

**THE EFFECTIVENESS OF ISLAMIC
COGNITIVE BEHAVIORAL THERAPY WITH
SELECTED ISLAMIC CONTENT FOR
DEPRESSED ADULTS IN LIBYA**

by

NAZIHA SULIMAN ABDELATI

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**KEBERKESANAN TERAPI KOGNITIF-TINGKAH LAKU
DENGAN KANDUNGAN ISLAMIK TERPILIH UNTUK ORANG
DEWASA MURUNG DI LIBYA**

ABSTRAK

Tujuan utama penyelidikan ini adalah untuk mendesain model kognitif tingkah laku Islam yang terdiri daripada teori Islam tentang kemurungan dan terapi kognitif Islam (CBT-IP) dan menyelidik keberkesanan CBT-IP dalam merawat golongan dewasa yang mengalami kemurungan. Data kajian ini dikumpul di Benghazi, bandar kedua terbesar di Libya. Peserta kajian dipilih secara rawak dari Universiti Gar Yunis dan syarikat elektrik kebangsaan. *Beck Depression Inventory* (BDI-II) dan soalan demografi telah diedarkan kepada 449 orang peserta. Selain itu, BDI-II juga telah digunakan terhadap 75 orang peserta (pesakit dalam dan luar) yang telah dikenalpasti mengalami kemurungan. Pengumpulan data melibatkan dua fasa iaitu survei yang menggunakan borang soal selidik dan psikoterapi untuk individu yang mengalami kemurungan. Kajian ini menggunakan kaedah kuantitatif dan kualitatif di mana penyelidik menjalankan survei dan eksperimen. Untuk bahagian kualitatif, penyelidik menganalisis pelbagai isi kandungan sesi, seperti pematuhan tugas, reaksi klien terhadap intervensi, dan interaksi antara ahli terapi dengan klien. Eksperimen pula menggunakan dua jenis terapi kognitif tingkah laku (CBT), iaitu terapi dengan kandungan agama (CBT-IP; 25 orang peserta) serta terapi dengan protokol standard (CBT; 25 orang peserta) untuk mengurangkan kemurungan. Sekumpulan peserta yang terdiri daripada 25 orang

individu yang mengalami kemurungan berada dalam senarai menunggu giliran dan tidak menerima terapi. Dapatan kajian ini menunjukkan bahawa peratus kemurungan dalam kalangan orang Libya adalah sangat tinggi iaitu sebanyak 68.8% terutamanya dalam kalangan golongan muda dan wanita. Sebanyak 60.8% wanita didapati murung dan usia mempunyai kesan signifikan terhadap kemurungan, terutamanya bagi kumpulan umur 17-29 tahun. Dapatan kajian juga menunjukkan bahawa CBT-IP lebih efektif dalam mengurangkan kemurungan berbanding CBT dan tanpa terapi (menunggu giliran). Akhirnya, data kualitatif pula menunjukkan bahawa peserta CBT-IP memberikan respon yang baik terhadap terapi dan mempunyai kadar penyelesaian tugas yang tinggi, menggunakan banyak sokongan kerohanian, dan mempunyai interaksi yang baik dengan ahli terapi. Dapatan kajian ini mempunyai beberapa implikasi. Pertama, dapatan kajian ini menunjukkan bahawa kemurungan lebih kerap berlaku dalam kalangan golongan muda dan wanita. Kedua, perlindungan kesihatan mental wanita bukan hanya cabaran kepada bidang perubatan tetapi juga budaya. Ketiga, kajian ini membuktikan kepentingan agama dalam merawat simptom kemurungan. Akhirnya, kajian ini memberikan beberapa panduan untuk memasukkan komponen agama dan kerohanian dalam intervensi psikososial untuk kemurungan.

