A Proposed Model for Islamically Integrated Cognitive Behaviour Therapy to Alleviate Depression

By

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Abstract

The main purpose of this study is to discern whether Islamically Integrated Cognitive Behavior Therapy (ICBT) is more effective for Muslim clients than traditional Cognitive Behavior Therapy (CBT). Traditional CBT may be described as very individualistic, and this does not coincide with the collectivist nature of Islam, thus tailoring it to be more consistent with the beliefs of Islam, will be more effective for these clients. The findings of this thematic literature review analysis show that the use of Islamically Integrated Cognitive Behavior Therapy (ICBT) is more productive when helping Muslim clients dealing with depression. The findings from the studies analysed suggest that Muslim clients found that when their religion and spirituality were included in the therapy process, they were more likely to stay in therapy and benefit from the tools and strategies used. This critical review involved a methodological analysis of ten key studies. An examination of many additional studies revealed the efficacy of Islamically Integrated therapy in clients healing from depression.

Therapists have contested the practicability of using CBT among the Muslim community. Debates have fixated on CBT's individualistic mindset and its compatibility with clients where Islam infuses most aspects of their lives. When used with Muslim clients, however, results may be improved by adapting traditional CBT. By culturally adapting traditional CBT treatment, a therapist may be better able to focus on different symptoms and diagnoses in their Muslim clients. The findings indicate that given the auspicious outcomes of ICBT, it can improve Muslim clients' abilities to cope actively with disorders that affect their mental well-being.

Keywords: Cognitive Behavioral Therapy, Islam, Psychology, Muslim, Culturally Adapted cognitive behavior therapy, Islamically Integrated CBT

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To all of those who have helped me along my journey. It has been a long and difficult three years. Life continued on as I embarked on this ride and took me through so many highs and lows. Things I never thought I could endure, I endured, grew and came out the other side stronger than I ever thought I could be.

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Chapter One: Introduction

Background

Muslims are a diverse group of people, that are growing populations around the world. The Government of Canada census (2022) reported that Islam ranked second in Canada in terms of reported religions in 2021, with approximately 1.8 million, or 1 in 20, reporting Islam as their primary religion. The census (2022) goes on to state that the percentage of Muslims in Canada has more than doubled in 20 years, rising from 2.0% in 2001 to 4.9% in 2021. The diverse cultures, customs, and life experiences that make up Muslim's identities are combined to create something new (Shah et al., 2023). Similar to other ethnically and culturally diverse groups, Muslims experience mental health problems that often go untreated due to stigma or lack of knowledge of resources (Islam et al., 2017; Karasz et al., 2019; Naeem et al., 2021). Muslims' quality of life and day-to-day functioning can be significantly impacted by social factors like migration, language barriers, dual identity, and cultural pressures (Karasz et al., 2019; Munawar et al., 2023; Naeem et al., 2021).

These social factors have a negative impact on mental health care access and utilization, which exacerbates discrimination against Muslims in mental health services (Naeem et al., 2021; Rathod et al., 2019). Furthermore, Muslims may be more susceptible to mood and anxiety disorders as a result of these detrimental social factors (Naeem et al., 2021; Shah et al., 2023). Researchers have investigated the possible barriers to Muslims seeking help and recognize the importance of taking into account the impact that a person's culture may have on how they view mental health (Munawar et al., 2023; Naeem et al., 2019). Barriers can make it harder to get services, prevent people from talking about mental health, and heighten stigma (Rathod et al., 2019). Therefore, improving mental health services for Muslims in Canada is important.

Depression is one of the most well-known mental illnesses in the world and a serious public health concern and affects an estimated 3.8% of people globally (Skaik & Inkpen, 2022). Steensma et al. (2016) stated that depression is a major contributor to the global disease burden. The authors continued to specify that depression significantly affects functioning, mortality from intentional injury, health care utilization, and health-related quality of life (HRQOL). The authors conceded that apart from these obvious adverse effects, depression has also been shown to raise the risk of cancer, coronary heart disease, stroke, and a decline in physical functioning. Depression is a risk factor for and a consequence of disease, so there are possibly reciprocal effects between the two.

Islamic Psychology is a religious-based concept that aims to integrate spiritual aspects and emphasize the importance of religion in the lives of individuals (Iqbal & Skinner, 2021). Islamic psychology must begin with the understanding of human nature; this includes the understanding of the spiritual nature of humans, the existence of Allah, and the guidance and teachings of Islamic sources (e.g., the Quran, Hadith, and the writings of Muslim scholars) (Iqbal & Skinner, 2021; Rothman & Coyle, 2018). Despite it being a newer concept in the field of psychology, Islamic psychology is distinct in that it places a strong emphasis on the value of Islamic sources for comprehending human nature (Iqbal & Skinner, 2021). Since Western Psychology ignores the numerous spiritual influences on a person's thoughts, feelings, and behaviors, it is limited when dealing with Muslim clients, who place high regard on their spirituality in every aspect of their well-being. Muslim psychologists would be able to incorporate knowledge from Islamic sources into their research and theoretical frameworks if Islamic psychology became a recognized paradigm. In the end, this would also lead to the development of fresh perspectives and innovative approaches for the general study of religion and human behavior (Iqbal & Skinner, 2021).

Research Problem

There have been many studies conducted on the efficacy of traditional CBT in treating individuals with depression and anxiety, but there is a gap in research that addresses Muslim clients using Islamically Integrated CBT. It is important for this issue to be addressed as the prevalence of depression and anxiety is increasing among the Canadian population. In a study conducted by the Centre for Addiction and Mental Health (CAMH) in Toronto, they found that more than 25 percent of survey participants reported feeling moderate to severe anxiety. In the same study, they found that roughly 22.3 percent of people reported having feelings of depression (Jabakhanji, 2022).

The issue being addressed in this paper is whether Islamically Integrated CBT should be applied to Muslim clients, specifically those dealing with depression, to better respect their culture and diversity. This paper is an attempt to propose and promote a model that would increase research on the efficacy of Islamically Integrated Cognitive Behavior Therapy (ICBT) to help Muslim clients with depression. The research question being: *Can using Islamically Integrated Cognitive Behavior Therapy (ICBT) acquire more beneficial outcomes for Muslim clients than traditional Cognitive Behavior Therapy (CBT) for clients with depression?*

Based on the gap in the research it is proposed that Islamically Integrated CBT will be the ideal form of treatment when helping Muslim clients dealing with depression, as it would meet their cultural and religious needs. Based on the Canadian Code of Ethics for Psychologists (2017) cultural diversity factors are held to the highest standards in dealing with clients. This is stated in the values statement of Principle I of the Code, which states that psychologists recognize that each individual is socially interdependent and inhabit social groups and are shaped by their history and development. The various social groups' histories, cultures, ethnicities, religions, social systems, and other traits are often fundamental to the identities of the people who belong to them and provide purpose to their lives. This is crucial for

psychologists to take into consideration, as Principle I hold the highest weight in the Code of Ethics, and we must take this into account in everything that we do when dealing with clients.

Significance of the Study

The purpose of this study is to prove that Islamically Integrated Cognitive Behavior Therapy (ICBT) is a more ideal mode of therapy to be used with most Muslim clients. The findings from this research project will be relevant for practitioners who are working with immigrants, refugees, or even Muslims who were born and raised here in Canada, as Islam is a faith that touches many from diverse backgrounds. This paper aims to educate both novice and seasoned clinicians on the multifaceted nature of Muslim clients and to assist them in providing their clients with effective and ethical mental health care. The model of ICBT discussed will create awareness among the educators of counselling programs in universities. Therapists may have a difficult time understanding the nuances of Islam and how the Muslim client if they are not knowledgeable about culturally and religiously based knowledge and skills in counselling.

Theoretical Framework

To conceptualize the unique complexities that accompany the treatment of Muslim clients two theoretical frameworks were implemented in this capstone, the social constructivist framework and the Islamic Psychology theory. These theories will aid in the comprehension of the ways in which Muslims and Islamic psychology have evolved and influenced lives.

Firstly, this project requires a constructivist framework in order to incorporate the subjective experiences of the Muslims seeking mental health therapy, which are the subject of the investigation. Constructivism recognizes that people interpret the meaning of their experiences and their surroundings in a subjective manner. Boyland states "Constructivism offers a paradigm of investigative thinking whereby the researcher journeys with participants into a space of interpreted reality that is as personal and individual as each person in the

collective sampling and as diverse as the collective of lived experiences that are profiled" (2019, p. 30).

When conducting research, objectivity, rationality, and scientific methodologies are often valued as the gold standard in research, while subjective, personal, and relational approaches are less ubiquitous. Harlene Anderson, an innovator in post-modern and collaborative therapeutic methods, presents an alternative viewpoint on the research process. She challenges the concept that research must adhere to a set of authoritative conventions encompassing the necessity of neutrality and objectivity (Anderson, 2014). According to Anderson (2014), research is a process of knowledge acquisition that actively includes the opinions of those being studied. Research can be seen through the lens of a social inquiry, rather than just a scientific lens. Anderson eloquently proposes that this shift in perspective from learning "about" to learning "with". This paper does not completely renounce conventional social science research constraints, it was purposefully decided to value both subjective and objective perspectives and to actively learn "with" Muslims about their experiences.

An innovator in social constructionism, according to Gergen (1985), our realities are shaped by the groups we interact with and the relationships we have within them. In essence, acts of communion are how we become who we are (Dole, 2021; Dole, 2017). This framework would be significantly important in the Muslim's self-development since they are members of a tight-knit community, that often engages in interactions and communions with each other. Many Muslims come from collectivist cultures, and this often is part of who they are. Thus, it is considered noteworthy and included in this paper to explore and examine the relationships that Muslims form in community with one another and how those interactions impact the sense of self.

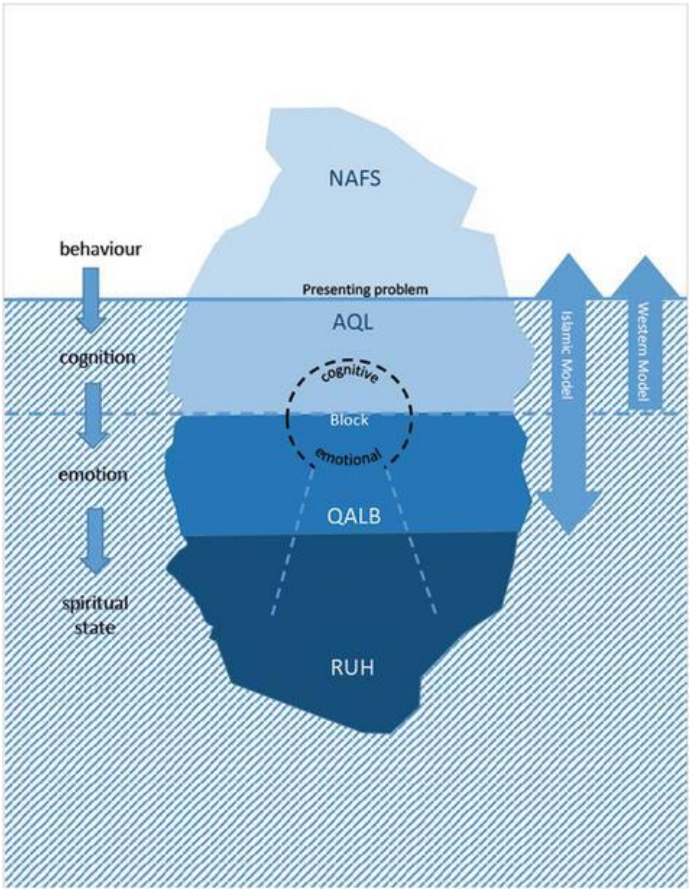
Dr. Abdullah Rothman & Adrian Coyle, (2020) researched Western psychology and came to the conclusion that the process of "Islamicizing" Western secular psychology and

psychotherapies—that is, changing fundamental ideas in these approaches to try to take into account Islamic values and commitments—cannot fully address the realities of religiously committed Muslims' lives or provide them with a deep, comprehensive level of engagement. The authors stated that there is a need to develop a new form of psychology that is entrenched in a model of the person, rooted in Islamic guidance, theology, ethics, and philosophy. Rothman and Coyle (2018) offered an Islamic conception of the "soul" specifically for the basis of Islamic psychology foundation for psychotherapy. The resulting model (Rothman & Coyle, 2020; Rothman & Coyle, 2023) has its roots in Islamic theology, and the Qur'an, which is the primary religious text of Islam, Hadith, which is a collection of the Prophet Muhammad's sayings and customs, and the writings of numerous early Muslim scholars all make reference to its various elements.

