Therefore, it seems that hope and spirituality have interactive effectiveness, meaning that it is possible to offer spirituality-blended hope to chronic patients. Creating a spiritual relationship with the Almighty God assures the person of the permanent support of a higher power. They are more likely to cope with their problems by spiritualizing the problem and are less likely to experience stress and anxiety. Furthermore, believing in the support and assistance of the Almighty God makes patients more hopeful about their recovery from the disease (29) (15;55).

Hope has a certain conceptual framework in Islamic resources. In the Holy Quran and the sayings of the Fourteen Infallibles, different words denote hope. Among them are "Raja" meaning hope as in "*Those who*

believe and those who migrate and struggle in the way of Allah, those, have hope of the Mercy of Allah. Allah is Forgiving and Merciful"(29)(18:110); and "*no believer is a true believer, except if he is hopeful and concerned at the same time*" (29)(65:3). "Ya'as" meaning despair as in "*Go and seek news of Joseph and his brother; Do not despair of the Comfort of Allah, none but unbelievers despair of the Comfort of Allah*"(29) (12:87); and "Qonoot" meaning despair as in "*They replied: 'In truth we have given you glad tidings, do not be one of those who despair'*"(29) (15;55); "Tawakkol" meaning trust as in "*and provide for him from where he does not expect, Allah is Sufficient for whosoever puts his trust in Him. Indeed, Allah brings about whatever He decrees. Allah has set a measure for all things*"(29) (65;3); accompanied by their derivations, imply different aspects of hope. The Holy Quran considers hope to meet Almighty God as an important factor in one's spiritual life and development, stating that hope leads one to good practice. To conclude, it can be said that according to the Holy Quran, the concept of hope is founded on an effective relationship with Almighty God.

From an Islamic perspective, hope leads to increased motivation and positive emotions and, as a result, more effort, success, and progress (30), thereby efficiently improving the quality of life and mental health of patients with CAD. Thus, the present study compares Islamic hope therapy with conventional hope therapy in terms of their effectiveness in decreasing depression and anxiety symptoms in CAD patients.

Materials and Methods

Study Population

The research population included patients with CAD who had been hospitalized at least once in a hospital in Qom (a province in central Iran) university hospitals. Participants were selected through convenience sampling and invited in person or via SMS to attend a briefing session, and the volunteers were enrolled. Out of 70 patients who received pre-tests, 45 patients met the inclusion criteria, including suffering from CAD, a lack of severe personality disorder, a lack of psychotic diseases, and being 65+ years of age. Participants were randomly divided into three groups and were matched to neutralize the effects of demographic variables. The exclusion criteria were personal cancellation and absenteeism in more than four sessions.

Instruments

The research instrument was the Hospital Anxiety and Depression Scale (HADS); a 14-item scale designed to assess two subscales of depression and anxiety symptoms in patients. The questionnaire is applicable to anyone aged 16 years and older and can be completed within five minutes. The scale consists of

seven questions about signs of anxiety (Questions 12, 9, 8, 5, 4, 1, and 13) and seven questions concerning signs of depression (Questions 11, 10, 7, 6, 3, 2, and 14), which are scored on a scale from 0-3. The authors recommended a score of 11 as the cutoff point, with higher scores bearing clinical significance.

Kaviani *et al.* (31) assessed HADS scores of 261 patients with anxiety or depression admitted to the Roozbeh hospital's (Tehran) outpatient ward and compared them with the scores of 261 healthy people who were matched in terms of gender. They reported that the scale's validity and reliability were optimal. The simultaneous validity of the depression scale and the Beck Depression Scale was 0.77. At the same time, the simultaneous validity of the anxiety subscale and Beck anxiety scale was 76.7. Furthermore, the reliability coefficients of the retest in 26 patients were 0.71 for the depression subscale and 0.75 for the anxiety subscale. They calculated the internal consistency values of the questionnaire (which were 0.7% for hospital depression and 0.85 for hospital anxiety) using Cronbach's alpha coefficient.