THE EFFECTIVENESS OF ISLAMIC COGNITIVE BEHAVIORAL THERAPY WITH SELECTED ISLAMIC CONTENT FOR DEPRESSED ADULTS IN LIBYA

ABSTRACT

The main purpose of this study was to design an Islamic cognitive behavioral model that comprises an Islamic theory of depression and Islamic cognitive behavioral therapy (CBT-IP) and examine the effectiveness of CBT-IP in treating depressed adults. Data for the current study were obtained from Benghazi, the second largest city in Libya. The participants were selected randomly from two places: Gar Yunis University and the national electric company. The Beck Depression Inventory (BDI-II) and demographic questionnaire were administered to 449 participants. Furthermore, 75 depressed individuals were randomly selected from the survey sample they had already been diagnosed with primary depression by BDI-II. Data collection involved two phases: a survey that used questionnaires and an intervention (psychotherapy) for depressed people. This research study used both qualitative and quantitative approaches with the researcher conducting a survey and an experiment. For the qualitative portion, the researcher analysed various contents of the sessions, such as homework compliance, clients' reaction to the intervention and the interaction between the therapist and clients. The experiment used two types of cognitive-behavioral therapy (CBT): one with religious content (CBT-IP; 25 participants)

and another with standard protocol (CBT; 25 people) to reduce depression. A group of participants (25 depressed people) were in the waiting list and received no therapy. The findings of the present study reveal that the prevalence of depression among the Libyan population was very high at 68.8%, especially among young adults and females. 60.8% of females were depressed and there was a significant effect of age on depression, particularly for the 18-29 age group. The findings also show that CBT-IP was significantly more effective in reducing depression than CBT and no therapy (waiting list). Finally, the qualitative data showed that CBT-IP participants had good responses to the therapy and a high homework completion rate, used spiritual support a lot, and had good interaction with the therapist.

CHAPTER ONE

INTRODUCTION

1.1 Depression as a Serious Problem

Depression is a mood disorder that “can vary in severity from a fluctuation in normal mood to an extreme feeling of sadness, pessimism, and despondency” (VandenBos, 2007). Depression is considered one of the major psychological problems in the world. It is the most common disorder, accounting for approximately 50% of psychiatric cases. Millions of patients suffering from some form of this disorder crowd the psychiatric and general hospitals (Clark, Beck & Alford, 2009; Sanders, 2003; Zauszniewski & Graham, 2009; Stewart & Chambless, 2009; Segal, Williams, & Teasdale, 2013). In a recent World Health Organization project for the year 2020, it was estimated that of all diseases, depression will become the second-largest burden of illnesses. At present, it is known to occupy fifth place among the greatest causes of death (Beck, 1995; Segal, Williams, & Teasdale, 2013). It also has effects on our society, economy and on the patients’ social life.

Depression is known to have negative effects on our society. For example, one in every five women experience clinical depression during their lifetime, whereas among men, the probability is one in ten (Artur, n.d; Lee & Kim, 2006). In fact, it is a strong irony that people who are depressed, like most others with mental health problems, are reluctant to seek mental health treatment, where only 12% see specialists for their problems. However, each

year, over 17 million people suffer from depression, of which fewer than 30% get treatment. In addition, depression is the mental disorder with the highest rate of suicide, so it has also been found to be a killer disease: Over 15% of depressive people commit suicide and 50% of all suicides have already been diagnosed as cases of depression (Graham, 2011; Segal, Williams, & Teasdale, 2013; Stephen, 2002).

Depression is also one of the most common causes of extended work absence among white-collar employees and is the cause of reduced productive work (Sanders, 2003). It also has a significant negative impact on the economy, costing an estimated \$44 billion a year (Segal, Williams, & Teasdale, 2013).

The negative effects of depression are not just on the society and economy: Depression can interfere with everyday life and frequently causes pain to those who have the disorder and also to those who care for them. Serious depression can destroy the life of the family, as well as that of the individual. It can also affect their studies if they are students (Sanders, 2013).

