INTEGRATING THE ISLAMIC COGNITIVE BEHAVIOURAL THERAPY (I-CBT) AND ITS EFFECTIVENESS IN TREATING DEPRESSION

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ABSTRACT

The study was aimed to develop a manualised treatment integrating the Islamic concept of hope, meaning and sense of gratitude into cognitive behaviour therapy (I-CBT) in treating depression among Muslims. Development of the therapeutic module was based on the Enriched Intervention Manual of Operations, and Cully and Teten's Brief Cognitive Behaviour Therapy, which was validated by three experts in the field of clinical and Islamic psychology. The study also examined Muslims' expression of depressive symptoms in relation to emotional and somatic complaints. Based on a mixed method research design, six Muslim participants from a military base in South-West Nigeria were selected through purposive sampling methods. The inclusion criteria for the study was English proficiency and a score of seventeen and above in the Beck Depression Inventory (BDI). Each participant passed through a 6-week session protocol, and the BDI was used to obtain the depression scores before and after the intervention. Also, the data from face to face interviews, daily records, sentence completion exercises, field notes and others, were analyzed through the Interpretative Phenomenological Analysis. The research findings indicated some decreased depression symptoms among the participants. Moreover, results also revealed that sense of gratitude and meaning served more as buffering effects in the participant's experience of decreased depressive symptoms. Hence, it could be deduced that the Islamic CBT as a manualized treatment is effective in reducing mild depression among Muslims. In conclusion, the findings of the present study calls for greater attention on why Muslim clinicians and counselors should explore their patients' religious values in helping to cope with emotional and life difficulties.

MENGINTEGRASIKAN TERAPI TINGKAH LAKU KOGNITIF-ISLAM (I-CBT) DAN KEBERKESANANNYA DALAM MERAWAT KEMURUNGAN

ABSTRAK

Kajian ini bertujuan untuk membangunkan manual rawatan dengan mengintegrasikan konsep harapan dalam Islam, makna dan rasa kesyukuran ke dalam terapi tingkah laku kognitif (I-CBT) dalam merawat kemurungan di kalangan umat Islam. Pembangunan modul terapeutik berasaskan *Enriched Intervention Manual of Operations* dan *Cully and Teten's Brief Cognitive Behavior Therapy*, yang telah disahkan oleh tiga pakar dalam bidang psikologi klinikal dan psikologi Islam. Kajian ini juga mengkaji expresi gejala kemurungan Muslim berhubung dengan aduan emosi dan somatik. Berdasarkan reka bentuk kaedah penyelidikan campur, enam peserta Muslim dari sebuah pangkalan tentera di Selatan-Barat Nigeria dipilih melalui kaedah persampelan bertujuan. Kriteria kemasukan untuk kajian ini adalah penguasaan bahasa Inggeris dan skor tujuh belas ke atas di dalam Inventori Kemurungan Beck (BDI). Setiap peserta melalui 6 minggu sesi protokol dan BDI telah digunakan untuk mendapatkan skor kemurungan sebelum dan selepas terapi. Selain itu, data dari temuduga bersemuka, rekod harian, jawapan kepada *Sentence Completion Test*, nota lapangan dan lain-lain, telah dianalisis melalui interpretasi analisis fenomenologi. Dapatan kajian menunjukkan penurunan sedikit gejala kemurungan di kalangan peserta. Selain dari itu, keputusan juga menunjukkan rasa syukur dan makna membantu menampan gejala kemurungan peserta. Oleh itu, boleh disimpulkan bahawa CBTIslam sebagai rawatan manualized amat berkesan dalam mengurangkan kemurungan yang ringan di kalangan umat Islam. Sebagai kesimpulan, dapatan kajian ini menimbulkan perhatian kepada terapis dan kaunselor Muslim supaya meneroka nilai-nilai agama pesakit mereka dalam membantu untuk mengatasi masalah emosi dan kehidupan.

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CBT	Cognitve Behaviour Therapy
I-CBT	Islamic Cognitive Behaviour Therapy
SAW	Subhana Wa Ta'ala (Be He glorified in the highest)
PBUH	Peace be upon him

CHAPTER 1

INTRODUCTION

1.1 Background of the study

It is a common knowledge that psychological disorders do affect people of every race and society worldwide. Depression for instance, has been categorised among the most common psychological disorders in the world with an estimate of about 330 million people suffering from the problem (Smith, McCullough & Poll, 2003). Looking back to some decades ago, numerous studies have examined the epidemiology, etiology and treatment of major depressive disorder which has resulted in a large body of knowledge and understanding of the disorder (Cuijpers, 2011).