Rothman & Coyle (2020; 2023) described the concept of the heart or *qalb* is seen as the divine center of an individual, and it is where the faculty of the intellect, or *aql* is located. The *qalb* has the possibility to go in one of two directions. It can become more misaligned with *fitrah* and turn toward the lower impulses of the self (*nafs*) due to the influence of *Shaytan*, also known as "the devil," or the *dunya*. This is supposed to lead to a state of forgetfulness or heedlessness of God, as well as an intensification of vices like lust, greed, envy, and rage. As an alternative, the *qalb* can face the spirit's higher, divine essence, *(ruh),* thus, bringing the soul closer to the state of *fitrah* and fostering greater virtues like wisdom, justice, courage, and temperance. Other Muslim scholars have described the human soul in a similar way to Rothman & Coyle, including Abu-Raiya (2012) and Keshavarzi and Haque (2013), particularly in the significance of the elements of the soul (*nafs, aql, qalb, and ruh*).

Rothman & Coyle (2020) developed Figure 1 and it summarizes the main conclusions from their analyses and shows an iceberg-like representation of the resulting Islamic psychology model.

Figure 1. Islamic Psychology Iceberg Model Rothman & Coyle (2020)



The majority of clients' presenting problems manifest "above the waterline," which is where the *nafs* level appears. This may manifest itself more covertly as personality traits or more overtly as behavior-oriented patterns. Accordingly, the majority of what was deemed to be "visible" in the client's presentation was thought to be indicative of imbalances or blockages further "below the waterline," at one of the other levels of the soul. The level of *aql*, which is where cognitions linked to maladaptive behavior or personality patterns originate and sustain those problematic behaviors or patterns, is situated just below the waterline. This is where cognitive-behavioral therapy can be utilized in reframing and reprogramming these maladaptive

thought patterns. Western psychological paradigms frequently concentrate on or only go up to the *aql* level.

Rothman & Coyle (2020; 2023) wanted to establish that simply modifying core concepts within Western secular approaches to try to accommodate Islamic values and commitments, can only go so far in speaking to the life world of religiously committed Muslims and engaging with this client group in a deep, holistic way. Instead, there is a need to develop a different psychology and psychotherapy rooted in a model of the person derived from Islamic theology, philosophy, ethics, and guidance. This research shows how to do just that the research's specific goal was to create a data-grounded model of Islamic psychotherapy based on the Islamic model of the soul. The findings of this study offer a guide for a psychotherapy strategy based on an Islamic understanding of the individual or soul, as well as mental health and wellness. The iceberg model that has been created in light of these findings provides fresh perspectives for the ongoing advancement of clinical interventions in Islamic psychotherapy.

Definition of Key Terms

Islamically Tailored Psychotherapy- “is a modern approach or orientation to psychotherapy that integrates Islamic teachings, principles, philosophies, and/or interventions with Western therapeutic approaches” (Fatemi, 2020).

Cognitive Behavior Therapy (CBT)- can be described as a set of therapeutic procedures that focuses on an individual's thoughts in the change process (Hepworth et al., 2006). CBT is a talk-based psychotherapy intervention that focuses on raising awareness of perceptions and behaviors in order to challenge false, counterproductive, or negative thoughts, beliefs, and attitudes (Ackerman, 2017; Mayo Clinic, 2019).

Islamically Integrated Cognitive Behavioral Therapy- is a manualized therapeutic approach may help to assist depressed Muslim clients to develop thoughts and behaviors to reduce depression, informed by their own Islamic beliefs practices, and resources (Sabki et al., 2019).

Depression- is a common and serious mood disorder. Truschel (2022) describes that individuals who suffer from depression experience symptoms such as persistent feelings of hopelessness and sadness, as well as loss of interest in activities that they once enjoyed. The author states that numerous factors, including the length of these unpleasant emotions, additional symptoms, physical effects, and the impact on the person's capacity to go about their everyday lives, are taken into consideration when diagnosing someone with depression.

Muslim- a person who follows the religion of Islam.

Reflexivity and Positionality

In accordance with research best practices, a statement of researcher positionality will be included (Creswell & Poth, 2018). I acknowledge my personal position in relation to the topic and my social location as it impacts the way I convey and interpret information. As an immigrant myself, who came to Canada with my family at the age of 4, I have seen the experiences of new immigrants and the first-hand struggles that they face. Also, growing up in Canada, but being an immigrant child, I also experienced things that my non-immigrant friends never experienced.

I have witnessed firsthand the struggles my parents faced, learning a new language, and culture and adapting to a new country. The isolation that many immigrants face, is often debilitating. Immigrants often come to Canada well-educated, but because their degrees do not transfer, they are forced to work low-paying, entry-level jobs, while they upgrade their education or find a new field altogether. These factors often play a role in their mental well-being. Now,

working with the immigrant population, and with many Muslim clients, I feel that it is important for therapists to understand the cultures, to better help their clients.

Often, within the Muslim community, there is a stigma regarding therapy and mental health. Currently, this bias is starting to shift, but we still have a significant amount of work to do to fully disregard this stigma among our community (Husain & Hodge 2016; Munawar et al., 2023). Often, when a Muslim is finally ready to embrace therapy, they may specifically look for a therapist from the same culture as themselves, so they feel understood and their beliefs validated. Other times, the client may look for a therapist that has no connection to the community, because they may be embarrassed, or ashamed of seeking therapy. They may also be weary of running into the therapist at different cultural events or religious celebrations. The client may also seek therapy from someone outside of their community because they may feel embarrassed about the issues that they are seeking therapy for. Examples of these may be things that are seen as sinful in Islam, such as drinking, extramarital affairs, pornography addiction, and so on. This is why it is important for non-Muslim therapists to understand the nuances of the Muslim client, to better help them in their healing journey. That is why I have chosen to help break down these barriers so that therapists from all cultures feel comfortable and competent to help their Muslim clients. It should go without saying that I acknowledge any biases I may have based on my interactions with this demographic. Reflexivity was used throughout to address how my values and background influenced this research project (Creswell & Creswell, 2018). This was evident early on in the study when I considered my positionality in the previous paragraphs and in the research prospectus. I plan to read articles that challenge my bias and present opposing viewpoints in order to counter any potential prejudices I may have on this topic.

Overview

This paper aims to synthesize the literature on the use of Islamically Integrated Cognitive Behavior Therapy when serving Muslim clients and propose a model for counselling and therapy. This chapter offered background information, research questions, and theoretical frameworks that justify the use of this method of therapy, which may allow clinicians to have a more refined response in their treatment and use of interventions. The upcoming Chapter 2 will include the method of gathering the research articles for review and provide a critique on the methodology of the studies. Chapter 3 will cohesively synthesize the literature and findings. Chapter 4 will offer recommendations for clinical application and Chapter 5 concludes with recommendations for future research and clinical practice.

Chapter Two: Methods

In this chapter, an overview of the procedures for collecting literature data and the methodological strengths and limitations of the selected studies used in the literature is given. Examining and critically analyzing the strengths and weaknesses of the chosen studies according to their design will help readers to preserve confidence in the researcher's explanations and in the writer's inferences to employ an Islamically Integrated Cognitive Behavior Therapy to support Muslim clients suffering from depression.

Literature Search Process and Selection of Articles

Numerous databases were accessed through the City University of Seattle library. PsycINFO, ProQuest, EBSCO, PubMed, and other databases and search engines were utilized to locate pertinent journal articles that addressed the research question. Peer reviewed and full-text articles were selected from the databases to guarantee high academic standards, outstanding quality, and writer accessibility. The initial key terms that were used in the search were Muslim, Depression, and Cognitive behavior therapy. However, to refine the search, the key terms were extended to expand the scope of the literature review, to include terms like Islamically integrated cognitive behavior therapy, and Islamic psychology. While the preliminary key terms produced dozens of results, the addition of terms yielded more relevant results. In order to guarantee the currency of the information, the search was further refined by using the published year, beginning in 2015. Instead of using a 7-year range, an 8-year range was employed to explain the decline in publications that resulted from the pandemic in late 2019.

Inclusion and Exclusion Criteria

Inclusion criteria focused on studies about Islamically Integrated psychology, as well as those that examined Islamically integrated cognitive behavior therapy. Studies that examined Muslim populations were examined, especially those within a Western context like the US and

Canada, although there were not many. Many of the articles that were located were from other countries that have done extensive research, such as Malaysia and Pakistan. Studies that focused on CBT and Muslims or cultural adaptations of CBT in regard to depression were included regardless of the country where the study was conducted. Studies that focused on the treatment of other ailments such as personality disorders, eating disorders or perfectionism were excluded.

Data Analysis Procedures

Evaluation, synthesis, and interpretation were the methods used to critically analyze the ten articles that were chosen. Examining each article's methodology—which serves as the lens through which the articles gathered their findings and assumptions—is crucial to comprehending the assumptions made in each article. The selected key articles were reviewed and examined through the methodological critiquing process in the following areas: data collection, validity and reliability of instruments, research paradigm, role of the researchers, sampling and participant recruitment, and data analysis. In these areas, more investigation and clarification will be offered in accordance with the article's qualitative or mixed-method nature. These differences are clarified, and limitations or recommendations that might help close the gaps found were added.

Additionally, analysis and synthesis was used to critically discuss the review of literature and findings. (Popenoe et al., 2021). In order to examine and provide a cogent response to the research question put forth in this paper, many articles from the current literature were examined. The main goal of exploring these articles was to assess and summarize the knowledge on a given subject (Popenoe et al., 2021). Overarching conclusions and recommendations were explored and provided to the reader through synthesis and analysis in the last chapter of this research project. The general themes identified in the reviewed articles will be used to discuss these conclusions and recommendations.

Methodological Strengths and Limitations

The methodological approaches of the ten key research articles listed in the table below were reviewed and summarized in the following section. The focus of this methodological critique will be on participant recruitment, sampling, research design, the researcher's role, data collection, and data analysis. The selected articles were examined and reviewed. In the chosen articles, eight used qualitative design, and two used mixed-method for their research.

A summary of the ten articles that were used in the methodological critiquing section of this paper are presented in Table 1.

Table 1

Reference List of Studies Reviewed

Author	Year	Title	Journal	Type
Rothman & Coyle	2020	Conceptualizing an Islamic Psychotherapy: A Grounded Theory Study	Spirituality in Clinical Practice	Qualitative
Rothman & Coyle	2023	The Clinical Scope of Islamic Psychotherapy: A Grounded Theory Study	Spirituality in Clinical Practice	Qualitative
Latif et al.	2020	Muslim Women's Mental Health A community-based research project		Qualitative
Oxhandler et al.	2018	Client Attitudes toward Integrating Religion and Spirituality in Mental Health Treatment: Scale Development and Client Responses	Social Work	Qualitative

Asghar et al.	2021	Development of Cognitive Behaviour Therapy with Islamic Concepts for Treatment of Depression and Anxiety	Pakistan Social Sciences Review	Mixed Method
Khoshbooii et al.	2021	Effects of Group and Individual Culturally Adapted Cognitive Behavioral Therapy on Depression and Sexual Satisfaction among Perimenopausal Women	International Journal of Environmental Research and Public Health	Mixed Method
Algahtani et al.	2019	Cultural adaptation of cognitive behavioural therapy (CBT) for patients with depression and anxiety in Saudi Arabia and Bahrain: a qualitative study exploring views of patients, carers, and mental health professionals	The Cognitive Behaviour Therapist	Qualitative
Naeem et al.	2024	Culturally Adapted Cognitive Behaviour Therapy (CaCBT) to Improve Community Mental Health Services for Canadians of South Asian Origin: A Qualitative Study	The Canadian Journal of Psychiatry	Qualitative

Tarabi et al.	2018	"Guide or conversation?" The experience of Second Generation Pakistani Muslim men receiving CBT in the UK	Counselling Psychology Quarterly	Qualitative
Rafiq et al.	2017	Efficacy of Surah Al-Rehman in Managing Depression in Muslim Women	Journal of Religion and Health	Qualitative

Strengths and Limitations of Qualitative Studies

Creswell & Creswell (2018) described that the general philosophical conceptions of the world and research that researchers bring to a study are called paradigms, or worldviews. The authors continued to iterate that the worldviews of the researcher may be influenced by their research orientation, mentors, advisors, as well as their previous research involvements. Paradigms are different from the research design, as the design can be demarcated as the strategies for inquiry. Of the key articles reviewed, eight qualitative articles were of the Constructivist paradigm (Algahtani et al., 2019; Latif et al., 2020; Naeem et al., 2024; Oxhandler et al., 2018; Rafique et al., 2017; Rothman & Coyle, 2020; Rothman & Coyle, 2023; Tarabi et al., 2018).

Creswell & Creswell (2018) assert that according to constructivism, reality is subjective since it is a creation of our minds. Constructivists reject the notion that there is a single methodology for producing knowledge, believing instead that all knowledge is derived from our experiences and reflections on those experiences. This paradigm's emphasis on experiences and subjectivity makes it most closely linked to qualitative research methodologies.