Intervention

The three groups underwent different training packages: Snyder hope therapy package, hope therapy package with an Islamic approach, and a stress relief package.

Snyder hope therapy package

This package is designed to promote hope in the form of group hope therapy through eight 1.5-hour sessions. Theoretically, hopeful thinking is an exchange process, making its group implementation more effective than its independent implementation. At first, participants were familiarized with the cycle of despair in heart disease, and the components of hope were explained according to Snyder's theory. Then, the components of hope were discussed collaboratively in a group setting and were strengthened in the participants as they learned how to use these components in their own lives and practice homework alongside them. The eight sessions focused on 1) familiarity with therapists and establishing a therapeutic relationship and familiarity with the cycle of despair; 2) familiarity with the cycle of hope; 3) training for goal-setting skills and determining meaningful, transparent, rational, accessible, and measurable goals; 4) routing skills to provide participants with several paths to move toward goals; 5) self-motivation skills and familiarity with motivational resources and mitigation prevention; 6) strengthening a sense of purposefulness and progress and evaluating movement towards goals; 7) the skills

needed to deal with obstacles and problem solving and changing goals or passages when necessary; and 8) conclusion and prevention of recurrence.

Hope therapy package with an Islamic approach

This package was designed based on the components of hope in Quran verses and religious narrations. It was developed by explaining the mechanism of Islamic instructions about hope and was implemented in eight 1.5-hour group sessions. The package designers included an Islamic ethics graduate with a master's degree in Islamic studies and a PhD student of psychology under the guidance and supervision of an Islamic ethics expert and a PhD in Psychology who was experienced in the psychology of religion, hope therapy, and group therapy. The package was offered to 12 experts in the field of Islamic studies and psychology who affirmed its validity. The eight sessions focused on 1) familiarity with therapists and establishing a therapeutic relationship and familiarity with the cycle of despair; 2) familiarity with the meaning and purpose of life from an Islamic point of view, strengthening the tendency towards it, and understanding the cycle of hope from an Islamic perspective; 3) training for goal-setting skills and determining meaningful, transparent, rational, accessible, and measurable goals; 4) the importance of trust to Almighty God and seeking help from Him and the skills of routing; 5) spiritual motivation skills and spiritualizing the goals; 6) strengthening a sense of purposefulness and spiritual progress with an emphasis on processes rather than outcomes; 7) the skills to deal with obstacles, problem solving and flexibility; and 8) conclusion and emphasis on effort for the sake of closeness to Almighty God.

Stress relief package

the control group received a stress relief package that was delivered in eight 1.5-hour sessions. The sessions included 1) familiarity with the therapist and establishing a therapeutic relationship and understanding the consequences of heart disease; 2) understanding the stresses due to heart disease; 3) understanding stress relief strategies; 4) self-calming training; 5) confronting negative mood training; 6) negative thoughts confronting skills; 7) self-reflection and rumination confronting skills; and 8) finalizing and reviewing sessions.

Ethical Considerations

The research objectives were clarified for patients by their treating physicians and a cardiologist and informed consent was taken. Ethical approval was

gained from the Shahid Beheshti University of Medical Sciences Ethics Committee (IR.SBMU.RETECH.REC.1395.845).

Results

As shown in [Table 1](#), the mean scores of depression and anxiety variables dropped after hope therapy in both case groups, whereas the mean post-test scores for the control group were not tangibly different from their pre-test scores. The results of the Levine test showed that the equation of scores' variance was true ($P < 0/05$). Furthermore, the results of m box test (equality of multiple variance-covariance matrices) affirmed the assumption of the equality of covariance in all

analyses. To evaluate the assumption of homogeneity of gradient regression, the interactions of dependent variables with diffraction were investigated. The results indicated that the multivariate covariance analysis test assumptions were true. [Table 2](#) summarizes the results of the covariance analysis.

