SOCIAL WORK INTERVENTION FOR PREVENTION AND PROMOTION OF HEALTH AND MENTAL HEALTH

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Islamic Spiritual Guidance: An Intervention Model of Depression Disorders for Type 2 Diabetes Mellitus Patients

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Abstract

Depression is a psychiatric disorder linked to a number of chronic diseases. Individuals with diabetic type 2 mellitus (DM) are at high risk for depression. Depression in people with diabetes mellitus is associated with poor control of blood sugar, dietary disobedience, lack of motivation from the family, and worrying about the occurrence of complications of diabetes. The presence of depression in diabetics will ultimately worsen the condition of diabetes one suffers. Islamic Spiritual Guidance is a treatment or healing of psychological disorders that are carried out systematically based on the concepts of al-Quran and as-Sunnah. Islamic Spiritual Guidance has proven to be effective in decreasing depression and other psychological disorders. Spiritual therapy is very influential to build a sense of self-acceptance so that the client does not regret his fate and feel depressed any longer. On the contrary, the client will be able to express his feelings on life and have better mental health. The spiritual approach plays an important role in expressing feelings and providing comfort for the client. Client's acceptance toward their illness will encourage the individual to be closer to God and consider his illness as a trial from God. In Islamic spiritual therapy, the peace of heart and mind are the targets of therapy in dealing with various psychological diseases. Islamic spiritual therapy is flexible, preventive, creative and rehabilitative.

Keywords: *depression, type 2 diabetes mellitus, Islamic spiritual guidance*

Preliminary

Depression is a serious public health problem. Depression ranks fourth in the world. About 20% of women and 12% of men, at one time of their lives have experienced depression. Women are said to be twice as vulnerable as men in depression (IDF, 2013). Depression is a psychological disorder that is often associated with long-term stressors such as chronic diseases, including Diabetes Mellitus (DM). Diabetes Mellitus is defined as a metabolic disease or disorder characterized by high blood sugar levels accompanied by impaired carbohydrate, lipid and protein metabolism as a result of insufficiency of insulin function. Insulin insufficiency can be caused by impaired insulin production by Langerhans beta cells of the pancreas gland or due to lack of responsiveness of body cells to insulin (Gregg EW, et al, 2007).

In 2013 it was estimated that 382,000,000 people had suffered from diabetes worldwide. This number is expected to increase to more than 580,000,000 people by 2035. Indonesia ranks seventh in the list of 10 countries with the largest number of DM patients in the world (Franco OH, et al, 2007). DM prevalence in Indonesia is 2.1%. The highest

prevalence of diabetes is found in D.I Yogyakarta (2.6%), DKI Jakarta (2.5%), North Sulawesi (2.4%), and East Kalimantan (2.3%). DM prevalence in Lampung Province is 0.7% (Hu G, et al, 2005).

Clinical depression occurs in 13% to 18% of people with DM. More than two-thirds of DM patients with depression have not yet received interventions. The emergence of depression on people with DM can increase the risk of developing DM complications (Jousilahti P, et al, 2005).

Mortality due to DM in men is relatively lower than mortality in female patients (Gregg EW, et al, 2007; Franco OH, et al, 2007). Women with diabetes have worse control of blood sugar, blood pressure and blood cholesterol than men with DM. Therefore, the risk of complications to death from DM in women is higher than that of men (Hu G, et al, 2005).

Several studies have shown that depression is more common in diabetic patient populations compared to the general population. The appearance of depression in DM can increase the risk of developing DM complications. The presence of depression is associated with a decrease in patient compliance with diet restrictions, medication compliance, and monitoring of blood sugar. This will cause uncontrolled diabetes (Hu G, et al, 2005).

The complications on uncontrolled diabetes can cause prolonged depression in patients. Finally, the emergence of DM and depression will form a "vicious cycle". Screening for depression needs to be done as a result of depression co-morbidity in DM patients (Jousilahti P, et al, 2005).