The researchers who implement a constructivist worldview are aware that they have wide-ranging knowledge that their experiences can shape the analysis of the data (Creswell & Creswell, 2018). Rothman & Coyle (2020; 2023) identified that the first and second authors divided the collected data and compared their findings. Results were disseminated to a range of stakeholders, resulting in external evaluation and indications of resonance to ensure subjectivity. In the article by Naeem et al. (2024) under the direction of the lead author, the research team that collected the data collaborated on the analysis. In the study conducted by

Algahtani et al. (2019), each interviewer began to analyze the data as soon as the interviews were completed, sharing the task. The same format was taken in the other studies (Latif et al., 2020; Oxhandler et al., 2020; Rafique et al., 2017; Tarabi et al., 2018). In addition, the researchers must assess their own prejudices and ensure that the interpretation offered is free from bias resulting from their personal experiences with the subject (Creswell & Creswell, 2018). However, they made no mention of any personal prejudice that might have affected the research they were doing. Since a team was presumably involved, there is no risk to the conclusions drawn from these studies. The ethical guidelines that each author abides by were followed in the collection and analysis of this data.

Examining the procedures used for participant recruitment and sampling contributed to the clarification of both internal and external validity. In this section the methods used for population recruitment and sampling will be discussed and critically analysed for its strengths and limitations.

Of the eight qualitative studies chosen five used purposive sampling to recruit the participants (Algahtani et al., 2019; Latif et al., 2020; Naeem et al., 2024; Rafique et al., 2017; Tarabi et al., 2018). Purposive sampling, as its name suggests, entails intentionality and setting parameters to research a population of interest (Creswell & Creswell, 2018). Evidently, one advantage of purposive sampling is that it allowed the researchers to focus their research on a

particular, homogenous population. However, external validity is restricted when the target population is less specific, such as in convenience sampling.

The other three studies used the snowballing technique to recruit participants. In the Rothman and Coyle studies (2020; 2023) many of the participants were known to the first author, then they used personal recommendations and snowballing technique to recruit the rest of the participants. In the study conducted by Oxhandler et al. (2018) they employed the snowballing technique and used email and social media posts to recruit participants for their study. Studying this particular population gives a more thorough understanding of the population under study, but it also complicates the sample's generalizability to the larger population if these studies' findings will be interpreted.

Interviews, paperwork, semi-structured observations, and visual materials can all be used to gather data for qualitative research (Creswell & Creswell, 2018). Algahtani et al. (2019), Latif et al. (2020), Naeem et al. (2024), Rafique et al. (2017), Rothman & Coyle (2020; 2023), and Tarabi et al. (2018) all used semi-structured interviews to gather data from the participants. The interviews ranged from 30-75 minutes in length and were conducted by the researchers involved in the studies. Oxhandler et al. (2018) was the only study that utilized surveys for data collection. Different techniques for gathering data were applied in these eight articles, providing an abundance of data.

Data organization, coding, theme identification, and result interpretation are all part of qualitative research data analysis (Creswell & Creswell, 2018). Algahtani et al. (2019), Latif et al. (2020), Naeem et al. (2024), Oxhandler et al. (2018), Rafique et al. (2017), Rothman & Coyle (2020), Rothman & Coyle (2023) and Tarabi et al. (2018) employed inductive thematic analysis, which is defined as creating themes and patterns and classifying the data into more abstract information units (Creswell & Creswell, 2018). Additionally, the researchers debated these

themes back and forth before coming to a consensus and determining that this was the best course of action for applying inductive data analysis.

In sum, all of the studies critiqued above had consistent analysis, especially between analysts, which improved the objectivity of the conclusions drawn from the data (Algahtani et al. 2019; Latif et al. 2020; Naeem et al. 2024; Oxhandler et al. 2018; Rothman & Coyle 2020; Rothman & Coyle 2023; Tarabi et al., 2018). Additionally, abundant details were frequently supplied, including background information about the study locations, time period, sampling, demographics, data gathering, and analytical procedures (Algahtani et al. 2019; Latif et al. 2020; Naeem et al. 2024; Oxhandler et al. 2018; Rothman & Coyle 2020; Rothman & Coyle 2023; Tarabi et al., 2018). The ample contexts provided allow for greater transferability (Creswell & Creswell 2018).

As for the qualitative studies in this literature review, eight articles used a qualitative research method (Algahtani et al., 2019; Latif et al., 2020; Naeem et al., 2024; Oxhandler et al., 2018; Rafique et al., 2017; Rothman & Coyle 2020; Rothman & Coyle 2023; Tarabi et al., 2018). These studies revealed a good deal of strengths. They began by using a constructivist worldview to investigate the phenomenon of human experience. These studies used a wide range of recruitment methods to acquire participants, such as, personal recommendations, clients already accessing services from hospitals and health centers, social media and email, which helped have a more well-rounded sample. Algahtani et al. (2018), Latif et al. (2020), Naeem et al. (2024), Rothman & Coyle (2020), and Rothman & Coyle (2023) described semi-structured interviews with their participants, which ranged from 30 to 90 minutes. Oxhandler et al. (2018) and Rafique et al. (2017) utilized surveys for their data collection. Through these interviews, a substantial amount of data was gathered by them. This in-depth interview gives researchers additional information to delve into themes. Finally, these articles provided a thorough and in-depth description of their data analysis processes. These articles offered a

great summary of the proper methods for conducting qualitative research and allowed other researchers to easily replicate the findings if necessary.

There were only a few limitations deduced from these studies. In the studies conducted by Rothman & Coyle (2020; 2023) it states that some of the participants were known to the authors. This may have affected the validity of the answers that they provided, since they may have wanted to please the authors, and not let them down. In such a case, it would have been better to utilize an outside source to conduct the interviews to ensure the responses were honest.

Strengths and Limitations of Mixed Method Studies

Creswell & Creswell (2018) state that when quantitative or qualitative data alone are insufficient to address the research question, mixed methods research is employed. There are numerous typical justifications for conducting mixed-methods research: Contextualization, credibility, and generalizability. Two of the studies used were mixed-method studies (Asghar et al., 2021; Khoshbooii et al., 2021), and they will be analyzed in this section.

Mixed-method research studies employ a particular research paradigm, just like qualitative studies do. Two mixed-methods studies were included (Asghar et al., 2021; Khoshbooii et al., 2021) that combined quantitative and deterministic techniques with qualitative techniques. The pragmatic paradigm was used in these studies. The tenet of pragmatism holds that investigators ought to employ the philosophical and/or methodological strategy that proves most effective for the specific research problem under investigation (Creswell & Creswell, 2018). The strength of the mixed-method studies, is that it employs the strengths of both quantitative and qualitative studies, thus strengthening the results of the data. Utilizing both qualitative techniques such as semi-structured interviews, as well as measurable surveys, makes the results plentiful and measurable, thus strengthening the validity.

In both of the mixed-method studies convenience sampling was utilized (Asghar et al., 2021; Khoshbooii et al., 2021). Compared to random sampling, convenience sampling is more frequently utilized because it is simpler to invite members of the target population (Creswell & Creswell, 2018). In the study conducted by Asghar et al. (2021) they recruited participants from a local hospital, and in Khoshbooii et al. (2021) the participants were from 4 local health centers. Recruiting participants in this manner, may alter the generalizability of the studies (Creswell & Creswell, 2018). Of the studies included, this was the case. Utilizing the mixed-method model did indeed make these studies generalize as well as able to be recreated by other, future researchers.

For their studies, the two articles solely employed convenience sampling. According to Creswell & Creswell (2018), this may affect the generalizability of the study's findings. Overall, the conduct of these studies was good, and the information found in the literature's methodological critique did not identify any significant, obvious limitations in the mixed-method studies.

In the study conducted by Asghar et al. (2021) they used interviews before, during and after their treatments, using Interpretative Phenomenological Analysis, a qualitative method, was used to analyze the data collected during the therapeutic process. The researchers also used surveys at the three different stages of treatment.

In the study conducted by Khoshbooii et al. (2021) the researchers used semi structured interviews, as well as surveys, at the three stages of treatment.

According to Creswell & Creswell (2018) in mixed-method studies, by combining the two forms of data allows you to gain from the specific, contextualized insights from qualitative data as well as the externally valid, generalizable insights from quantitative data. The strengths of one type of data may mitigate the weaknesses of the other. Mixed methods are less bound by

preexisting research paradigms and disciplines. They give you more creative freedom when planning your study, enabling you to incorporate elements from several study kinds to extract the most informative findings. This was highlighted in the two mixed-method studies examined (Asghar et al., 2021; Khoshbooii et al., 2021).

In the study conducted by Asghar et al. (2021) through the application of interpretative phenomenological analysis (IPA), themes were extracted from the data. In the study conducted by Khoshbooii et al. (2021) the statistics were analysed using the Version 25 of the Statistical Package of Social Sciences (SPSS). The demographic data of the participants was analyzed using descriptive statistics. Subsequently, tests were conducted to verify the assumptions of homogeneity of variance between the two groups and normality of dependent variables. Levene's test was used to determine the baseline results, and the results showed that there was no significant difference in any of the three groups, indicating that the groups were homogeneous at the pre-treatment time (T1). In order to supplement and improve the interpretation of the quantitative data from the self-report measures, the qualitative data were gathered. The transcriptions were manually coded and subjected to thematic analysis. The process of coding and theme allocation can be facilitated by revisiting earlier transcripts and incorporating new insights into the subject guide for subsequent interviews through the use of thematic analysis. In using the procedures that they utilized, the researchers were thorough in collecting data, and making sure that the research they conducted was exhaustive and reliable.

To summarize the methodological analysis, the data was gathered, compiled, synthesized, and analyzed using a variety of techniques in the ten core articles. Researchers of the selected studies used various paradigms, sampling, recruitment, demographics, and data collection and analysis techniques were applied in both the mixed-method and qualitative studies. The writer was able to apply a critical lens to derive general findings and conclusions

from the studies. The researchers of the core studies made it possible for the writer to gather information from a variety of sources about applying ICBT.

Chapter Three: Review of the Literature

This literature review will provide insight into the research question: *Can using Islamically Integrated Cognitive Behavior Therapy (ICBT) acquire more beneficial outcomes for Muslim clients than traditional Cognitive Behavior Therapy (CBT) for clients with depression?* This chapter will include an explanation of traditional CBT for depression and analyzing the research on Islamically Integrated CBT (ICBT) for Muslims experiencing depression. ICBT refers to adjusting traditional CBT while maintaining the theoretical framework to benefit a diverse population (Naeem et al., 2021). This analysis is a review of recent ICBT studies, the need for ongoing ICBT research, recommendations for adapting CBT for Muslims who are depressed, and the implications for future cultural adaptation of CBT. In order to adapt CBT and understand its limitations, this literature review for the proposed model also addresses common concerns for Muslims and barriers to help-seeking behavior. Understanding and acknowledging barriers to help-seeking behaviors can help counselors focus on their practice.

Cognitive Behavior Therapy

Cognitive Behavioral Therapy (CBT) can be described as a set of therapeutic procedures that focuses on an individual's thoughts in the change process (Hepworth et al., 2006). Change is achieved by shifting different facets of the thinking process, which is presumed to affect an individual's behavior and moods. CBT is occasionally referred to as cognitive reframing or restructuring of thoughts (Hodge, 2008). The early founders of CBT, such as Albert Ellis (1962) and Aaron Beck (1976) stated that cognitive therapy characteristically comprises several steps. First, therapists and their clients determine the unhealthy schema that causes unproductive behaviors. Then, they recognize constructive thought patterns that lead to more productive, and not so negative thought patterns. Lastly, they change the dysfunctional self-statements with more productive statements that lead to healthier ways of coping with different issues. Due to CBT's effectiveness and popularity, it has been considered one of the

fastest-growing therapeutic modalities (Husain & Hodge, 2016; Cucchi, 2022). CBT has been used successfully to address an assortment of mental health concerns in clinical settings (Husain & Hodge, 2016; Hodge, 2008).

CBT is a talk-based psychotherapy intervention that focuses on raising awareness of perceptions and behaviors in order to challenge false, counterproductive, or negative thoughts, beliefs, and attitudes (Ackerman, 2017; Mayo Clinic, 2019). In the 1960s, psychiatrist Aaron Beck developed and used CBT; during this time, he studied idiosyncratic content and cognitive distortions in depressed clients (Chand et al., 2023). The motivational-affective model was the main focus of earlier psychological research on depression, which Beck addressed in his groundbreaking work (Beck, 1963). Instead of focusing on cognitive processes, this model classified and interpreted the verbal behaviors of people who are depressed (Beck, 1963). When Beck first started working with people who had depression, he observed illogical distortions in their thought processes (Chand et al., 2023). This finding revealed that depression is more of a cognitive issue than a mood disorder (Beck, 1963; Chand et al., 2023). Chand et al. (2023) reiterates that the emphasis shifted from behavioral emphasis to incorporating cognitive, emotional, and behavioral aspects thanks to Beck's clinical observations and empirical data. The individual and the counselor can address negative patterns and ascertain their impact on presenting concerns and day-to-day functioning by incorporating cognitive, emotional, and behavioral components into therapy.