According to the Diagnostic and Statistical Manual of Mental Diseases Fifth edition (DSM-V), the definition of depressive disorder have eight

symptoms which include: depressed mood, loss of interest/pleasure, problems with sleep, changes in appetite or weight, feelings of guilt/worthlessness, fatigue or loss of energy, suicidal ideation, and inability to concentrate or indecisiveness (American Psychiatric Association, 2013). Thus, based on this definition, a person can be diagnosed of major depression or major depressive disorder (MDD) if the above symptoms are experienced nearly every day for at least two weeks, (with depressed mood or loss of interest or pleasure among other five or more), start to interfere with daily and occupational functioning, and are negatively affecting interpersonal relationships (American Psychiatric Association, 2013).

In what looks like the historical background of depression, Malik Badri's recent book; *Abu Zaid al Balkhi's Sustenance of the soul,* reveals Al-Balkhi's clinical discoveries in the 9thcentury. Badri (2013) posits that through the use of incisive observation and distinguished clinical orientation, Al-Balkhi categorizes depression into three which includes; normal state of sadness (*huzn*), endogenous and reactive depression. According to Malik Badri;

> The important discovery of differentiating between endogenous mental and psychological disorders, originating from within the body, and those originating due to exogenous or environmental factors from outside the body, took a further ten centuries before inappropriately being credited to Emit Kraepelin whose work was only published towards the end of the nineteenth and the early years of the twentieth century (Badri, 2013, pp.19-20).

Hence, it could be deduced that the modern-day classification of depression according to the DSM V has its roots from al-Balkhi's categorization in the 9th century. Obviously, clinical psychologists and psychiatrists generally benefits from Balkhian dichotomization based on the differing causes of depression which are linked to environmental and internal or biochemical dysfunctions (Badri, 2013).

According to Balkhian classification, normal sadness are further classified into two which include the one caused by environmental factors like loss of loved ones, bankruptcy etc; and the one caused by unknown organic factors, an abrupt affliction of distress (*ghummah*) that triggers depressive feelings, and linked to impurity in the blood (Badri, 2013). Furthermore, endogenous depression, which is previously known as psychotic depression (currently major depression) involves psychotic symptoms like hallucination and delusion and other symptoms like chronic guilt feelings, mental retardation, sleep difficulties, anhedonia (loss of pleasure in previously pleasurable activities), severe depressed mood, etc. While reactive depression which is triggered by environmental factors involves moody thoughts and feelings about a real life challenge or expected loss and grief without any link to psychotic symptoms (Badri, 2013).

Consequently, the Balkhian classification has been proven experimentally to be accurate through clinical observation and biochemical and hereditary research findings (Badri, 2013). Moreover, from the historical discourse of depression, it could be deduced that there are mood-related symptoms like hopelessness-helplessness syndrome; feeling of sadness, loneliness, etc, which may make it difficult for the person to have the drive to start or even engage in treatment. Likewise, there are cognitive-related symptoms which entail those negative beliefs about the self, the world, and the future with prevailing sense of low self-regard (Holmes, 2006).

Furthermore, Murray and Lopez (1996) reported the finding of a study conducted by the World Health Organization and Harvard School of Public Health that depression is anticipated to be the world's second primary cause of disability by the year 2020. This calls for more efforts in relation to rigorously embarking on research and interventions in treating the problem. In all, depressive disorders are often categorized into three which includes major depressive disorders, minor depression and dysthymia. While a person suffering from minor depression is affected with lesser symptoms when compared with major depression, both of them are linked with experiencing depressed mood during the same two-week period as mentioned earlier on (American Psychiatric Association, 2013).

In addition, as depression affects a person with no apparent medical or physical illness, it do affects medically ill patients as the nature of depression seen in primary care medicine are often as a result of life changes caused by chronic medical illness in which interventions in this regards tend to be directed to helping patients adjust to difficult life events (Ward, King, Lloyd, Bower, Sibbald, Farrelly, et. al., 2000). Depression, in the description of Koenig (2012) remains a problem that on one hand, destroys a person's quality of life, while the effects on the physical, physiological and psychological functioning on the other. Besides, it is seen as often a function of an individuals' negative worldview that often characterizes his situation as hopeless and without existential meaning (Koenig, 2012).