1.2 Depression in Libya

Libya is a developing Middle Eastern country of six million people that is undergoing rapid modernization. The population is highly urbanized: More than 85% of the population resides in urban areas. 100% of the population is Muslim. The health-care system is relatively advanced. There are three major psychological health service providers under the Ministry of Health (MOH), which provides free-cost services to the population. MOH psychological clinics

are located throughout the country; 95% of the population can reach these clinics in 20 minutes or less.

Depression may be highly prevalent in Libya. However, up until 2010 there were no official statistics. Ali (2008) found a prevalence of depression of greater than 30% among 550 randomly selected female and male patients presenting to primary health-care clinics in Libya. Abu Nasiry (2005) reported that depression is highly stigmatized in the Arab world, particularly one that may have a heritable component, and often results in extensive efforts to deny or conceal it to preserve the family reputation. The director of the Mental Health Hospital expressed that the stigma of depression is especially strong for women and that even the intimation of mental illness would affect their prospects for marriage (Ali, 2009).

Ali (2008) also found that the treatment of depression varied widely; it was suggested that many clients sought treatment with private psychiatrists or outside of the local area because of privacy issues. Treatment of depression with medication was also felt to be problematic. As is common in many other developing countries, patients fearing stigmatization often refuse to go to a psychiatric centre. The director of the Mental Health Hospital reported that they used benzodiazepines and anticonvulsants most frequently in treating depression (Ali, 2009).

Ali (2008) reported that psychotherapy, such as cognitive therapy, behavioral therapy and analytic therapy or counselling, is a limited option in the treatment of depressed clients in Libya. Further, Islamic principles

principles psychotherapy has not been used until now. In general, psychiatrists felt that they did not have the training to counsel patients.

“Despite wide acknowledgement of the role of culture in human behavior, the study of culture on the practice of psychotherapy in general, and cognitive behavior therapy (CBT) in particular, has been largely ignored in mainstream psychology” (Ghassemzadeh, 2007, p. 53). Up until 2010, psychotherapy practice, including CBT, was guided by assumptions that the constructs and principles developed in the United States with European-Americans applied to Muslim clients in Libya (Useef, 2010).

1.3 Cognitive Behavioral Therapy for Depression

There are many kinds of psychotherapeutic treatments that are aimed at helping individuals to overcome stress, relationship problems, negative habits and behavior, thought disorder and depression (Beck, 2011). Many psychological treatments are available for depression, and some have been shown to be successful and useful, such as cognitive behavioral therapy, interpersonal psychotherapy, psychodynamic psychotherapy and existential therapy (Anderson, 2008; Ghassemzadeh, 2007; Huang¹, Peng, Chen, & Lu, 2009).

One of these psychological treatments is cognitive behavioral therapy (CBT). This is a universally classified psychotherapeutic approach which seeks to solve psychological or neurotic disorders, behavior problems concerning dysfunctional emotions, and behavior and cognitions through a goal-oriented

systematic procedure (Albano & DiBartolo, 2007). The modern CBT was formed from the integration of cognitive and behavioral therapies.

Cognitive behavioral therapy (CBT) for depression is “a form of treatment aimed at symptoms reduction, through the identification and correction of cognitive distortions. These involve negative views of self, one’s current world and the future” (DSM-IV-TR, 2004, p. 770). Vital components of CBT for depression include a focus on helping clients solve problems; become behaviorally activated; and identify, evaluate, and respond to their depressed thinking, especially to negative thinking about themselves, their worlds, and their future (Beck, 2011). In a nutshell, CBT proposes that dysfunctional thought (which influence the clients’ mood and behavior) is common to depression. When individuals learn to evaluate their thinking in a more realistic and adaptive manner they experience improvement in their emotional state and in their behavior (Ghassemzadeh, 2007; Pim et al., 2008 & Beck, 2011).