Therapists use Cognitive Behavioral Therapy (CBT) to develop treatment plans by exploring a client's beliefs and experiences to elicit cognitive beliefs, emotions, and behaviors (Rathod et al., 2019). Culture can have an impact on mental health issues because it shapes an individual's experiences, beliefs, and presumptions about themselves, other people, and the world (Ackerman, 2017; Rathod et al., 2019). Thus, a key component of the cultural adaptation

process is addressing the ways in which culture shapes attitudes toward health, health care, trust, and knowledge of services (Rathod et al., 2019).

Since its inception, CBT has been the psychotherapy that has been studied and applied the most, and there is evidence to support its efficacy (Ackerman, 2017; Chand et al., 2023). Focus is currently placed on automatic thoughts, which are interpretations of events, cognitive distortions, which are logical thinking errors that result in incorrect conclusions, and beliefs or schemas, which are fundamental concepts about oneself and the world, presumptions, and rules (Chand et al., 2023). Counseling can strive toward modifying CBT to benefit culturally diverse populations by keeping these fundamental ideas in mind. Counselors can more effectively adapt and modify CBT to meet cultural needs when they are aware of the theoretical underpinnings of the field.

Integrating Spirituality and Religion into Psychotherapy

In an interesting article written by Vieten & Lukoff (2021) the authors discussed the importance of integrating a clients spiritual and religious beliefs into therapy. This can often improve the success rate of therapy for the client (Vieten & Lukoff, 2021). In the field of psychology, religion and spirituality (R/S) should be explicitly addressed as significant facets of human diversity.

Vieten & Lukoff (2021) indicated that the majority of people's psychological functioning is significantly influenced by their spiritual and religious background, beliefs, and practices (SRBBPs), and a substantial amount of research suggests that SRBBPs are related to psychological well-being. The authors continued by saying that similar to other aspects of multicultural diversity, religion and spirituality are significant components of cultural diversity. If left unaddressed, however, they can lead to insufficient or insensitive care and also, increase

barriers to care. The authors implore that addressing the spiritual and religious aspects of individuals' lives is a way to demonstrate clinical and cultural competence.

Those from different religious and spiritual traditions have very different worldviews, meaning systems, guiding principles, and modes of existence. There is a great deal of variation even within religions. Spiritual and religious practices and beliefs can vary greatly throughout a person's life, with different spiritual and religious developmental stages having different effects on an individual's perceptions and actions at different times of life (Walsh, 2011). Spiritual and religious practices and beliefs can be viewed as a strength and a helpful resource, it can also be connected to historical oppression, discrimination, and intergenerational trauma and be related to psychological issues in an individual (Vieten & Lukoff, 2021).

It is of utmost importance for therapists to practice with cultural competence. Cultural competence is a set of abilities and behaviors that result in services that are appropriate and respect the ethnocultural beliefs, values, attitudes, and customs of the clients (Bhui et al., 2007; Vieten & Lukoff, 2021). Practicing psychology with multicultural competency helps reduce disparities by making the practice more responsive to ethnocultural differences, more attractive, more engaging, more helpful, and less biased for more marginalized populations. Unfortunately, most of the training that is currently available in the realm of multicultural competency focuses on racial and ethnic diversity, not the spiritual or religious aspects of diversity in multicultural training (Shafranske, 2016; Vieten & Lukoff, 2021). Spiritual and religious competence includes the therapist's basic knowledge, attitudes, and skills. These include becoming aware and recognizing how our personal beliefs about religion, spirituality, or nonreligion and nonspirituality may affect or slant our work as psychologists, asking questions about religion and spirituality in clinical and research settings, having the ability to successfully enquire about the spiritual and religious background, beliefs, and practices of a client or research participant, incorporating SRBBPs into treatment planning and overall assessment when necessary, or being prepared to

collaborate and refer to clergy when necessary (Vieten & Lukoff, 2021). Rather than advanced expertise, competence refers to the fundamental attitudes, knowledge, and skills that all psychologists should possess.

For most Canadians, religion and spirituality are very important aspects of their lives. According to studies more participation in religion and spirituality, communities and practices is associated with improved psychological health (Vieten & Lukoff, 2021). Religion and spirituality have been associated with higher levels of resilience, happiness, meaning, and purpose (Abu-Raiya & Pargament, 2015; Pargament & Mahoney, 2009; Vieten & Lukoff, 2021). SRBBPs are linked to (a) fewer instances of mental, medical, and substance abuse issues; (b) improved outcomes from substance abuse, mental disorders, surgeries, and illnesses; and (c) decreased rates of anxiety and depression in adults and adolescents, both domestically and internationally (Oman, 2018; Vieten & Lukoff, 2021). Many people find that their SRBBPs are a strength that enables them to handle challenging situations in life (Vieten & Lukoff, 2021). During trying times, people usually turn to attending more religious or spiritual services and interacting with clergy or spiritual leaders as coping mechanisms (Gall & Guirguis-Younger, 2013; Vieten & Lukoff, 2021). "A secure relationship with a transcendent force, a sense of spiritual connectedness with others, and a benevolent worldview" are characteristics of positive religion and spiritual coping strategies (Pargament et al., 2011, p. 51) such as getting strength from one's connection to a spiritual source or sensing or believing that one is a part of God's plan. In various populations, positive religious and spiritual coping has been associated with successful stress management as well as improved biomarkers and outcomes for both physical and mental health (Gall & Guirguis-Younger, 2013; Vieten & Lukoff, 2021). Research on religious and spiritual coping has continuously shown how beneficial it is for promoting recovery and wellness in people obtaining mental health services (Oxhandler et al., 2018; Vieten & Lukoff, 2021). One of the most crucial abilities for rapidly demonstrating to a client that the therapist is cognizant of spiritual and

religious diversity, that discussing religion and spirituality is acceptable in the therapeutic setting, that the therapist is willing to talk about these issues and cares about this aspect of their client's life, is assessing the client's religious and spiritual history (Vieten & Lukoff, 2021).

Alegheband et al. (2018) investigated that people with mental and physical illnesses frequently turn to psychotherapy and religion/spirituality as resources. The authors continue by stating that a spiritual component is now included in the World Health Organization's (WHO) definition of health, indicating that religious beliefs are becoming more and more important in terms of overall health, happiness, and well-being. According to the authors, religion is an established set of beliefs that upholds faith in God or a higher power and includes rituals, ethical principles, and contributions to a religious community. Beliefs in religion are a useful coping mechanism for terrible situations, unpleasant memories, and illness symptoms. The authors continued to state that religion also affects human relations during times of struggle. Since we may likely encounter clients from different cultures, it is important to examine the effectiveness and significance of using culturally adapted cognitive behavior therapy with Muslim clients. This is why I have chosen to research Islamically Integrated CBT (I-CBT) with regular CBT.

Depression Perceived in Islam

Depression is one of the most common mental health ailments in the general population and it is recurrently encountered in different healthcare settings (Sabki et al., 2019). It is a common and serious mood disorder. Truschel (2022) state that individuals who suffer from depression experience symptoms such as persistent feelings of hopelessness and sadness, as well as loss of interest in activities that they once enjoyed. The author asserts that numerous factors, including the length of these unpleasant emotions, additional symptoms, physical effects, and the impact on the person's capacity to go about their everyday lives, are taken into consideration when diagnosing depression. In the DSM-5-TR in order to diagnose depression numerous symptoms must be present. The DSM-5-TR (APA, 2022) stipulates the criteria to

include: Depressed mood for most of the day, loss of interest, increase or decrease in appetite, fatigue, feelings of worthlessness, diminished ability to think or concentrate, and suicidal ideation. These symptoms must result in clinically significant distress or impairment in social, occupational, or other important areas of functioning for the person to be diagnosed with depression. It is imperative that the symptoms do not stem from substance abuse or any other medical condition.

It is important for this issue to be addressed as the prevalence of depression is increasing among the Canadian population. In a study conducted by the Centre for Addiction and Mental Health (CAMH) in Toronto, they found that more than 25 percent of survey participants reported feeling moderate to severe anxiety. In the same study, they found that roughly 22.3 percent of people reported having feelings of depression (Jabakhanji, 2022).

Our mental and emotional health is greatly impacted by social, cultural, and economic factors in life. Mental health is adversely affected by different factors experienced by Muslims. There are compelling arguments to suggest that Muslims in Canada face mental health stressors as a result of various, intertwined facets of their lived identities, including the fact that they are frequently perceived as visible members of racialized and religious minorities, that they are frequently linked to religious and cultural groups that have undergone difficult immigration experiences, and that they come from cultural backgrounds that may stigmatize mental health issues (Latif et al., 2020; Naeem et al., 2023). Muslims' reactions to mental illness are influenced by their cultural identities, which also influence how they react to stigma and whether or not they decide to seek help.

Khan et al. (2022) stated that by placing life's issues in perspective, reordering priorities appropriately, and balancing all the relationships between a person and his inner and outer environments, the Islamic system seeks to create a balanced existence for Muslims. When this

harmonious equilibrium is upset, people experience depression or sadness. In these situations, Islam intervenes—not to condemn the emotion, but to provide a means of regaining mental and psychological equilibrium.

The role of Islam in an individual's life is very important. It often helps Muslims cope with events in their life that may be perceived as negative. This, in turn, helps with the prevention as well as the treatment of depression. The religion of Islam encourages hope and discourages hopelessness. Islam is based on the idea that Allah is kind and merciful to his people. Allah gives his people hope by telling them that good things will come after adversity so they shouldn't lose hope (Asghar et al., 2021).

Despite the optimism and grace found in Islam, we find that there is a significant number of Muslims who deal with depression. Many of these individuals prefer to have treatment that takes into account their religion and spirituality (Khan et al., 2022; Vieten & Lukoff, 2022).

Thematic Findings from the Literature Review

There are several different relevant themes that arise when investigating the effectiveness of Islamically Integrated CBT. Two main themes were postulated, as well as three subthemes for each. The studies reviewed highlight several different areas of importance when adapting CBT for Muslim clients. This section examines and interprets the findings from the literature. Upon reviewing the articles, numerous contributory aspects become apparent when looking at the efficacy of ICBT. Many of the articles found that many aspects are positively affected by integrating ICBT, including the therapeutic alliance, adherence to therapy, intrapersonal changes, and development of trust in the system, and therapist (Algahtani et al., 2019; Asghar et al., 2021; Latif et al., 2020; Naeem et al., 2019; Rothman & Coyle, 2020; Rothman & Coyle, 2023; Tarabi et al., 2018; Khan et al., 2020; Khoshbooii et al., 2021).

Additionally, the barriers that are encountered by Muslim clients when seeking therapy, such as the mistrust in the system, language barriers and financial barriers, once recognized and understood by the therapist, may be overcome, to help the client benefit from therapy (Algahtani et al., 2019; Khoshbooii et al., 2019; Latif et al., 2020; Naeem et al., 2023).

Table 2

Overview of Findings

Theme	Topic
Overall Theme	Islamically Integrated CBT for Depression
Theme 1	Therapeutic Outcome in ICBT
Subtheme 1a	Enhanced Therapeutic Relationship for Muslim Clients
Subtheme 1b	Islamically Modified Tools in CBT
Subtheme 1c	Intrapersonal Changes that happen due to ICBT
Theme 2	Challenges of ICBT in treating Depression
Subtheme 2a	Language Barriers
Subtheme 2b	Financial Barriers
Subtheme 2c	Systemic Barriers (Mistrust of the System)

Theme 1. Therapeutic Outcome in ICBT

Given that cognitive behavioral therapy (CBT) was developed and implemented primarily in the West, it is influenced by Western values (Algahtani et al., 2019). It has been proposed that CBT may need to be modified to account for the cultural backgrounds of non-Western clients since comprehension of the cultural context has been linked to improved therapy outcomes (Algahtani et al., 2019; Asghar et al., 2021; Khoshbooii et al., 2021; Naeem et al., 2023; Rothman & Coyle, 2020; Rothman & Coyle, 2023). CBT has been researched and practiced all over the world as is proven in its efficacy and success with clients (David et al, 2018). Furthermore, the majority of research has been conducted on CBT theoretical models and mechanisms of change, which align with the prevailing mainstream paradigms of human behavior and mind (David et al., 2018; Naeem et al., 2023). Of the key studies, 6 were conducted in Western countries, Canada, the USA, and the UK (Latif et al., 2020; Naeem et al., 2024; Oxhandler et al., 2018; Rothman & Coyle, 2020; Rothman & Coyle, 2023; Tarabi et al., 2018) and 4 were conducted in Eastern countries, Saudi Arabia, Pakistan and Iran (Algahtani et al., 2019; Asghar et al., 2021; Khoshbooii et al., 2021; Rafique et al., 2017).

Studies conducted in Western countries focus on adapting Islamic counseling methods within non-Muslim-majority societies. This requires integrating Islamic principles into secular therapeutic frameworks, potentially diluting the cultural depth that these therapies have in Muslim-majority countries. The effectiveness and client engagement levels may vary since participants may experience a sense of cultural dissonance or conflict between Western therapeutic norms and Islamic values.