The three groups showed significant differences in terms of depression and anxiety ([Table 2](#)). In other words, participants who received Islamic hope therapy, conventional hope therapy, and stress relief packages indicated a significant difference during the post-test phase, at least in terms of one of the dependent variables.

Table 1. Research variables (mean and standard deviation)

Variable	Study groups	Pre-test		Post-test	
		Mean	SD	Mean	SD
Hope	Case (Islamic hope therapy)	13.6	2.1	32.6	5.1
	Case (conventional hope therapy)	13.8	2.1	29.5	3.4
	Control	12.6	3.2	22.8	3.3
Depression	Case (Islamic hope therapy)	25.9	2.1	15.8	3.6
	Case (conventional hope therapy)	25.8	2.3	15.8	2.4
	Control	26.8	2.2	21.3	2.7
Anxiety	Case (Islamic hope therapy)	20.8	3.8	15.5	2.8
	Case (conventional hope therapy)	21.3	1.4	19.5	2.4
	Control	21.8	2.5	20.9	2.9

Table 2. Results of multivariate analysis of covariance (MANCOVA) of research variables

Test	Value	F	Hypothesis df	Error df	P-value	Squat
Pillais Trace	0.961	12.027	6.000	78.000	0.000*	0.481
Wilkes' Lambda	0.195	16.036b	6.000	76.000	0.000*	0.559
Hotelling's V-Test	3.334	20.562	6.000	74.000	0.000*	0.625
Roy's Largest Root	3.074	39.962c	3.000	39.000	0.000*	0.755

The results in [Table 3](#) show significant differences between the moderated post-test modalities in the scores of hope, anxiety, and depression among the groups. The effects of the therapy on increasing hope and decreasing depression and anxiety were 62%, 46.5%, and 3%, respectively. To assess the post-test differences between the groups, a paired comparison was performed using the Bonferroni test ([Table 4](#)).

The results of the Bonferroni post-hoc test indicated that Islamic hope therapy and conventional hope therapy were more effective in increasing hope when compared to the

stress relief package. No significant difference was observed between Islamic hope therapy and conventional hope therapy groups.

In terms of reducing depression, the Islamic and conventional hope therapies were both effective, with no significant difference revealed between them.

In terms of reducing anxiety, Islamic hope therapy was more effective than the conventional hope therapy and the stress relief package. The scores of the conventional hope therapy group and the control group were not significantly different.

Table 3. Results of single-variable analysis of covariance (ANCOVA)

Source	Dependent variable	Sum of squares	Degree of freedom	Squares mean	F value	P-value	ETA coefficients
Group	Hope	963.466	2	481.733	32.447	0.000*	0.619
	Depression	266.745	2	133.373	17.357	0.000*	0.465
	Anxiety	8.201	1	8.201	1.348	.253	0.033

* Significant

Table 4. Results of Bonferroni test

Variables	Groups		Mean difference	P-value
Hope	Islamic hope therapy	Conventional hope therapy	3.4917	.0730
	Islamic hope therapy	Control	10.4917	0.000*
	Conventional hope therapy	Control	7.0000	0.000*
Depression	Islamic hope therapy	Conventional hope therapy	-0.6125	1.000
	Islamic hope therapy	Control	-6.2125	0.000*
	Conventional hope therapy	Control	-5.6000	0.000*
Anxiety	Islamic hope therapy	Conventional hope therapy	-4.1208	0.000*
	Islamic hope therapy	Control	-4.2542	0.000*
	Conventional hope therapy	Control	-0.1333	1.000

* Significant

Discussion

his study aimed to determine the effectiveness of an Islamic hope therapy package in comparison with conventional hope therapy in increasing hope and decreasing depression and anxiety in patients with CAD. The findings indicated that Islamic hope therapy and conventional hope therapy were significantly more effective than a stress relief package for all of the examined variables. Although there was no significant difference between the two hope therapy packages in terms of their effect on hope and depression, the Islamic hope therapy package was significantly more effective in decreasing anxiety than the conventional hope therapy package.