One intervention that can be given to DM patients who experience Depression is Islamic Spiritual Guidance. The assistance is in the form of help in the mental and spiritual fields, with the intention that the DM patients are able to overcome their difficulties with abilities within themselves, through the power of faith and piety (Arifin. 1988: 2).

Discussion

A. Depression of Diabetes Mellitus

Depression is a general mental disorder. Depressive symptoms include: depressive mood, loss of interest or pleasure, guilt or inferiority feelings, sleep or appetite disturbance, decreased energy, and loss of concentration. These problems can become chronic and cause individuals' ability interference to take care of their own lives (Morling JR, et al, 2013). Depressive episodes usually last for 6 to 9 months, but it can last for 2 years or more to 15-20% sufferers (Perusicova J, 2002).

The exact basis for the cause of depression is still unknown. Many studies have been conducted to find out the cause of this psychological disorder. Factors associated with the causes of depression can be divided into biological, genetic and psychosocial factors. Biogenic amines, norepinephrine, and serotonin are the three neurotransmitters that have the most roles in the pathophysiology of mood disorders. Norepinephrine is associated with decreased regulation of *Badrenergic* receptors and antidepressant responses so that clinically indicates the role of the noradrenergic system in depression. Another evidence of the association of adrenergic presynaptic receptors in depression is that the activation of these receptors will result in a decrease in the amount of norepinephrine released. These receptors are also located in serotonergic neurons and regulate the amount of serotonin released. Dopamine is also often associated with the pathophysiology of depression. Other neurochemical factors such as *gamma amino butyric acid* (GABA) and *neuroactive* peptide (vasopressin and endogenous opiates) have been involved in the pathophysiology of mood disorders. Next factor is genetic factors. Research data states that a significant factor in the development of mood disorders is genetic. In major depressive disorders in twins, the incidence of depression

in *monozygotic* twins is 50%, while *dizygotic* are 10-25% (Katon, WJ, 2008). According to the study, the depression on late onset patients occurs because of the mutations in the *methylene tetrahydrofolate reductase* gene which is the most important cofactor in monoamine biosynthesis. This mutation cannot be found in early onset sufferers of depression (Hermanns, 2013).

In addition, psychosocial factors are also influential. Occurrences or events in life that are full of tension often precede episodes of mood disorders. A theory explains that stress or tension will cause functional changes in neurotransmitters and intraneuronal signaling systems which ultimately cause a person to have a higher risk of suffering from subsequent mood disorders (Katon, WJ, 2008).

Research shows no certain personality as a predisposition to depression. All people with any personality traits can experience depression, even though personality types such as dependent, obsessive compulsive, and histrionic have a greater risk of depression compared to others (Perusicova J, 2002; Katon, WJ, 2008).

Freud in 1917 stated that there is a connection between the loss of objects and melancholy. He stated that the anger of depressed patients was directed to themselves because it identified the missing object. Freud believed that introjection was an ego way to escape the lost object (Hermanns, 2013).

The factor of helplessness also plays a role in the incidence of depression. In experimental animal studies, where animals are repeatedly confronted with electric shocks that they cannot avoid, the animal finally gives up and does not try at all to avoid further electric shocks. They learn that they are helpless. For sufferers of depression, they can find the same thing from the state of helplessness (Roy T., Lloyd CE, 2012)

In cognitive theory, Beck showed attention to cognitive impairment in depression. He identified three main cognitive patterns in depression called cognitive trias, namely; 1) negative views on the future, 2) negative views on oneself: individuals considered themselves incapable, stupid, lazy, worthless, 3) and negative views on experience (Noble RE, 2005).

In sufferers of depression, it can be found several common signs and symptoms according to the Diagnostic Manual Statistics V (DSMV), namely: Physical changes in the form of decreased appetite; sleep disorders; fatigue or lack of energy; agitation; pain or headache; muscle cramps; and pain without physical causes. In addition, it is also found in depressed patients disorders of mind changes such as feeling confused; finding it difficult to make decisions; lacking of confidence and feeling guilty, a change in feeling in the form of decreased interest in the opposite sex; feeling sad; often crying without clear reasons; and irritability. Furthermore, in depressed patients it is found changes in daily habits such as distancing themselves from the social environment; decreasing in physical activity; and postponing homework (APA, 2013).