Studies in Eastern settings operate within predominantly Muslim societies, where Islamic counseling is more aligned with cultural norms. The findings are generally more reflective of a population already familiar with Islamic concepts, which could enhance participant

comfort and therapy effectiveness. However, these studies may lack insight into how Islamic counseling practices are received in more religiously diverse settings.

Enhanced Therapeutic Relationships for Muslim Clients

As we know, the therapeutic relationship is crucially important to the success of therapy. The therapeutic alliance is one of the most reliable indicators of outcomes across a variety of treatments (Lindqvist et al., 2023). The authors go on to state that according to conceptualization, a therapeutic alliance is made up of three components: the patient and therapist's relationship, agreement on the tasks involved in treatment, and goals of treatment. Thus, a respectful, and safe relationship between a client and a therapist is only one aspect of a therapeutic alliance. Alliance is a common factor that is thought to function in various treatment modalities. Studies show that clients who have a weaker therapeutic alliance have a higher likelihood of quitting therapy (Lindqvist et al., 2023). However, in the study conducted by Tarabi et al. (2018) the researchers concluded that some of the participants felt more comfortable seeking treatment from a therapist that is not from their community. They found that they felt less likely to feel judged when discussing matters that are considered sinful in the religion, such as premarital sexual relationships, questioning one's religion, substance use and other such topics.

When a therapist includes cultural adaptations to therapy, the clients are more likely to benefit from therapy. Culturally adapting CBT enhances the therapeutic alliance (Algahtani et al., 2019; Latif et al., 2020; Naeem et al., 2019; Rothman & Coyle, 2020; Rothman & Coyle, 2023), and improves the client’s adherence to therapy (Naeem et al., 2023). When the client feels like the therapist understands the nuances to their Muslim religion then they will be more likely to benefit from therapy (Asghar et al., 2021; Rothman & Coyle, 2020; Rothman & Coyle, 2023).

At times, some Muslim clients may be more comfortable with a therapist that has the same values and beliefs as them (Latif et al., 2020; Rotman & Coyle, 2020; Rothman & Coyle, 2023). Other times clients may feel less likely to open up to a therapist that is from their community and may prefer someone who is not from the community (Naeem et al., 2019; Tarabi et al., 2018). Despite whether or not the therapist is from the community or not, it is of utmost importance for the therapist to be aware of the client's culture, and intersectionality, to develop a strong therapeutic relationship, where the client feels comfortable to open up and be honest and vulnerable (Algahtani et al., 2019; Latif et al., 2020; Naeem et al., 2019; Rothman & Coyle, 2020; Rothman & Coyle, 2023).

Islamic counseling often requires therapists to bridge Islamic principles with secular therapeutic techniques, which can create inconsistencies or tensions in therapeutic methods. For clients, this might affect the depth of engagement if they perceive a mismatch between their spiritual beliefs and the therapist's methods. Western-based studies, like those by Rothman and Coyle (2020; 2023), reveal the complexities of navigating roles between spiritual guidance and psychological counseling, which may impact how deeply clients can relate to and benefit from therapy.

In Eastern studies, like those by Asghar et al. (2021), Algahtani et al. (2019), Rafique et al. (2017) and Khoshbooii et al. (2021), therapists and clients often share similar cultural and religious backgrounds, potentially strengthening rapport and engagement. However, this close alignment may lead to assumptions about the client’s religious understanding or commitment, which could limit individualization of care. Additionally, this shared context may limit findings, as it doesn’t address potential barriers faced by those with less traditional views or mixed religious identities.

Islamically Modified Tools utilized in CBT therapy

Cognitive-behavioral therapy (CBT) has brought forth many innovations, one of which is the use of adjuncts to therapy in the form of conceptual (like psychoeducation) and concrete (like worksheets) tools (Consoli et al., 2018). Furthermore, a defining feature of CBT has been the use of planned, structured activities that cater to the specific needs of clients both during and outside of therapy hours (Asghar et al., 2021; Consoli et al., 2021).

In the context of therapy, cultural adaptation entails changing particular protocols to make them culturally consistent with the meanings and values of the clients (Algahtani et al., 2019; Naeem et al., 2019; Rafique et al., 2017). Taking into account cultural, religious, and spiritual factors, service structure, delivery, and resources, as well as clients' knowledge and beliefs about health, illness, and treatment, is necessary for CBT to be acceptable, accessible, and helpful for clients from non-Western cultures (Algahtani et al., 2019; Naeem et al., 2023; Rafique et al., 2017; Rothman & Coyle, 2020; Rothman & Coyle, 2023). Consequently, it has been suggested that before being used in non-Western cultures, CBT needs to be culturally adapted (Algahtani et al., 2019; Rafique et al., 2017). Adapting tools that are used in CBT is important for the client so that they will adhere to them, and continue to benefit from therapy (Naeem et al., 2019; Rafique et al., 2017). Making such changes includes adaptations to the self-statements that are used in therapy as the traditional self-statements are quite individualistic in nature (Asghar et al., 2021; Khan et al., 2022; Rothman & Coyle, 2020; Rothman & Coyle, 2023). When adapting them to Muslim clients, they may put more emphasis on the role that God plays in the clients' existence, as Muslims believe that every aspect of their life, is by the will of God (Asghar et al., 2021; Rothman & Coyle, 2020; Rothman & Coyle, 2023).

Adapting the CBT process by integrating Quranic verses into the cognitive restructuring phase is often helpful for Muslim clients (Khoshbooii et al., 2021; Khan et al., 2022; Rafique et al., 2017). The Quran makes frequent reference to the idea that our thoughts, beliefs, and

behaviors all have an impact on how we feel (Khoshbooii et al., 2021), which falls in line with the fundamental concepts of CBT, and which makes it a great therapy to use with Muslim clients.

Many devout Muslims do not seek out psychotherapy services because they believe therapists will not discuss their religious beliefs with them in an open and informed way (Rothman & Coyle, 2020; Rothman & Coyle, 2023). Adapting the therapy process to be more culturally appropriate to the client, in this case, who is Muslim, will increase the likelihood of success in therapy for the client. Therapists should be aware of the various ways Muslims create their own identities in addition to the distinctions based on race, ethnicity, gender, ability, and migration history (Algahtani et al., 2019; Asghar et al., 2021; Latif et al., 2020; Naeem et al., 2019; Rothman & Coyle, 2020; Rothman & Coyle, 2023; Khan et al., 2020; Khoshbooii et al., 2021).

In the studies conducted by Latif et al. (2020), Khoshbooii et al. (2021) and Rafique et al. (2017), the researchers found that when the participants reflected on self-care, their methods of self-care were often linked to a religious or spiritual practice. This is important for therapists to note when seeing Muslim clients because often, spiritual practices are tailored into their mental health care, making it more successful for them. The development of a culturally sensitive therapy is influenced by the political, religious, and cultural contexts in which a client receives care (Algahtani et al., 2019; Latif et al., 2020; Khoshbooii et al., 2021). Providing care to Muslim clients in particular necessitates understanding the implications of their faith, which may include needs for discretion and modesty, dietary and medical restrictions, and the significance of incorporating spirituality into clinical practice (Latif et al., 2020; Rafique et al., 2017; Rothman & Coyle, 2020; Rothman & Coyle, 2023; Khoshbooii et al., 2021).

Intrapersonal Changes that happen due to ICBT

Through the research it has been discerned that many positive changes happen to a person when acquiring therapy. Specifically, it has been demonstrated that CBT is effective in treating a variety of mental health issues (David et al., 2018). This section will discuss some of the intrapersonal benefits that clients in the studies gained from ICBT.

In the study conducted by Tarabi et al. (2018), one of the main improvements that the participants experienced from CBT was that they discovered and understood their emotions more clearly. This is an important takeaway from therapy as it helps the client understand and deal with their emotions on a cognitive level. The participants in this study also reported advantages in their overall perception of the CBT procedure, which was also found in the studies conducted by Latif et al. (2020) and Naeem et al. (2023).

Individuals reported that their journeys toward mental health included connections involving religion, culture, and identity in the study conducted by Latif et al. (2020). This is reiterated in the studies conducted by Naeem et al. (2023) and Rafique et al. (2017) where the participants noted a positive increase in their levels of spirituality.

Another positive aspect that the participants acquired is that they attained more awareness of self-care, and how to integrate religion into their self-care routine (Asghar et al., 2021; Latif et al., 2020). The participants felt that they would benefit more from self-care strategies that tailored their religion, and be more likely to continue to use it, as they felt comfortable doing it, as it increased their spirituality. In the reflections from the participants, it included descriptions of self-care, and these descriptions were frequently connected to religious and spiritual practices (Asghar et al., 2021; Latif et al., 2020; Naeem et al., 2023).

Latif et al. (2020) discovered that the participants had more positive experiences and impressions of mental health were shared by participants, who mostly discussed what makes

for positive experiences of receiving care, whether in the setting of healthcare services, within families, or within cultural and religious communities.

Asghar et al. (2021) and Naeem et al. (2023) ascertained that ICBT assisted the clients in cultivating an attitude of forgiveness and mercy, the clients' cognitive distortions regarding the relationship problems decreased. This also benefited the clients in that it incorporated their spirituality into their healing process. Participants in ICBT came to believe that everything in life happened because of God, which aided in their recovery.

Another positive change that developed from therapy in the studies was improved socialization and fostered stronger bonds between an individual and those around them (Asghar et al., 2021; Latif et al., 2020; Naeem et al., 2023).

The limitations related to intrapersonal changes arising from Islamic counseling across these studies include that several studies note that intrapersonal changes are often subjective and difficult to measure quantitatively. Islamic counseling, by incorporating personal religious beliefs, may influence individuals' self-perceptions and emotions in ways that are challenging to objectively quantify or compare across populations. The subjective nature of these changes means that what might be seen as a positive outcome for one person might not hold the same meaning or impact for another.

Furthermore, Islamic counseling draws heavily from Islamic beliefs and values, which may limit its applicability or perceived relevance for individuals who may not fully align with these views or are only moderately religious. Studies such as those by Rothman and Coyle (2023) highlight that intrapersonal changes may reflect the individual's cultural background and faith adherence, but this may reduce effectiveness and relatability among those with differing levels of religiosity or cultural beliefs within the Muslim community.

Additionally, the deep integration of religious elements in Islamic counseling often blends spiritual well-being with psychological improvement. This can make it challenging to determine whether intrapersonal improvements are due to religious alignment or actual psychological changes, leading to possible confounding effects. This overlap, noted in both Khoshbooii et al. (2021) and Oxhandler et al.(2018) can impact the clarity of psychological outcomes and the precise understanding of intrapersonal change.

Theme 2. Challenges of ICBT in the Treatment of Depression

Some barriers that may be encountered when dealing with Muslim clients may be: language barriers (Asghar et al., 2021; Latif et al., 2020), mistrust of the system (Latif et al., 2020), as well as financial barriers (Naeem et al., 2023; Latif et al., 2020). These barriers may prevent clients from seeking the therapy that they need to heal. In this section, these barriers will be addressed.

Language Barriers

Oftentimes, when someone is new to a country they may not speak the language. Many people may seek language classes or courses, while others may be forced to work right away to support themselves and their families. If someone does not speak the language then this can be a major barrier to seeking therapy (Latif et al., 2020; Naeem et al., 2023; Tarabi et al., 2018). Muslim immigrant communities, more than the general population, face limited access to mental health supports because of things like language barriers (Algahtani et al., 2019; Latif et al., 2020; Naeem et al., 2023).

It was difficult for many participants to communicate their needs in English in many of the studies (Algahtani et al., 2019; Latif et al., 2020; Naeem et al., 2023). It was discovered that cultural nuances are mistranslated, which made it challenging for many people to completely

explain their mental health issues (Algahtani et al., 2019; Khoshbooii et al., 2019; Latif et al., 2020; Naeem et al., 2023).

Naeem et al. (2023) stated that oftentimes when clients come with a language barrier then there is a need for a translator to translate during the sessions. The authors go on to say that if the therapist does not speak their language, clients who are coming here and for whom English is not their first language will not be able to communicate. If they choose to speak with the therapist, they must do so through a translator. Additionally, they might not feel comfortable disclosing their most private information to a third party if the translator is present, which may hinder the treatment process, or even driving a wedge in the therapeutic alliance.

Financial Barriers.

Frequently, access to mental health services is hampered by cost, and insurance frequently did not provide enough coverage for services (Algahtani et al., 2020; Latif et al., 2020; Naeem et al., 2023). Should their medical health care plan not cover therapy, some Muslim clients would be unable to pay for it, as is the case with many Canadians (Latif et al., 2020; Naeem et al., 2023). Many people who received extended insurance for therapy sessions reported that the small number of sessions offered was insufficient to meet their needs (Naeem et al., 2023).