The results concerning the significant effect of Islamic hope therapy in increasing hope and decreasing depression and anxiety are in line with the findings of Salehi (25). Moreover, our finding that hope therapy significantly increases hope and reduces depression and anxiety is consistent with several studies (16,19,22,32). Our findings are also congruent with the findings of a number of studies on the significant effect of spirituality and spirituality-based therapies on reducing anxiety and depression (27).

People with high levels of hope are purposeful and, subsequently, often experience positive emotions (33). To explain the effects of hope therapy on reducing depression, it seems that hope therapy strengthens the skills that lead to setting clear, reasonable, and

measurable goals. This type of therapy also recommends multiple paths that participants can take to achieve their goals (19). Having goals (and being hopeful that they can be achieved) provides a person the idea that their life has meaning and places them on a special route. On the other hand, behavioral strategies act as a step toward activating a person and helping them to actively pursue goals, which reduces depression (34). According to Beck's theory, despair is the main symptom of depression; it not only cripples the will but makes the present situation intolerable, enticing one to escape from it (23).

Snyder (14), names three patterns of goal blockage that lead to clinical depression: 1) blocking an important and essential goal, 2) setting disadvantageous goals, and 3) having a general expectation for failure. For Snyder, reduced motivation through blocked goals, combined with an inability to create suitable goals, may predispose a person to depression. Hope therapy programs are designed to correct these patterns, hence reducing depression and lessening vulnerability. Depressed people lose their motivation when they confront barriers because they have fewer agents and passages, which causes negative emotions. In fact, despair is the main component of depression (35). As such, depressed people are taught to create more and more goals within themselves and to generalize an expectation for success by focusing on their past achievements while

maintaining their motivation and using alternative passages (21).

Hope gives meaning to life and makes it easier for people to tolerate psychological problems in life through attitude changes (14), ultimately preventing anxiety. Anxiety leads to a distorted view of the future, while hope corrects this view by reducing anxiety and its inevitable clinical signs. Therefore, hope therapy helps cardiovascular patients improve their sense of hope through a continuous positive internal conversation, conveying that they can achieve their goals and never give up. Ultimately, they experience few negative excitations because of this hopeful dialogue, thereby lessening the likelihood that they will develop mental disorders. They know how to turn their thoughts towards hope and optimism, which enables them to overcome depression and despair (22).

Hope improves the quality of life through human abilities and capacities like happiness and optimism. In difficult situations, hope provides a person with the energy needed to deal with difficulties, achieve their goals, and adapt to different conditions (35).

In explaining the significant effect of Islamic hope therapy on increasing hope and reducing anxiety and depression of patients, it should be noted that, as Snyder underscores, the goal must be valuable enough for a person to strengthen their conscious thoughts about obtaining it. The monotheistic world view based on Islamic teachings makes sense to all human life and makes life goals clear and worthwhile, thus providing precise and informative plans in this regard (26).

Regarding Islamic resources, hope is accompanied by reliance on divine power. When one's abilities and potential exceed what is needed to overcome the problem, one is hopeful. Therefore, believing and relying on the help of Almighty God, who has infinite power and ability, gives rise to hope (26).

Praying to Almighty God, seeking his help, and feeling a personal relationship with the supreme power creates a positive outlook on life (22), hence helping individuals find meaning in their lives and becoming hopeful about the future (29). Therefore, as a result of the reliance of individuals on Almighty God's power, the Islamic hope therapy package was significantly more effective than the conventional hope therapy package in reducing anxiety in the present study.

The lack of a follow-up is a notable limitation of this study. It is also noteworthy that the participants entered the study voluntarily, and their internal motivation cannot be ignored.

Conclusion

Based on the findings of this study concerning the effectiveness of Islamic hope therapy on increasing hope and reducing depression and anxiety, it is suggested that the benefits of the Islamic hope therapy package should be used as a companion to medical care to facilitate CAD patients' recovery.

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Conflict of Interest

Authors declared no conflict of interest.

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