JOURNAL OF COMPLEMENTARY MEDICINE RESEARCH, 2020
VOL 11, NO. 3
10.5455/jcmr.2020.11.03.18

RESEARCH ARTICLE

Open Access

Evaluation the Effectiveness of Anxiety Treatments: Cognitive Therapy in Comparison to Spiritual Therapy

Maryam Safara[1,2*], Mehdi Mesri[2], Hossein Shamsi Gooshki[2], Ali Ghazvini[3]

[1]Department of Psychology, Women Research Center, Alzahra University, Tehran, Iran
[2]Medicine, Quran and Hadith Research Center, Baqiyatallah University of Medical Sciences, Tehran, Iran
[3]Chemical Injuries Research Center, Systems Biology and Poisoning Institute, Baqiyatallah University of Medical Sciences, Tehran, Iran.

ABSTRACT

Anxiety disorders comprised of about 12% of the population, which leads to mild to severe impairment. Anxiety defines as a state of tension, worried thoughts and concern over the idea of risk or danger. The authors investigated the impact of cognitive and spiritual therapy in female students diagnosed with anxiety disorder. Data were collected by means of Spielberg anxiety questionnaire. Results revealed that the levels of anxiety were decreased by cognitive and spiritual therapy. The findings of this study highlighted the possible benefits of cognitive and spiritual therapy in reducing anxiety. However, literature review shows that spiritual therapy could be more effective in comparison to cognitive therapy for treating anxiety.

ARTICLE HISTORY
Received May 04 2020,
Accepted June 05, 2020
Published October 09, 2020

KEYWORDS
Cognitive therapy, spiritual therapy, anxiety.

INTRODUCTION

Anxiety disorders comprised of about 12% of the population, which leads to mild to severe impairment. Catastrophizing is a frequent condition in anxiety which is described by nervous thoughts appear to be forward-looking and marked by danger forecasts. Busse and Pfeiffer (1969) describe anxiety as a condition of frightful anticipation that roughly describes the source of fright. It consists of anxiety, restlessness, elevated heart rate and sweating, which all signify readiness to fight or escape. Compared to Lang's (1968) principle of mental multi-systems, signs are cognitive (eg, systemic thinking), physiological (e.g., heart racing) or behavioural (e.g., avoidance) existence. The cognitive aspect of anxiety is correlated with nervous thoughts that establish components for information processing in response to cognitive disturbances in perception, understanding and memory. The physiological aspect of anxiety disorders involves autonomous or somatic sensations. While individuals experience anxiety physiological symptoms in reaction to stressful circumstances, individuals with fear disorders experience abnormal physiological symptoms of length or severity for a specific circumstance or stimuli. The Lang tri-system model (1968) offers a strong basis to explain the anxiety phenomena. In short, this model indicates that the emotion of fear expresses itself in three systems : (1) a cognitive mechanism marked by subjective feelings of worry, and thoughts on the circumstance or sensation of risk, (2) a behavioural mechanism linked to the nervous person's measurable response in threats (i.e. battle, flight or freezing of reactions), and (3) a physiological mechanism that fixes the physical effects of palpitations, sweat and shaking, which increase concentration and brace the body for emergency action.

From the view point of psychoanalysis, anxiety is the most important factor in the mental diseases. There are individual differences in the level of anxiety;

* **Contact** Maryam Safara,, Department of Psychology, Women Research Center, Alzahra University, Tehran, Iran

some people have anxiety at particular times. While there are the persons who are most of the time in the state of anxiety. These kinds of anxieties made the psychologists to think that there are two kinds of anxieties.

One of them is in particular situation and the other is in specifically related to the person. The particular anxiety is the temporary reaction or momentary, which occurs under a temporary situation, which is sometimes has intensity, while fluctuating. The specific anxiety has long duration. Those who have specific type of anxiety at a high level they live most of the time in the state of anxiety. Trait anxiety emerged as a psychodynamic term that was incorrectly related to the controlled and the Freudian defensive mechanisms sought to describe recurring symptoms of anxiety.

Table 1: Differences between spiritual therapy and cognitive therapy on anxiety in Iran

		Levene's Test for Equality of Variances		t-test for Equality of Means						
		F	Sig.	t	Df	Sig. (2-tailed)	Mean Difference	Std. Error Difference	95% Confidence Interval of the Difference	
									Lower	Upper
Post state anxiety Irania n	Equal variances assumed	.151	.703	3.800	14	.002	9.125	2.401	3.975	14.275
	Equal variances not assumed			3.800	1.292E1	.002	9.125	2.401	3.935	14.315

Taylor (1996) separated the vulnerability of anxiety from the anxiety of traits by recognizing that while trait anxiety typically forecast future fears, the vulnerability of anxiety actually predicts future anxieties. An additional significant distinction is that the two constructions use separate metrics (past anxieties vs ASI convictions) to forecast potential anxiety and terror. In fact, the one factor that suggests anxiety vulnerability is that many phonics believe like this entity is safe; what they fear is an uncontrollable anxiety / panic response to the stimuli, not the dangerous essence of the stimuli itself.