Financial challenges are highlighted as a major barrier, particularly among immigrants, who noted that therapy costs are often not covered under their medical plans. Even when insurance is available, it typically offers limited sessions, insufficient for effective treatment. This financial barrier discourages seeking mental health services, especially among recent immigrants who may be in low-wage jobs or facing economic instability (Algahtani et al., 2020; Latif et al.,2020; Tarabi et al., 2018; Naeem et al., 2024).

In Oxhandler et al., the authors observe that many clients who might benefit from spiritually integrated therapy face financial challenges that hinder access. Those from lower socioeconomic backgrounds may find the cost of counseling prohibitive, especially when religious or spiritually integrated counseling options are not widely available in affordable settings. Khoshbooii et al. (2021) also mention that private therapy sessions, even when culturally adapted, can be expensive for individuals. This is particularly relevant for women who may face additional financial constraints and may not have the disposable income to afford regular therapy sessions, leading to limited access to consistent, culturally relevant mental health care. In studies like Rothman and Coyle (2023), it's suggested that while Islamic counseling might benefit certain populations, there is often limited financial assistance available for culturally or religiously tailored therapy. This financial limitation particularly affects individuals from lower-income backgrounds who may not be able to afford specialty care not covered by insurance.

These financial barriers demonstrate that the cost of therapy—particularly when specialized or culturally adapted—can be a significant obstacle to accessing mental health services, especially in economically disadvantaged or immigrant populations.

Systemic Barriers/ Mistrust of the System

Numerous studies have also shown that Canadians who belong to religious communities are less likely to use mental health services because they don't trust or are unfamiliar with the system (Latif et al., 2020; Naeem et al., 2023; Tarabi et al., 2018). When a client feels that the therapist is culturally aware of their religious beliefs and practices they will be more likely to adhere to therapy and benefit from it (Latif et al., 2020; Naeem et al., 2023; Vieten & Lukoff 2021). Due to a lack of resources, some Muslims turned to their local primary care physicians or

spiritual leaders for mental health treatment rather than mental health professionals (Latif et al., 2020).

In addition, many healthcare professionals don't know enough about the range of religious and cultural practices that their clients follow. This can make therapy sessions unsatisfactory or require the client to inform the professional about their unique background or ask for religious accommodations (Latif et al., 2020). If mental health professionals lack the necessary tools to address the cultural, psychological, and spiritual needs of Muslim clients or find it difficult to communicate with these populations, the mental health care system may become even more problematic (Latif et al., 2020; Naeem et al., 2023). It was found that a dearth of qualified mental health professionals who are conversant with Islam and Islamic culture, made some Muslims turn to their local primary care physicians or spiritual leaders for mental health treatment rather than mental health professionals (Latif et al., 2020).

Summary

Oxhandler et al. (2018) suggest that it is crucial to take into account a client's spirituality and religion when providing mental health treatment. In particular, integrating a client’s religion and spirituality appropriately into their treatment has the potential to improve a variety of mental health concerns. Many people practice religion as a way to help them deal with and heal from a variety of life circumstances.

A client may prefer to engage in positive religious and spiritual coping strategies such as religious reframing to provide a religious or spiritual meaning to an otherwise difficult life circumstance (Oxhandler et al 2018; Rothman & Coyle, 2020; Rothman & Coyle, 2023). Other times clients may prefer to engage in religious or spiritual activities that provide them healing and comfort (Oxhandler et al., 2018).

In conducting this literature review, and studying the articles, it is apparent that when religion and spirituality are tailored into therapy the client experiences more success in the therapeutic outcome (Asghar et al., 2021; Khan et al., 2020; Khoshbooii et al., 2021; Oxhandler et al., 2018; Rafique et al. (2017) Rothman & Coyle, 2020; Rothman & Coyle, 2023). Although, it is important to note, that the client must *want* to integrate their religion and spirituality into the therapy process, otherwise, as therapists we cannot force them to integrate religion and spirituality into their treatment. It was found that clients receiving Islamically integrated cognitive behavior therapy were more affected than other clients whose support system included religious or spiritual individuals (Asghar et al 2021; Khoshbooii et al., 2021; Oxhandler et al., 2018; Vieten & Lukoff, 2021).

However, the study conducted by Tarabi et al. (2018) showed that traditional CBT may still be effective with Muslim clients as well. The participants who were put in the group that received traditional CBT showed a positive response to treatment. This is to say that traditional CBT may still be effective to use with Muslim clients, but many Muslim clients may still prefer to have their religion tailored into the therapy process to make it more personalized and effective (Asghar et al., 2021; Khan et al., 2020; Khoshbooii et al., 2021; Latif et al., 2020; Rothman & Coyle, 2020; Rothman & Coyle, 2023; Vieten & Lukoff, 2021).

Ethical Considerations

Research that is conducted on a minority group, such as Muslims requires adherence to high ethical standards, particularly because they are a vulnerable minority group. Researchers in Canada are expected to abide by the Canadian Psychologists Association's (CPA) 2017 Code of Ethics as well as the Tri-Council Policy Statement for the Ethical Conduct for Research Involving Humans (Canadian Institutes of Health Research [CIHR], Natural Sciences and Engineering Research Council of Canada, & Social Sciences and Humanities Research Council of Canada, 2022). The CIHR et al. (2022) state that respect for persons, concern for welfare,

and justice are the values to uphold. Likewise, the CPA (2017) upholds the following values: respect for the dignity of persons and people, responsible caring, integrity in relationships and responsibility to society. A critical discussion of the ethics displayed by the researchers in the reviewed articles will be presented in this section. This section will address the Tri-Council Policy Statement, the CPA/CAP resources for professional ethics, and the significance of research and clinical ethics in relation to therapeutic interventions.

Of the ten articles used in this review, all of them mentioned ethics (Asghar et al., 2021; Algahtani et al., 2019; Khoshbooii et al., 2021; Latif 2020; Naeem et al., 2023; Oxhandler et al., 2018; Rafique et al., 2017; Rothman & Coyle, 2020; Rothman & Coyle, 2023; Tarabi et al., 2018). This section provides a critical discussion on the ethics demonstrated by the researchers of the chosen articles.

Informed Consent and confidentiality

Informed consent and client best practices must be taken into account when working with minority clients in a therapeutic setting. Principle I: Respect for the Dignity of Persons and Peoples is outlined in the Canadian Code of Ethics for Psychologists (CPA, 2017) sections I.16-I.26 and emphasizes the significance of appropriate informed consent procedures. In research, informed consent entails explaining to participants the boundaries of confidentiality, the nature of the study, how the data will be used, and how their information will be safeguarded (CPA, 2017). In order to obtain participants' informed consent, they must also be informed of the possible advantages and disadvantages of participating in the research procedures. This is especially important when it comes to minority clients. In addition, the Tri-Council Policy's informed consent and confidentiality guidelines stipulate that researchers must adhere to the Principle of Respect for Persons, which upholds the participants' inherent worth as human beings and encourages them to exercise autonomy (CIHR et al., 2022).

All ten of the studies provided information about the study to the participants (Algahtani et al., 2019; Asghar et al., 2021; Khoshbooii et al., 2021; Latif 2020; Naeem et al., 2023; Oxhandler et al., 2018; Rafique et al., 2017; Rothman & Coyle, 2020; Rothman & Coyle, 2023; Tarabi et al., 2018). These eight studies also explicitly state that consent was obtained and sought by the researchers. This is important to psychologists conducting research since informed consent distinctly marks the principle and values of honouring an individual's dignity (CIHR et al., 2022, Article 3.1, Article 3.2; CPA, 2017, Principle I.20).

It is crucial to safeguard participants' personal information in accordance with Principle I of the Code of Ethics for Canadian Psychologists (CPA, 2017, Principle I.40). Regrettably, none of the studies discussed anonymity in any way. The only studies that had any discussion regarding participant privacy/ confidentiality were Rothman & Coyle (2020), Rothman & Coyle (2023) and Tarabi et al. (2018). In this they state that the names of the participants in the study have been changed, when publishing the articles. Although their names were changed in the publications, the participants were known to the researchers, so there was no confidentiality in their answers to the researchers, which may have made them not speak as freely as if their answers had been confidential. Participants may provide false information in an effort to hide their identity if their privacy and confidentiality are not respected.

Incentives

In the context of research, compensation is a topic that is frequently discussed. Some contend that using compensation could be coercive, particularly for those who are struggling financially (Fontes, 2004). However, participants offer valuable information to enhance treatment interventions, researchers also have an ethical duty to reimburse them for their time and effort (Creswell & Creswell, 2018).

Only two of the studies provided compensation or incentive for participation (Latif 2020; Oxhandler et al., 2018). The compensation provided was very minimal in both studies: Latif provided $20 compensation while Oxhandler et al. (2018) provided $1 US for participation. In general, the compensation were not large amounts, and were distributed in a fair manner (CIHR et al., 2022, Article 3.1). When incentives are offered, participants may be sufficiently motivated to complete the questionnaires thoughtfully and accurately. Furthermore, researchers should compensate participants when appropriate in accordance with the Tri-Council Policy; however, special attention should be paid to potential conflicts of interest (CIHR et al., 2022). When deciding whether to compensate participants, researchers should consider the advantages and disadvantages of doing so and be open about any potential ethical dilemmas that may arise.

Debriefing

Regarding the debriefing protocols for the chosen studies, there are a few points that need to be considered. Principle II Responsible Caring, section II.20 and II.24 state that in order to reduce harm and optimize benefits of treatment, participants should be informed about how their participation in research has advanced knowledge (CPA, 2017). The majority of studies (Algahtani et al., 2019; Asghar et al., 2021; Khoshbooii et al., 2021; Naeem et al., 2023; Oxhandler et al., 2018; Rafique et al., 2017; Rothman & Coyle, 2020; Rothman & Coyle, 2023) did not engage in debriefing or follow up procedures with participants. Only Latif et al.'s study from 2020 and Tarabi et al., (2018) debriefed participants to get their informal input on the effectiveness of the intervention and their perspectives on the course of treatment. It is concerning that the majority of the chosen studies did not address debriefing in terms of ensuring that participants benefited from treatment and minimizing potential harm. Debriefing is a crucial component of the ethical practice of research and should be taken into account when studying psychological interventions. It may have been an oversight to not mention this clearly in the articles. According to the Tri-Council policy, in an attempt to be transparent, researchers

should conduct sufficient debriefing procedures with study participants, even if they may not have been informed of every detail (CIHR et al., 2022). Although the researchers in the chosen studies did follow these guidelines, many of the studies would have benefited from additional debriefing procedure elaboration in order to maximize participant benefits and minimize participant harm.

Protection of Participants

As was previously mentioned, the top priority when it comes to research is protecting the participants. In order to emphasize the significance of safeguarding vulnerable populations, such as minority clients, Principle II Responsible Caring is especially pertinent (CPA, 2017). Furthermore, when conducting research, researchers should make sure they are safeguarding the interests and wellbeing of their participants, according to the Tri-Council Policy's principle of respect for persons (CIHR et al., 2022). All of the studies reviewed explicitly discussed the psychological interventions used (Algahtani et al., 2019; Asghar et al., 2021; Khoshbooii et al., 2021; Latif et al., 2020; Naeem et al., 2023; Oxhandler et al., 2018; Rafique et al., 2017; Rothman & Coyle, 2020; Rothman & Coyle, 2023; Tarabi et al., 2018) as most were studies using CBT as the main form of therapy.

It's also critical to discuss how researchers should recognize any potential power imbalances that may exist between participants and researchers and how these might affect the results of their studies (CPA, 2017). When working with clients who are members of minority groups, in particular, researchers may find themselves in a power imbalance due to their often higher social status and educational backgrounds (Creswell & Creswell, 2018). In order to prevent power imbalances, clinicians—particularly when assuming the expert role in therapy—should practice power-sharing behaviors. This may involve granting participants autonomy over the location, mode, and timing of their therapy sessions (Asnaani & Hofmann, 2012). In order to better serve the clinical population and lessen power disparities between practitioner and

participant, none of the studies engaged in these behaviors by hiring practitioners from the neighborhood who spoke the language and shared a similar culture. It is imperative to acknowledge that the selection of practitioners for recruitment may present a potential risk of dual roles or conflict of interest, particularly if the practitioners hold multiple roles within the local community. When working with clients, psychologists should avoid taking on dual roles and, whenever feasible, steer clear of conflicts of interest, according to Principle III: Integrity in Relationships sections III.28-III.32 (CPA, 2017). However, there are situations in which having multiple roles is acceptable from an ethical standpoint. For example, in small communities with limited resources, clinicians may have multiple relationships with their clients (CAP, 2019). To provide the most ethical practice to clients and research participants in these circumstances, it is critical to recognize the potential ethical dilemmas that may arise from having dual roles and to apply appropriate ethical decision-making techniques.

Deception

One significant component of research that merits consideration in relation to ethical behavior is deception. Principle III of the Code of Ethics, Integrity in Relationships, emphasizes the need to avoid lying in research whenever feasible and the circumstances in which partial disclosure may be acceptable (CPA, 2017).