In practice, some questionnaire tools can be used to make it easier for doctors to detect clinical / subclinical depression in patients. These tools include the Beck Depression Inventory, the Hamilton Depression score (Lepine, et al, 2011).

Depression is a disease that results in disability in women. Epidemiological studies show that the incidence of major depression in women is twice as much as men (21.3% and 12.7%, respectively). These results were obtained from research in several countries and involved various ethnic groups. Data shows that differences in prevalence in each sex began to emerge at the age of 10 years and continued into middle age, where the prevalence of depression in men and women began to converge. Therefore, women of childbearing age are more prone to depression than men of productive age (Lepine, et al, 2011). Several factors are associated with the vulnerability of women to depression. Among these factors are genetic factors, vulnerability to hormonal fluctuations, and the

central nervous system that is sensitive to hormonal changes. Besides, psychosocial factors such as the role of women in society, certain stereotypes for women, habits of harboring feelings, and unfavorable social status can also play a role in women's vulnerability to depression (Lepine, et al, 2011).

Women are also more vulnerable than men to experience stress-triggered depression. Depression in women can occur in any part of the reproductive cycle (premenstrual dysphoric disorder, depression in pregnancy, postpartum depression, post-menopausal depression). The trigger factors for depression related to reproduction in other women include infertility, miscarriage, hormonal contraception, and hormone replacement therapy (Lepine, et al, 2011).

Depression with type 2 of DM can affect each other. Diabetes is a disease because the body is unable to control the amount of sugar, or glucose in the bloodstream. This situation causes hyperglycemia, a state of high blood sugar that is already dangerous (Roy T., Lloyd CE, 2012). Gender factors also play a role in the risk of DM. In prevalence, women and men have the same chance of developing diabetes, but research shows that as many as 67.0% of women suffer from diabetes while men have 33.0%. Women are more at risk of developing diabetes because physically women have a greater chance of increasing their body mass index. Post-menopausal monthly cycle syndrome (premenstrual syndrome) that makes the distribution of body fat easily accumulated due to the hormonal process so that women are at risk of developing type 2 diabetes. In addition, in pregnant women there is a hormonal imbalance, high progesterone, which increases the body's work system to stimulate developing cells (including the fetus), the body will give a signal of hunger and at its peak will cause the body's metabolic system not be able to receive direct calorie intake and use it in total so that women are also more at risk of increased blood sugar levels during pregnancy (Spellicy, 2013).

An article showed that DM patients had a slightly greater risk (15%) suffering from depression compared to people without DM. Meanwhile, people with depression have a 60% greater risk of developing type 2 diabetes (Katon, WJ, 2008). Depression in people with diabetes is associated with worse glycemic and metabolic control, faster acceleration of complications, and risk of morbidity twice as large as those without depression (Spellicy, 2013).

In addition, the quality of life of people with DM is also significantly worse than people who only have depression, diabetes, or people without diabetes or without depression. Furthermore, diabetic patients with depression also show more sick days, longer hospital days, and more frequent treatment times than diabetic patients without depression. Therefore, the management of diabetic patients with depression is not only to improve the quality of life of patients, but to reduce costs needed for general health needs (IDF, 2013).

The risk of depression in people with DM is caused by chronic psychosocial stressors due to the chronic disease they suffer. Conversely, depression can be the risk factor for DM. The mechanism underlying depression becomes a risk factor for DM is not yet clear. Theoretically, depression is resulted from the process of secretion increase and action of contraceptive hormones, changes in glucose transport function, and increased inflammatory activation. According to one study, the incidence of anxiety and depression in female DM patients was more than in male DM patients (Sadock, et al, 2010). The mortality due to DM in men is relatively lower compared to mortality in female patients (Lepine, et al, 2011; Spellicy, 2013). Women with diabetes have worse control of blood sugar, blood pressure and blood cholesterol than men with DM. Therefore, the risk of complications to death from DM in women is higher than that of men (Sadock, et al, 2010)