Cognition is one of the important variable that affects anxiety. The cognitive aspect of anxiety is linked to anxiety that evolves components of information processing in the reaction to cognitive disturbances to perception, understanding and memory (Lang, 1968). Though individuals experience physiological arousal symptoms in response to anticipated circumstances, persons with anxiety disorders experience symptoms which, for a specific circumstance or stimuli, are extreme in length or severity. In the life of the human, the negative cognitive triangle is more critical than the others. Cognitive therapy (CT) is a type of psychotherapy that functions with depressed adolescents. Beck, A.T (1985) said cognitive therapy notes that the conceptualization of individual psychiatric problems requires five interrelated components. Beck, J.S (1995) said that these components include the interpersonal / environmental meaning, the psychology, the emotional processing, the behaviour and intellect of the individual. Both these distinct characteristics alter and communicate with each other to create a fluid and complex structure.

Oras (1996) suggests that clinicians rely more on emotional issues and pay less attention to their functional dimension. They think that fear is affected by perception and that people can reduce the severity

of anxiety by modifying their awareness. Cognitive therapy is first aimed at negative unconscious thoughts which mediate depressive symptoms and anxiety and then concentrates on substituting more positive forms of negative thinking.

From the beginning of human history, fear has always been linked to political, moral and philosophical issues. Religion has been found in particular in the case of anxiety to reduce psychiatric disorders. Some of the important causes in psycho-sociology is moral conviction. Religion plays a significant part in the individual's experiences and in the individual's comprehension.

Spirituality is a life-sensitive phenomenon. Spirituality can help a person deal with mental health. According to Rhi (2001), spiritual growth historically is related to religious devotion, piety, and particularly in monastic life. At present, faith is mostly more realistic to boost one 's health or to save the planet Earth and the like.

Alavi (2001) claimed that theological doctrines determine that one's opinions and observations affect one 's rational (concrete) views of reality, perceptions and emotions decisively. Randy et al (2007) indicated that religious values and behaviours are related to better mental health. Vahabzadeh, Dehghani, and Khorasani (2001) studied religious beliefs and their role in reducing anxiety among Tehran high school students and found that the average anxiety scores were higher in the students with lower religious convictions. Therefore, it is discovered that there is a strong connexion between the level of terror and the religious conviction of the students.

MATERIAL AND METHOD

Participants

Participants were 128 female students in grades, A. D, B. A, M. A, ranging from the age of 18 to 45-years initially recruited from some counselling centres in Iran and India. Of these students, 64 indicated high scores on anxiety and were the focus of the analyses. In the present study, sample comprised of only women because they demonstrated more motivation for treatment rather than men. Less than on sixth (4.7%) of the females completed Master's degree, 82% received a bachelor's degree and 13.3% of the sample completed advanced diploma. In total 68% reported being married and 32% reported being unmarried.

Procedures

The present study was divided into three parts. The first part of study covered the Anxiety questionnaire that distributed among female students that they have come to counselling center for first time. Students who reported high level of anxiety were chosen for this study. Therefore, sixty-four female students from each country were selected. In the second part of the study, the participants were divided into two groups i.e. control group (N= 64) and experimental group (N= 64). Experimental group further was equally divided into two groups i.e. receiving cognitive therapy and spiritual therapy. They all were assured anonymity and were told that this is a research project and would not lead to any personal evaluation that would affect their reputation or adjustment in the universities.

Standard procedures of cognitive and spiritual therapy were followed. Each subject of the experimental group has been engaged in 10 talking sessions of 45-minutes duration each. Similarly, each subject of the experimental group has been individually administered 10 session of cognitive therapy or spiritual therapy and each session was of 45 minutes duration. The first step was devoted in understanding the subject, their relationship with themselves, parents, world, siblings and the other family members, their relationships with peers and teachers and their attitude toward University. Questions such as" what makes you anxious?", "what do you do when anxious?", "how often do you feel anxious?" etc. were asked. And in the main sessions, the therapy focussed on getting the subjects to discuss about their self- concept (what they like or dislike about themselves?). Thereafter, they have been given insight into their anxiety and alter their behaviour. The participants have been made to imagine that the reduction in the symptoms of anxiety would have a positive impact on their overall quality of life. This helped the participants to understand more clearly the consequences of their negative behaviour and rewards in case of altered behaviour which led to thought reconstruction and development pro-social skills.