According to the Tri-Council Policy (2022), withholding information from participants or misleading them about the purpose of the study are examples of situations in which deception may be required in research. To promptly notify clients of the deception, further actions should be taken, such as conducting a debriefing. No researcher acted dishonestly in any of the chosen studies (Algahtani et al., 2019; Asghar et al., 2021; Khoshbooii et al., 2021; Latif et al., 2020; Naeem et al., 2023; Oxhandler et al., 2018; Rafique et al., 2017; Rothman & Coyle, 2020; Rothman & Coyle, 2023). This is appropriate given the vulnerable nature of the minority client population and the possible effects on therapeutic efficaciousness.

Withdrawal

As participants should be informed during the informed consent process that they may withdraw from therapy at any time, withdrawal is a crucial component of ethical research practice (CAP, 2019). The studies that were chosen (Algahtani et al., 2019; Asghar et al., 2021; Khoshbooii et al., 2021; Latif et al., 2020; Naeem et al., 2023; Oxhandler et al., 2018; Rafique et al., 2017; Rothman & Coyle, 2020; Rothman & Coyle, 2023; Tarabi et al., 2018) all participated in informed consent practices, which, when carried out competently, would involve addressing the client's right to refuse services or to end therapy at any time (CPA, 2017). Although only four spoke directly to the concept of withdrawal (Algahtani et al., 2019; Khoshbooii et al., 2021; Rafique et al., 2017; Tarabi et al., 2018). Similar emphasis is placed by the Tri-Council Policy on providing participants with information about the possible risks and benefits of participating in research as well as the option to withdraw at any time during the study (CIHR et al., 2022).

Summary

In general, the way that ethical considerations were handled was comparatively lacking. Some of the studies discussed ethics very little or not at all, while others focused on specific ethical guidelines but neglected to address others. All of the research, nevertheless, was able to give a sufficient justification for their work and an explanation of how it would advance society. In all the studies, there was an adequate discussion of the clinical implications and future directions, which aligns with the fourth principle of the Code of Ethics for Canadian Psychologists (CIHR et al., 2022; CPA, 2017, Principle IV.1).

Chapter Four: Applications to Clinical Practice

This chapter will examine the potential clinical applications of the study's findings. This section will address the researcher-practitioner's reflexivity, clinical and therapeutic applications, societal well-being, and cultural implications. Investigating these facets is essential since they will influence the conclusions and recommendations.

Clinical Applications

The global Muslim population has experienced substantial growth, which has led to a rise in demand for mental health services tailored to this specific clientele (Rafique et al., 2019). Research indicates that spirituality and religion can be effectively incorporated into psychotherapy and that management plans may be impacted by religious beliefs (Rafique et al., 2019; Vieten & Lukoff, 2021).

Integrating ICBT

It is well-recognized that a variety of psychotherapies are effective in treating depression. Cognitive Behavioral Therapy (CBT) is the most widely used evidence-based treatment (Munawar et al., 2023; Sabki et al., 2019). Many clients who identify as religious or spiritual prefer to bring up these topics gradually during therapy, which aids in forging a therapeutic alliance with the therapist. As long as the therapist is able to incorporate the religious perspective (mindfulness, prayer, religious concepts), the effectiveness of such interventions depends more on the patient’s religious commitment than on the therapist's beliefs (Sabki et al., 2019). In studies conducted, researchers found that clients' depressive symptoms improve more quickly when they integrate healthy religious beliefs and values into their thoughts, deeds, and emotions (Munawar et al., 2023; Sabki et al.,2019; Vieten & Lukoff, 2021).

It has been found that Muslim clients experiencing anxiety, depression, or bereavement respond much more quickly to Islamic-based psychotherapy (Munawar et al., 2023; Sabki et al.,2019). Clients are encouraged to identify concerns pertaining to their illness and culture as well as to recognize negative thoughts (Sabki et al., 2019). They are guided to follow the precepts of the Quran and Hadith, as well as to lead a life in accordance with the teachings of Islam as promulgated to the Prophet Muhammad (Rafique et al., 2019; Sabki et al., 2019).

Sabki et al. (2019) concur that according to research, religiousness and spirituality are lifelong processes that are influenced by cognitive, affective, and psychosocial factors. These factors also have a strong correlation with mental health and quality of life. The authors go on to say that religion improves the quality of life, is adversely related to drug and alcohol abuse, and increases one's capacity to deal through prayer with difficult life events, illness, and disability.

With psychiatrists and psychologists starting to integrate religiously based concepts and beliefs into a biopsychosocial-spiritual approach, the integration of these entities into Cognitive Behavioral Therapy (CBT) has gained momentum in recent years (Sabki et al., 2019; Vieten & Lukoff, 2021). It is appropriate that Religiously Integrated Cognitive Behavioral Therapy (RICBT), which integrates religious practices, beliefs, and behaviors with resources for the treatment of depression, be introduced to clients who identify as religious (Sabki et al., 2019).

According to Sabki et al. (2019) Islamically Integrated Cognitive Behavioral Therapy's (ICBT) primary goals are:

1. Using an Islamic approach that complies with Shari'ah (Islamic law) and is based on the Hadith and the Qur'an, as taught by Sunni scholars.
2. to implement behavioral and cognitive restructuring based on the Qur'anic values that uphold mental and spiritual well-being

3. to offer a structured intervention that can be applied to the management of Muslim clients with chronic illnesses and depression as well as research development.

The four dimensions of a person's inner self—the spirit (*Ruh*), heart (*Qalb*), intellect (*Aql*), soul (*Nafs*), and outer self—as well as their body, are the foundation of Islamic psychology (Sabki et al., 2019). It is important to integrate all of these parts of the person into the therapy sessions, to achieve proper healing (Rothman & Coyle, 2020; Sabki et al., 2019).

ICBT Contents

Appendix A provides a sample of ICBT as laid out by Sabki et al. (2019).

While many Muslim therapists with a religious inclination often use an Islamic approach, ICBT might provide a more structured intervention. Therapists must acquire the skills necessary to incorporate their clients' practices into CBT in a way that respects ethics, culture, and, most importantly, Islamic teachings.

A three-step method is required to construct culturally relevant CBT (Hodge & Nadir, 2008). The writers explain that first, the therapist is required to familiarize themselves and understand the principles engrained in the self-statements characteristically utilized in CBT. It is important to understand the fundamental concept that the statement is trying to convey. The authors go on to say that following the identification of this idea, it must be appraised to guarantee that it is cohesive with Islamic values. It is critical to be aware that diagnoses of pathology and mental health are not widespread. As outlined in the DSM-5-TR (American Psychiatric Association, 2022), criteria can differ across cultures. A statement that postulates a disorder among individuals living in the West may not designate a disorder among the Muslim population. Therefore, in cases in which the notion runs against the norms of Islam, therapists should rethink and restructure the concepts to better align with an Islamic worldview.

Presuming that the fundamental notion is compatible with Islamic values, the concept will then be rephrased in a way that coincides with the Islamic narrative. Put differently, the therapist will want to rephrase the notion in a way that echoes Islamic values and norms. To reiterate, it is essential to eliminate the secular viewpoint from the original therapeutic notion, assess the concept to certify its equivalence with Islamic values, and then be sure that the concepts resonate with Muslims.

Some examples of regular self-statements given by Hodge & Nadir (2008) are:

1) Self-control and change

Because when I insist that I have instant gratification, I frequently cause myself to become unruly and counterproductive. I can give up my "short-range "needs," look for happiness in the here and now, and pursue life's fulfillment in a methodical manner.

2) Self-worth

I am a valuable individual with both good and bad qualities.

3) High frustration tolerance

Nothing is dreadful or horrible; at most, it's just very inconvenient. I never have to like hardships and adversity, but I can tolerate them to a great extent.

4) Acceptance of others

I can accept that people will make mistakes and act improperly because we are all imperfect. I don't have to minimize them as flawed humans; I can accept them for who they are, flaws and all.

5) Achievement

Although I would rather perform well and gain the respect of those I care about, I never need to in order to demonstrate my worth as a person.

Examples of the Islamically modified self-statements used by Hodge & Nadir (2008) are:

1) Self-control and change

Allah, or God, bestowed upon us the capacity for free will, which includes nafs (self). Furthermore, Allah has provided us with numerous chances to exercise self-control by fasting throughout Ramadan. These are some of the ways we can improve our self-discipline and make positive changes with Allah's assistance.

2) Worth in Allah

Because Allah created us, we are valuable. We all have both strengths and weaknesses from birth.

3) High frustration tolerance

Both blessings and misfortunes come from Allah. Misfortunes are not horrible or horrible; rather, they are a test. Adversities may not be pleasant, but they are not insurmountable. Allah assures us that He will not put us through more than we can handle. We can overcome life's obstacles by routinely performing dua, or informal prayer, and reminding ourselves of Allah's goodness.

4) Acceptance of others

People will make mistakes because they are fallible beings. Islam teaches us to accept people for who they are, flaws and all, rather than passing judgment on them for their faults.

5) Achievement

While receiving praise from others and feeling accomplished are nice, they are not essential for leading a fruitful life. The Quran states that for someone who trusts in Allah, Allah is sufficient.

People with mental and physical illnesses frequently turn to psychotherapy and religion/spirituality as resources. (Alagheband et al., 2018). Alagheband et al. (2018) continue by stating that a spiritual component is now included in the World Health Organization's (WHO) definition of health, indicating that religious beliefs are becoming more and more important in terms of overall health, happiness, and well-being. According to the writers (2018), religion is an established set of beliefs that upholds faith in God or a higher power and includes rituals, ethical principles, and contributions to a religious community. Beliefs in religion are a useful coping mechanism for terrible situations, unpleasant memories, and illness symptoms. The authors continue to state that religion also affects human relations during times of struggle. This is why it is important for therapists to be able to accommodate their Muslim clients with religiously Integrated CBT, if that is what they need and want.

Cultural and Diversity Implications

The percentage of Muslims in Canada is 4.9% as of the 2021 census (Government of Canada, 2022). In addition, Qasqas & Perry (2014) indicate that it is anticipated that by 2030, there will be roughly 2.7 million Muslims residing in Canada. The authors go on to assert that research on the worldviews and intracultural variations of Muslims is still lacking, despite the large numbers and projected growth of this population. The authors go on to state that counselors and psychologists must have a thorough understanding of Muslim worldviews and intracultural differences in order to practice in a way that is both culturally competent and antidiscriminatory, especially in light of the growing recognition of Muslims' psychosocial needs. However, counselors and psychologists may inadvertently participate in unethical prejudiced

and discriminatory practices if they are unwilling to confront preconceived notions and biases in their own minds or if they do not know how to do so. The authors want psychologists and counselors to work with Muslims in particular and nondominant populations in general with an aspirational level of ethical practice.

One important ethical concern that frequently comes up when offering religion-based therapy is the therapist's clinical competence. Before engaging in religion-based therapy, therapists should be aware of their own knowledge gaps and clinical expertise, be ready to undergo professional training and supervision, and seek advice from knowledgeable colleagues. They should also be well-versed in the religious beliefs and practices of their clients. It is imperative for a Muslim psychologist to avoid imposing religious values on their Muslim clients. Instead, a comprehensive evaluation of cultural and religious factors should be conducted before deciding whether religious integration is suitable (Sabki et al., 2019). This coincides with the Code of Ethics Principle I.

Well-Being of Society

According to the American Psychological Association's (APA) Ethics Code, psychologists who want to incorporate religious or spiritual themes into their work as professionals must take ethical considerations into account (Sabki et al., 2019). The same is to be expected from Canadian psychologists when they are dealing with Muslim clients. It is in the Code of Ethics for Psychologists (2017) Principle I, Respect for the Dignity of Persons and Peoples, the principle that carries the highest weight, it explicitly states “The different cultures, ethnicities, religions, histories, social structures, and other such characteristics of social groupings are often integral to the identity of the individuals who belong to them and give meaning to their lives. As such, respect for the dignity of human beings includes respect and moral consideration for social groupings such as couples, families, organizations, communities, and peoples. In their work, psychologists acknowledge, respect, and take into account the uniqueness, diversity, and role

structures involved". If integrating ICBT into your practice will help the client heal, then it is our responsibility as psychologists to do so, for the betterment of our clients and society.

Chapter Five: Conclusions and Recommendations

The final section of this study will present conclusions from the methodological critique and the literature analysis. The following recommendations are intended to be applied at the therapeutic/clinical level when dealing with Muslim clients and are informed by these conclusions. Lastly, the section will discuss potential options for future research to provide a more comprehensive understanding of working with Muslim clientele.

Conclusions From Literature Analysis

Through this literature review it has become apparent that client's needs in therapy vary. Some clients may prefer a more spiritual approach in therapy, while others may prefer traditional methods of therapy.