1.2 Depression and Cultural Effects

A person's personal insight about life events which may be linked to his cultural and religious background goes a long way in determining its understanding and response to depressive stimulating events. For instance, Kirmayer (1989) posits that culture influences the understanding and expression of psychological suffering with marked differences in the occurrence, symptoms and effect of psychological illness based on geographical factors. This is buttressed with general assumptions from studies

that cultural differences in the recognition, labeling and clarification of abnormal behaviour do affect the outcome of major psychological disorders.

In relation to this, the cultural factor may sometimes even cut across close geographical lines. Kleftaras and Psarra (2012) agrees that psychological well-being, existential meaning and depression are predisposed by cultural factors. They argue that the multifaceted nature of culture remain a dynamic process that connects the past to the modern day lifestyles.

According to Desjarlais, Eisenberg, Good, and Kleinman (1995), the cultural background of a person may be regarded as a factor when he experiences depression in terms of physical or psychological platforms. Here, one can mention that the experience of depressive illness is identified in any cultural setting; however, there may be a lot of differences in its clinical presentation. For instance, Bhugra and Mastrogianni (2004) mention that major symptoms of depression like depressed mood or amnesia (loss of interest) may not be noticeable in many cultures. Likewise, symptoms like suicidal ideation or suicide may not be experienced among Muslim populations due to their religious beliefs, with the point that suicide rates have been reported to be low among general populations in individual Islamic countries (Lester, 2006).

So far, psychologists are still in doubt whether the personal and social effects of depression symptoms are similar across cultures. Tsai and

Chentsova-Dutton (2002) posit that studies across cultures on depression have much to contribute to understanding human psychological functioning and disorder, which is highly important towards the development of effective interventions and treatment approaches for depression across different cultural settings.

Moreover, it has been a serious challenge among researchers as to how to view depression in various different cultures. This is evident in the two varying angles the concept is being viewed by researchers over some years now; the ethnographic and biomedical approach. According to Tsai and Chentsova-Dutton (2002), researchers in the ethnographic school believes that the meanings and effects of depressive symptoms is considerably different across cultures due to the fact that diverse structures and values determine the meaning of these depressive symptoms when compared to those from the West. On the other hand, they mention that researchers in the biomedical school hold that there is no difference in terms of depression symptoms experiences across cultures, as most of the researches in this area focuses on the predominance of depression in various cultures.

Numerous studies have found that the predominance rate of depression varies significantly across national and probably, ethno-cultural basis. Simon, VonKorff, Picvinelli, Fullerton, and Ormel (1999) in a World Health

Organization (WHO) study conducted in 1991 compared the prevalence of mental disorders in the primary care clinics of 14 countries in five continents. Results showed that the prevalence rate of major depression showed significant difference across countries based on DSM-V criteria. They reported that while the prevalence rates are higher in Western countries like United Kingdom (17.1%), it was the opposite in Japan (2.4%).

Considering some of the reasons for these variations aside geographical lines, some of the psycho-social factors in Tsai and Chentsova-Dutton (2002) views are linked to the cultural differences in the idea of mental illness. In this case, it is previously known that depressed patients in cultural settings (where somatic symptoms are being presented for depression) is highly common in non-Western cultures, as there are also growing evidence buttressing the claim that Western cultures are now viewing emotional problems as separate from physical problems more than Asian cultures (Bhatt, Tomenson, & Benjamin, 1989).

Another factor is the differences in relation to the amount of stigma attached to psychological disorders where there tends to be higher stigmatization of emotional problems like depression in Asian cultures than in the West, hence, social stigma associated with mental illness in some cultures may be a serious factor of cultural difference. However, Fogel and Ford (2005)

posit that stigma levels on depression may be changing in some cultural entities possibly due to acculturation.

In addition, it is also possible that another reason behind the differences in the prevalence of depression among cultural entities is as a result of the diagnostic tools used among psychotherapists, psychiatrists, and other mental health practitioners (Tsai and Chentsova-Dutton, 2002). They assert that cultural preference do exist and often influences outcomes when standardized diagnostic tools are used. This position can be logically accepted due to how the cultural conceptualization of mental problem of a group may influence the categorization of specific behaviors as normal and healthy or otherwise. This is supported from the findings of a study conducted by the WHO which revealed that the possibility of acknowledging depression problems by primary care therapists differs significantly across various cultures (World Health Organization, 2012).