Third part of the study comprised of the post assessment after completion of cognitive therapy and spiritual therapy intervention. Spielberger State-Trait Anxiety Inventory have been administered to both the groups after 10 sessions, and the percentage of changes have been obtained with respect to the base scores.

Instrument

The State-Trait Anxiety Scale consists of separate self-report measures for the assessment and self-administration of two separate anxiety concepted concepts: condition anxiety (A-state) and trait anxiety (A-Trait). STAI was created in partnership with Charles D. Spielberger, R.E. J.Montuori & D. Lushene & D. Platzek in 1970. In 1970. It was originally developed as a research instrument for investigating

anxiety phenomena in "normal" (Non-Psychiatrically Disturbed) adult, but has also been found to be useful in the measurement of anxiety in junior and senior high school students. The A-Trait scale consists of 20 statements which allow people to explain how they feel generally. The A-state scale often contains 20 sentences, but the guidelines allow participants to show how they feel at a given moment. The A-Scale is referred to as C-1 and A-Trait as C-2. The A-Trait scale provides a way of screening secondary and university students for anxiety and of assessing the degree to which neurotic anxiety disorders impact students pursuing treatment and advice. The critical attributes measured by the A-state scale include anxiety, nervousness, worry and fear. The spectrum of possible STAI ratings for both A-Status and A-Trait subscales ranges from a minimum score of 20 to a maximum score of 80. The subjects are graded on a three-point scale in response to each STAI object. The test-test correlations for the A-Trait scale are mild, illustrating all psychometric shortcomings. The scale and volatility of the form of the personality. Nevertheless, the A-Trait stability coefficient is slightly higher than the A-State coefficient. Since the correct A-State calculation will reflect the effect of the particular situational variables present in the study, low STAI A-State correlations are predicted. Internal consistency coefficients for the scale have ranged from .86 to .95.

RESULTS

Statistical analysis for the present study was done with SPSS v. 16.0 for Windows. Group differences have been evaluated by independent sample t-test and paired sample t test. Additionally, the data for the two groups (experimental and control) have been compared by using ANCOVA.

Table 1 shows the frequencies and percentages for two types of therapy based on the respondents' scores. The result demonstrated that the calculated value of F was found significant (F=.151, p<0.05*)*. Spiritual therapy and cognitive therapy have been shown to have a different influence on fear in Iranian students living in Iran.

According to Table 2, post- test of subjects on anxiety with Cognitive Therapy (Mean=43) was higher in comparison with the Post test of subjects on anxiety with Spiritual Therapy (Mean= 33.88). It means that Spiritual Therapy was more effective than Cognitive Therapy in decreasing the level of anxiety in Iranian Student residing in Iran.

Table 2: Group Statistics

	Therapy state anxiety Iranian	N	Mean	Std. Deviation	Std. Error Mean
Post state anxiety Iranian	Cognitive	8	43.00	5.451	1.927
	Spiritual	8	33.88	4.051	1.432

Table 3: Differences among spiritual therapy and cognitive therapy on state anxiety in India

		Levene's Test for Equality of Variances		t-test for Equality of Means						
		F	Sig.	t	Df	Sig. (2-tailed)	Mean Difference	Std. Error Difference	95% Confidence Interval of the Difference	
									Lower	Upper
Post state anxiety Indian	Equal variances assumed	3.371	.088	3.750	14	.002	16.125	4.300	6.903	25.347
	Equal variances not assumed			3.750	1.215E1	.003	16.125	4.300	6.769	25.481

Table 4: Group Statistics

	Therapy state anxiety Indian	N	Mean	Std. Deviation	Std. Error Mean
Post state anxiety Indian	Cognitive	8	50.75	10.138	3.584
	Spiritual	8	34.62	6.718	2.375

The frequencies and percentages of the respondents' scores on two kinds of therapy (spiritual therapy and cognitive therapy on state anxiety in India) have been showed in Table 3 it is clear that the calculated value of F was found significant (F=3.371, p<0.01). Therefore, the null hypothesis is rejected. It is revealed that spiritual therapy and cognitive therapy have significant different effect on the level of anxiety in Iranian Student residing in India. As it has been indicated in the Table 4, post-test of subjects on the state of anxiety with Cognitive Therapy (Mean=50.75) was higher than the Post test of subjects on the state of anxiety with Spiritual Therapy (Mean= 34.62). It means that Spiritual Therapy was more effective than Cognitive Therapy on the state of anxiety in Iranian Student residing in India.