Conclusions drawn from the analysis of the literature indicate that:

1. Implementing Islamically Modified CBT with Muslim clients aids them in their healing, as it draws on their spirituality to help in the healing process. As long as the psychologist conducting the therapy is well aware of the different aspects of ICBT then the client often responds better to integrating their religion into the therapy process, as Muslims often place their religion in high importance in their daily life. This is most evident in the examination of integrating ICBT into therapy (Asghar et al., 2021; Algahtani et al., 2019; Latif 2020; Munawar et al., 2023; Sabki et al., 2019; Rothman & Coyle, 2020; Rothman & Coyle, 2023).
2. When the therapist implements ICBT with their Muslim clients, it enhances the therapeutic alliance and improves the client's adherence to therapy. The difference in the studies stated that the clients may be comfortable with a therapist who is not from their community, but has an understanding of their religion and faith, thus strengthening the alliance.

3. In therapy, cultural adaptation involves modifying specific protocols to align them with the cultural meanings and values of the clients, thus making it important to culturally adapt the tools used in CBT. Modifying tools utilized in CBT is crucial for clients to ensure their adherence and ongoing therapeutic benefits. Adapting strategies such as the self-statements, and integrating Quranic verses into the cognitive restructuring portion of CBT is immensely helpful for Muslim clients. Utilizing these tools in this fashion, increases the likelihood of success in therapy for the client.
4. The intrapersonal growth that happened when clients integrated ICBT included understanding their emotions more clearly. When integrating ICBT into therapy the clients noted that there is a positive increase in their levels of spirituality, and an increased awareness of self-care, which all lead to better healing.
5. When therapists take into account the different barriers that are involved in Muslims accessing therapy, then they are more likely to be more empathetic and understanding to their clients, thus strengthening the therapeutic alliance.
6. When a therapist takes time to understand the cultural barriers, financial barriers, and mistrust of the system that Muslim clients may encounter than they will be more likely to implement tools and strategies to make their client feel more comfortable and trusting of them and the therapy process.

Conclusions From Methodological Analysis

The methodological analysis of these studies on Islamically Integrated Cognitive Behavioral Therapy (ICBT) reveals several conclusions regarding their strengths, limitations, and areas for improvement:

1. Limited generalizability due to homogeneous samples: many studies focus on specific cultural subgroups or regions (e.g., South Asian Canadians, Iranians, or Pakistanis), limiting the findings' applicability to the broader Muslim population or to diverse cultural

backgrounds within Islam. This narrow focus restricts the generalizability of conclusions on the effectiveness and adaptability of ICBT for Muslims worldwide, as well as for individuals with varying levels of religiosity.

2. Challenges in maintaining core CBT principles: the adaptation of Islamic concepts into CBT introduces potential distortions to CBT's foundational assumptions, such as a focus on empirical evidence and secular objectivity. The integration of religious values and concepts (e.g., reliance on divine will, Quranic teachings) may shift focus from individual agency to spiritual determinism, creating tension between traditional CBT's evidence-based approach and the spiritual framework added by Islamic adaptation.

3. Reliance on self-reported measures and subjective biases: many studies depend on self-reporting to measure intrapersonal and psychological changes, which may introduce response biases, especially in cultures where social desirability or adherence to religious expectations is high. This limitation affects the objectivity and validity of findings, as it becomes challenging to separate spiritual satisfaction from measurable psychological improvements. Future research would benefit from incorporating more objective, validated tools tailored to religiously integrated therapy.

4. Short follow-up periods limit insights into long-term efficacy: most studies lack longitudinal data, focusing instead on short-term effects, which limits understanding of the durability of ICBT outcomes. Without extended follow-up, it is unclear if the therapeutic effects persist over time, particularly as religiously integrated therapy may provide immediate emotional comfort but may not necessarily lead to sustained psychological growth.

5. Insufficient standardization in ICBT training: the studies indicate a need for consistent training and methodology in ICBT, as variations in therapist religious knowledge and cultural sensitivity can lead to inconsistent application. Establishing a standardized, evidence-based training protocol could enhance both the reliability and ethical practice of ICBT, ensuring that practitioners provide culturally and religiously sensitive therapy without compromising clinical standards.

Overall Conclusion:

The methodological analysis underscores the value of ICBT for Muslim clients seeking spiritually congruent therapy, but it also highlights limitations in sample diversity, measurement objectivity, long-term applicability, and accessibility. Addressing these limitations through standardized training, expanded cultural diversity, objective assessment tools, and affordable delivery options would strengthen the evidence base, applicability, and ethical foundations of ICBT across diverse settings. Future research that tackles these methodological challenges would greatly enhance the robustness and reach of ICBT for broader and more varied populations.

Recommendations

Clinical and Therapeutic Interventions

There are a number of clinical recommendations that can be derived from the research findings:

1. When working with Muslim clients it is important to take into account the client's spirituality and religion. It is up to the therapist and the client to decide if integrating those aspects into therapy would aid in the clients healing journey.

2. With the rising immigration rates of visible minority groups, such as Muslims, clinicians must be prepared to manage this population with professionalism and grace. Cultivating the continuous process of enhancing cultural competency and elevating critical consciousness is imperative. Furthermore, clinicians must develop their awareness of the institutional and systemic factors that continue to pathologize and oppress Muslim people and their cultural values.
3. The importance of the therapist understanding and using the client's religion and spirituality in the therapy process, increases the therapeutic alliance and thus resulting in therapy being more successful.

Details have been provided in the previous chapter for ways of using Islamically integrated CBT/ psychology into practice, but much more professional training needs to be readily available to clinicians who would like to access it. Currently, there are only two opportunities to access such trainings, and currently, the enrollment in these trainings is only Muslim counselors/ psychologists that access them.

Future Research Recommendations

Based on the findings and the information that is missing from research on Islamically Intigrated CBT**,** future studies could focus on:

1. Expand cultural and religious diversity within Muslim samples: since many of the studies focus on specific subcultures (e.g., South Asian or Middle Eastern Muslims), which limits the generalizability of findings. Future research should include diverse Muslim subgroups from different cultural backgrounds and with varying levels of religiosity. This would improve the applicability of ICBT across the global Muslim population and help refine culturally adaptable therapeutic approaches.

2. Increase sample size for greater statistical power: many of the existing studies on ICBT, involve small sample sizes, limiting the ability to detect statistically significant effects or generalize findings. Future studies should aim for larger sample sizes to improve statistical power and allow for a more robust analysis of treatment effects across diverse variables, including demographic factors like age, socioeconomic status, and level of religiosity.

3. Examine long-term efficacy and intrapersonal changes: short follow-up periods in current studies make it challenging to assess the sustainability of intrapersonal changes from ICBT. It is recommended to conduct longitudinal studies to measure the durability of therapy outcomes, such as spiritual well-being, symptom reduction, and quality of life. This would help determine whether ICBT provides lasting benefits beyond the initial treatment phases.

4. Increase comparisons between Islamically integrated CBT and standard CBT: few studies directly compare the effectiveness of Islamic-integrated CBT with traditional CBT, limiting understanding of how religious adaptation impacts therapy outcomes. Design controlled trials that compare ICBT with standard CBT across various mental health conditions. This would clarify the unique benefits or limitations of Islamic adaptation and guide its use in both Muslim-majority and minority settings.

5. Develop culturally sensitive and objective measures for spiritual and psychological changes: most studies rely on self-reported data, which may be influenced by cultural or religious expectations. Future studies should develop validated measures specifically tailored to assess spiritual growth, religious alignment, and psychological well-being in a culturally sensitive manner. These instruments would enable more accurate and standardized assessment of intrapersonal changes due to ICBT.

6. Address financial and structural barriers to accessing ICBT: financial barriers limit access to culturally adapted therapies, especially in Western countries where therapy may not be covered by insurance. Studies should explore cost-effective models for delivering ICBT, such as group therapy formats, online modules, or community-based programs. Examining the feasibility of subsidized or publicly funded Islamic counseling services would also be beneficial for addressing accessibility challenges.
7. Standardize training for ICBT practitioners: studies highlight a need for consistency in the training and application of Islamic principles within CBT, as some therapists may vary in their integration approaches. Future research could develop and evaluate standardized training programs for ICBT practitioners, ensuring that therapists have both psychological and theological expertise. This would improve consistency in therapeutic practice and ensure ethical, culturally appropriate counseling across diverse settings.
8. Explore ethical challenges in integrating religious values into therapy: the integration of religious values in therapy may conflict with CBT's secular focus on objectivity and client autonomy. It is suggested to conduct qualitative studies that investigate potential ethical challenges, such as value imposition or conflicts between religious and therapeutic goals. Understanding these dynamics would guide best practices for therapists working with religiously integrated models like ICBT.

In conclusion, these recommendations emphasize the need for greater diversity, rigorous comparisons, tailored measures, and accessibility-focused solutions in future research on ICBT. Implementing these strategies would enhance the evidence base, applicability, and effectiveness of Islamic CBT across various cultural and religious settings.

Currently, there is an emergence of research on Islamically Integrated psychology, but very little research coming out of Canada and the US. Those Muslim clients who live in Canada

and the US often have different worldviews than those who live in predominately Muslim countries. Muslims who live in Canada and the US may be immigrants, refugees, newcomers, Muslim adults who immigrated at a young age with their families or were born here. All of these different varieties of people will hold different views, traditions, and worldviews, that will need to be taken into account when coming to therapy. Furthermore, more research needs to be conducted on Islamically Integrated Cognitive Behavior Therapy, as much more current information is needed in this field.

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Appendix A: Sample ICBT Sessions

Over a period of five to ten weeks, ICBT is given in ten sessions. Every session lasts between fifty and sixty minutes and has a standard structure (Sabki et al., 2019).

Session 1: *"Building Rapport, Assessment and Introduction to ICBT"* requires the therapist to establish a therapeutic alliance with the client and to explain the program's basic structure, which calls for the therapist to discuss the patient's spiritual struggles in relation to their faith. In order to analyze a patient's spiritual and religious experiences and comprehend their faith tradition and religious beliefs in order to incorporate them into client-centered therapy, the IIUM Religiosity Scale (modified version), which is based on the concept of Tawheed (oneness of God), is used.

Session 2: *"Behavioral Activation: Walking by Faith"* Reiteration of the client's comprehension of the purpose of the treatment, mood, and activity self-monitoring is provided. In order to help the client become more aware of and involved in the ICBT model, the therapist's job is to gain their cooperation and participation. Motivate the client to interact with the Muslim community (behavior activation).

Session 3: *"Identifying unhelpful thoughts: The battlefield of the mind"* emphasizes how to identify the ideas that give rise to negative feelings. Using passages from the Quran or Hadith, contemplative prayer—which is akin to meditation—is presented. It's crucial that the therapist leads the client in this practice before the session ends.

Session 4: *"Challenging Unhelpful Thoughts: Bringing All Thoughts Captive*" is an extension of session 3, which looks for any challenges in the patient's "Thought Log" and talks about how the Prophet Muhammad (pbuh) and his companions overcame hardships to show how a strong faith in God can lead one towards a meaningful life. The therapist challenges the patient's

dysfunctional thoughts by using his or her resources and the client's faith (prayer and Quran) or by means of introspective prayer.

Session 5: *Dealing with Loss"* is to help the patient identify any losses (biological, psychological, social, and spiritual) resulting from the illness; this is comparable to the idea of "filling up the heart with positivities." Based on the patient's "Thought Log," verses from the Quran are used in cognitive restructuring. The therapist might reference passages from the Quran that describe the lives of the prophets and those who endure as heroic examples of fortitude and hope.

Session 6: *"Coping with Spiritual Struggles and Negative Emotions"* addresses the fundamental experience brought on by disease and depression, which may have an impact on the patient's belief in God or their own religion. In order to facilitate healing and ultimately spiritual development, it is imperative that the therapist evaluate the patient's genuine negative feelings toward God during session 6.

Session 7: *"Gratitude"* emphasizes the Islamic concept of gratitude, which includes being thankful for the experiences, people, and things that God has provided as they are portrayed in the Quran. The exercises "Gratitude Exercise - Counting Our Blessings" and "Gratitude Exercise - Celebrating Our Blessings" align with the cognitive restructuring model, which enhances mood and facilitates the client's ability to express gratitude by identifying a living person with whom they can share their gratitude.

Session 8: *"Altruism and Generosity"* emphasizes going over thankfulness exercises again, which leads to a kind of introspection and personal growth. It is crucial to ascertain whether the clients are prepared to integrate thankful thoughts, feelings, and actions into their lives through conscious focus.

Session 9: *"Stress-Related and Spiritual Growth"* explore the idea of growth related to stress and spirituality. Additionally, the therapist must get the patient ready for the upcoming last session.

Session 10: *"Hope and Relapse Prevention"* examines the ideas of benefit-finding—which is the process of drawing positive development from adversity—in order to examine the concepts of hope and faith. This is presented in order to foster hope, discover meaning and purpose in hardship, and recognize and uphold spiritual development in order to attain happiness, particularly in the Hereafter. In addition to reviewing thoughts and behavior with reference to the Quran and Hadith, the patient is encouraged to use the worksheets as tools and to keep a journal to record daily activities and mood.