The occurrence of specific depressive symptoms may also be a factor for the differences in predominance rates of depression across cultures (Tsai and Chentsova-Dutton, 2002). They posit that the diagnostic criteria for a disorder according to the DSM for instance, may include symptoms that occur more or less often in a particular cultural entity when compared to the Western cultural context where the norm of diagnostic criteria was established. This may lead to

situation where cultural differences in the frequency rates of the illness may rise. For example, Asian and Arab cultures (like Koreans, Turkish, Japanese) tends to emphasize the somatic symptoms of depression as they remain more prominent to people from non-Western cultures and due to their beliefs in the body-mind relationship, as in the case in the United Arab Emirates and Turkey where there is more likelihood of describing their depression in terms of somatic complaints (Hamdi, Amin, & Abou-Saleh, 1997). These beliefs can said to be a major player in every cultural setting, and it is quite obvious that culture being a major determinant in the conceptualization of depression, and the role of religion and spirituality cannot be overemphasized in this regard.

From the above discussion, it could be deduced that while depression is often experienced universally, there are some factors that reflects some marked differences in the way people understand, feel and even experienced the symptoms. This is why one of the objectives of the present study is to explore and unravel the conceptualization of depression among non-Western samples in a bid to ascertain the accurate meaning, symptoms, and possibly mode of treatment.

1.3 Treatment of Depression

It is generally accepted that depression is highly susceptible to treatment based on the fact that over eighty percent of depressed people who seek treatment do record improvement in their life (National Institute of Mental Health, 2005). In a recent link of the physiological and psychological effects of depression, Leonard and Myint (2009) mention that sickness behaviour (like that of depression) can be a function of the stimulation of pro-inflammatory cytokines unveiling the possibility of how the physiology of depression (caused by persistent stress) is being influenced by immune and endocrine functions. In essence, as various antidepressant drugs is being used to treat depressive problems, clients tend to be less likely to develop their own personal coping mechanisms to resolve their depression as they often attribute it to chemical imbalance and see any improvement to effects from the drug (Shapiro and Morris, 1978). However, an alternative psychotherapeutic approach is viewed differently.

According to Beck, Rush, Shaw, and Emory (1979), based on some of the benefits of cognitive behavioural therapy for instance, it is believed that effective passage of psychotherapy overshadows chemotherapy in the long run due to what the patient stands to learn from therapeutic experience, and as such, expect to effectively cope with any depressive symptoms in later times.

Furthermore, several numbers of psychotherapeutic approaches have been adopted in treating depression. However, Naeem (2011) posits that the preference of the patients and how competent and trained the therapist is remains the major factor on the kind of psychotherapy to be used despite more structured psychotherapies like interpersonal therapy and cognitive behaviour therapy (CBT) have greater effectiveness in the treatment of depression.

So far, based on the level of severity, history, and the persistence of depressive symptoms, the kind of suitable treatment involves antidepressant medication, psychotherapy, or a combination of both. Cognitive-Behavior Therapy (CBT) is one of the most operational short-term psychotherapeutic interventions supported by various research studies for the treatment of depression. Moreover, several studies outcome uphold that one of the most empirically validated approaches for treating depression over some time now is CBT (Beck, et. al., 1979; Leahy, 2004; Serfaty, Haworth, Blanchard, Buszewicz, Murad, & King, 2009). The world of cognitive and behavioural therapy involves a body of therapeutic interventions like cognitive therapy, rational emotive and behavioral therapy, schema-focused therapy, interpersonal therapy, etc.), sharing a common foundation that is related to addressing dysfunctional thoughts that is causing depression.

1.4 History of Cognitive Behaviour Therapy

At a time, the world of psychology and psychotherapy in particular are primarily concerned with the theory and practice of Freud's psychoanalysis. This school of thought is centered on the unconscious, and believes human emotions and behaviour are governed by sexual and aggressive instincts were later faced with much criticism. This is due to the fact that some psychoanalytic theories and practices are grossly less scientific, and according to Badri (2013), most experts in the field of clinical psychology redirected their attention away from the unconscious sexual and aggressive conflicts as the causes of mental disorders.

This scientific nature of empiricism married with psychology led to the development of the behaviourist school. Based on the principle of learning, behaviourist like Ivan Pavlov and Skinner landed some ground-breaking empirical research in psychology. Behaviourism upholds that human behaviour is a function of the forces within a person's external environment, and psychological disorders are determined by negative environmental experiences. As Badri (2013) puts it, as the new field of behaviour is springing up the treatment of various anxiety-related disorders, it was evidently clear that psychological symptoms is not tied to any unconscious past, but are rather