B. Islamic Spiritual Guidance

1. Definition of Islamic Spiritual Guidance

Islamic Spiritual Guidance is a service that provides spiritual alternative to patients and their families in the form of giving motivation to be steadfast and patient in facing trials by providing prayer guides, ways of purification, prayer, and other acts of worship carried out in sick conditions (Bhukhori, 2005 : 19). The spiritual assistance to individuals and families is expected to make them able to live in harmony with the provisions and instructions of Allah SWT so that they can achieve happiness in life in the world and the hereafter (Faqih, 2001: 4). The spiritual guidance is given with the aim that the diabetic patients are able to overcome their difficulties with abilities within themselves through the power of faith and piety (Arifin. 1988: 2). It also works as an effort to perfect medical endeavors with spiritual endeavors. The guidance process carried out by spiritual energy is an effort to provide peace and coolness of heart with encouragement and motivation to remain patient and trustful and always carry out their obligations as servants of Allah (Salim, 2005: 1). The forms of guidance given can be guidance in faith, worship, morals and good deeds through various types of services and supporting activities based on faith and devotion contained in the Qur'an and Hadith. (Jaya, 1994: 6).

2. The foundation of Islamic Spiritual Guidance

Giving spiritual guidance to diabetic patients is in line with the functions of the Qur'an and prophetic tasks of Prophet Muhammad. The existence of the Qur'an for humans is one of its functions as al-mau'izah (advice) and ash-syifaa (medicine or sedative) (Komarudin, 2008: 91). One of the Islamic Spiritual Guidances at the Hospital is taken from the words of God: "O mankind, indeed has come to you a lesson from your Lord and a healer for diseases (which are) in the chest and guidance and mercy for those who believe." [10]: 57). In verse, God said: "And We send down from the Qur'an a sedative and mercy to those who believe and the Qur'an does not add to those who do wrong but harm" (Surat al-Isra [17]: 82). The Prophet (Peace be Upon Him) also affirmed: "I have left something for all of you, if you want to hold on to it firmly, you will never be lost forever. Something that is in the form of the book of Allah and the sunnah of His Messenger "(H.R. Ibnu Majah). Normatively the Quran and Hadith are the basis for Islamic spiritual guidance. However, clergy can develop guidance methods according to the patient's psychological situation and condition.

3. The Purpose of Islamic Spiritual Guidance

The purpose of spiritual guidance is to provide assistance to others in the forms of advice, opinions, or instructions so that he is able to cure diseases that are lodged in their soul. More clearly, the objectives of Islamic spiritual guidance include: 1) to awaken the patients to understand and accept the trials they are suffering with sincerity, 2) to participate in solving and alleviating the mental problems that are being suffered, 3) to provide understanding and guidance of patients in carrying out daily obligations that are done within the limits of their abilities, 4) to take care and give treatment with religious guidance, 5) to show good behavior and speech in accordance with the medical code of ethics and religious guidance (Pratiknya and Sofro, 1985: 261).

4. Function of Islamic Spiritual Guidance

The function of Islamic spiritual guidance is as a facilitator and motivator of patients in an effort to overcome and solve life's problems for patients with the ability (faith) within themselves. The function of Islamic spiritual guidance is as follows: 1)

Preventative or preventive functions, namely keeping off or preventing problems coming to diabetic patients; 2) Curative or corrective function, which helps individuals solve problems that are being faced or experienced; 3) The preservative function, is to help individuals maintain the resolved problems from returning to bad situations and conditions (causing problems again); 4) Developmental function, which is to help individuals maintain and develop good situations and conditions remain good or even better which will not allow the problems to happen to them (Musnamar, 1992: 34).