The frequencies and percentages of the respondents' scores on two kinds of therapy (spiritual therapy and cognitive therapy on trait anxiety in Iran) of the research instrument have been recorded. In Table 5 it is clear that the calculated value of F was found significant (F=1.656, p<0.01). It is revealed that spiritual therapy and cognitive therapy on trait anxiety in Iranian Student residing in Iran have significant difference at 0.01. According to Table 6 post test of subjects on trait anxiety with Cognitive Therapy (Mean=46.12) was higher than the Post test of subjects on trait anxiety with Spiritual Therapy (Mean= 35.25). It means that Spiritual Therapy was more effective than Cognitive Therapy on trait anxiety in Iranian Student residing in Iran.

Table 5: Differences among spiritual therapy and cognitive therapy on trait anxiety in Iran

		Levene's Test for Equality of Variances		t-test for Equality of Means						
		F	Sig.	t	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference	95% Confidence Interval of the Difference	
									Lower	Upper
Post trait anxiety Iranian	Equal variances assumed	1.656	.219	4.590	14	.000	10.875	2.369	5.793	15.957
	Equal variances not assumed			4.590	1.324E1	.000	10.875	2.369	5.766	15.984

Table 6: Group Statistics

	Therapy trait anxiety Iranian	N	Mean	Std. Deviation	Std. Error Mean
Post trait anxiety Iranian	Cognitive	8	46.12	5.276	1.865
	Spiritual	8	35.25	4.132	1.461

The frequencies and percentages of the respondents' scores on two kinds of therapy (spiritual therapy and cognitive therapy on trait anxiety in India) of the research instrument have been recorded. In Table 7 it is clear that the calculated value of F was found significant at the 0.05 level of confidence (F=.481). Therefore, the null hypothesis is rejected. It is revealed that spiritual therapy and cognitive therapy on trait anxiety in Iranian Student residing in India have significant difference at 0.05. According to Table 8 post test of subjects on trait anxiety with Cognitive Therapy (Mean=46.12) was higher than the Post test of subjects on trait anxiety with Spiritual Therapy (Mean= 35.25). It means that Spiritual Therapy was more effective than Cognitive Therapy on trait anxiety in Iranian Student residing in India.

Table 7: Differences among spiritual therapy and cognitive therapy on trait anxiety in India

		Levene's Test for Equality of Variances		t-test for Equality of Means						
		F	Sig.	t	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference	95% Confidence Interval of the Difference	
									Lower	Upper
Post trait anxiety Indian	Equal variances assumed	.481	.499	2.441	14	.029	10.500	4.301	1.275	19.725
	Equal variances not assumed			2.441	1.398E1	.029	10.500	4.301	1.274	19.726

Table 8: Group Statistics

	Therapy trait anxiety Indian	N	Mean	Std. Deviation	Std. Error Mean
Post trait anxiety Indian	Cognitive	8	49.50	8.767	3.100
	Spiritual	8	39.00	8.435	2.982

DISCUSSION

In the present study we examined the effectiveness of both cognitive and spiritual therapies in the managing and treatment of anxiety among Iranian female students residing both in Iran and India. In this research we use two kinds of therapy, cognitive therapy and spiritual therapy. The approaches of cognitive therapy to use the methods and procedures in cognitive therapy according to Beck's theory and the approaches of spiritual therapy to use methods and procedures in spiritual psychotherapy according to Karasu's theory.

More precisely, this research explored how behavioural counselling can alleviate anxiety rather than cognitive therapy, and how Iranian students living in India encounter less consequences of anxiety medication than Iranian students. For any patient, the average state anxiety and trait anxiety are important before and after treatment.

The findings found that the mean of state fear standards for students living in Iran with cognitive therapy and spiritual therapy is substantially different. The mean value for state anxiety with cognitive therapy was 43 and the average value for state anxiety with spiritual therapy was 33/88. And the contrast with cognitive therapy and spiritual therapy of Iranian students living in India shows that the average of state anxiety level with cognitive therapy was 50/75 and the average of state anxiety with spiritual therapy was 34/62. Findings found that in contrast with cognitive therapy, spiritual therapy decreased the level of state insecurity and insecurity regarding features in Iranian students worldwide and in Iranian students living in Iran and India separately. The findings were confirmed in the Vasegh and Mohammadi (2007) study, which explored the connexions between religious factors, anxiety and depression in a Muslim student population. Such results offer additional proof that faith has a defensive function against fear. This theory can also be confirmed in the Finkler research (1980), which looked at the connexion between the belief system of a patient and the cycle of spiritual cure. The change was, according to Finkler, both the functional manipulation of medical signs and the abstract exploitation by the spiritualist healers of societal conditions. In fact, Katherine et al (2006) explored the association between religious factors and death anxiety and depression in 200 individuals. The findings suggest that they are less stressed and

nervous and are more devout. Therefore, the impact of behavioural therapy on state anxiety and feature anxiety may be inferred rather than the impact of cognitive therapy.

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