5. Islamic Spiritual Guidance elements

1. Subject.

Subjects are officers or people who are considered capable of providing direction, counseling, and guidance to patients who are suffering from an illness. The subject in this case is a clergyman. Clergy should be people who have professional expertise in the religious field. Since the task of spiritual guidance is not easy, the clergy are required to have certain mental personal conditions. The conditions are: 1) having religious knowledge, noble character and active in carrying out religious teachings, 2) having high personality and dedication, 3) having the ability to communicate well, 4) having a sense of commitment to human values, 5) having tenacity in the internal and external environment, 6) having a sense of love and work ethic, 7) having a good personality, 8) having a sense of sensitivity to the interests of patients, 9) having smart thinking skills so that they are able to understand what the patient wants, 10) having a healthy and intact personality which is not easily destroyed by frustration, 11) having mental maturity in all outward and inner changes (Arifin, 1977: 50-51).

2. Object.

Object is a person who receives the spiritual guidance. In this case the patient is the object of guidance. When communicating and conveying messages to patients, the clergyman must know who he is in dialogue with; whether they are elderly, mature, or still young. Clergy should understand the patients' character and who will be guided. When delivering his advice, a clergyman needs to know the classification and character of his patient. This is important for the messages to be well received by the patient (Amin, 2009: 15). Clerics must approach their patients with a persuasive approach. Regarding to this, there are several terms for persuasive messages as described in the following verses of the Qur'an: 1) Qaulan Balīgā (words that imprint on the soul); 2) Layul Qaulan (meek words); 3) Qaulan Maisura (mild words); 4) Qaulan Karima (noble words); 5) Qaulan Sadida (Right Speech) (Mubarok, 2002; 132-143).

3. Order (maudu ').

Islamic spiritual guidance is the content of messages delivered by clergy to patients. In this case it is clear that the material for Islamic spiritual guidance is the teachings of Islam itself. Guidance materials from both the Qur'an and Al-Hadith that are appropriate to be conveyed to patients include aqeedah, akhlaq, ahkam, ukhuwah, education and amar ma'ruf nahi mungkar (Umary, 1984: 56-57).

6. Islamic Spiritual Guidance Method

Islamic Spiritual Guidance is a form of spiritual therapy and care that can be combined with other types of medical therapy (Arifin, 2009: 14). There are two methods of Islamic spiritual guidance, namely direct and indirect methods. 1) The direct method is the method used by the spiritual officer to direct his guidance (face to face) with the patient. This method can be further broken down into individual methods and group methods. An individual method is where spiritual officers provide

guidance directly to patients one by one. The techniques used are conversations, patient home visits (home visits), and work observations. Meanwhile, the group method is where the spiritual officer conducts guidance with patients in groups, for example guidance is done by giving certain material (lecture) to a group (Musnamar, 1992: 49); 2) Indirect methods are methods used by spiritual officers through mass communication media. This can be done individually or in groups. In individual, it can be done through telephone, correspondence, etc., while in group, it can be done through books, guidance boards, newspapers or magazines, brochures, radio (audio media) and television (Musnamar, 1992: 50).

7. Islamic Spiritual Guidance Material

In general, Islamic spiritual guidance material can be classified into three main issues, namely: 1) Aqidah Problem. In Islam, aqidah has i'tiqad bathiniyah characteristic which covers issues that are closely related to the pillars of faith. Aqidah (belief) is something that is believed to be unanimous in the least of the doubts, which can lead to the nature of the soul reflected in the words and deeds. Aqidah is centered in the belief and faith that God is the one and only; 2) Shari'ah problem. Shari'ah in Islam relates to birth practice in order to obey all the laws and laws of God to regulate life and how to live, and to regulate human relationships with God; 3) Aklaq Problem. It is an attitude or condition that encourages people to do good or bad deeds. This act is seen from its motives or intentions base that include morals like devotion to parents, mutual respect, help, and so on (Syukir, 1983: 60-62).

Summary

Depression is a serious public health problem. Depression ranks fourth in the world. About 20% of women and 12% of men, at one time in their lives have experienced depression. Women are said to be twice as vulnerable as men in depression. Depression is a psychological disorder that is often associated with long-term stressors such as chronic diseases, including DM. Men and women are different in facing a stressor. One effort to deal with depression in DM patients is giving Islamic spiritual guidance that aims to awaken the sufferer so that they understand and accept the trials they are suffering with sincerity.

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