1.4 Islamic principles and Cognitive Behavioral Therapy

One of the main objectives of the Qur’an when it was revealed is modifying human behavior, as Allah addressed humans to change their behavior. Likewise, the main techniques of cognitive behavioral therapy aim to modify the behavior of individuals and their feelings by modifying distorted ideas. CBT techniques are compatible with Islamic teachings/principles and should be modified to suit Muslim populations since many Muslims believe in

the efficacy of faith. Furthermore, the theoretical background of CBT focuses on the clients' thoughts of "here and now" and is harmonious with the practices of the Islamic principles religion.

Additionally, cognitive behavioral therapy harmonizes with Islamic principles in a clear and realistic manner to emphasize thinking. The theory of cognitive behavioral treatment states that human beings have the ability to guide and improve themselves (Abd Alstar, 2009). This view is consistent with an important Islamic principles: "...Surely never will Allah change the condition of people *until they change what is in themselves*¹..." (Qur'an, 13: 11).

Currently, there is an important need to focus on religion as a means of treatment for many different types of psychological illness. Most, if not all, the treatments and counseling approaches used nowadays originated in the West and thus might not be compatible with Islamic cultures and principles (Hamdan, 2008). In other words, Muslim clients might find a psychotherapy that is compatible with their faith to be more suitable and effective. In fact, many Muslims believe that most serious illnesses could be treated by faith in Allah, enabling the human being to realize that everything, good or bad, comes from Allah. This was clarified by Ibn Al-Jawzeeh who reported that true faith opens the door of happiness, goodness and pleasure for the believer (Abd Alstar, 2009).

¹ The researcher used two versions of Quran translation, Yusuf Ali and Muhsin Khan. The italicized words from the Qur'an underline the focus of this study.

If psychological well-being is the main purpose of psychotherapy, Islam as a religion can offer a suitable solution because it teaches its adherents to strive for psychological well-being. It can be argued that human beings need faith to face the challenges in life. In particular, faith is a fundamental principles of Islam and is considered the main factor for psychological well-being, relating the human being to the cosmos and Allah, the creator. In this regard, Allah says: "...for without doubt, in the remembrance of Allah do hearts find satisfaction..." (Qur'an, 13: 28).

Finally, CBT-IP aims to benefit from integrates CBT techniques to help Muslim clients to gain a strength, derived from their surrender to Allah's will, and a confidence in their ability to recover. This positive power helps revive clients' spiritual strength to manage the daily stresses of life. Psychotherapy with Islamic principles appears to be synergistic with widely accepted principles and psychotherapy practices. The key to Psychotherapy with Islamic is a central and overarching focus on spirituality (Ismail, 2008).

1.5 Statement of the Problem

Several findings concluded that there is an urgent need to pay more attention to psychological disorders (e.g., depression) in Libya and Islamic principles countries such as Qatar (Bener, Ghuloum, Abou-Saleh, 2009), Saudi Arabia (Alansari, 2006), United Arab Emirate (Ahmadi, Kamel, Ahmed, Bayoumi, 2008) and Pakistan (Husain, Creed, Tomenson, 2000). With regard

to Libya, Charlson, Steel, Degenhardt, Chey, Silove (2012) estimated that nearly 50% of Libyans developed depression, while Ali (2008) found that the prevalence of depression was greater than 30%. According to WHO (2001) estimates, one in every four people or 25% of individuals develops one or more mental or behavioral disorders at some stage in life, in both developed and developing countries (Bener, Ghuloum, Abou-Saleh, 2011). It is important to note that the prevalence of mental disorders in Libyan population is far higher than the WHO estimate and at the same time it is comparable to the rates found in some other Islamic principles countries (Charlson, Steel, Degenhardt, Chey, Silove, 2012). Table1.1 shows that depression is high in some Islamic countries.

The Islamic principles world has rich cultures which extend to diverse methods and processes of treating, caring for and supporting Muslims who have psychological and spiritual problems. Many of these methods and processes are found in the Qur'an, the Prophetic Sunnah (sayings and doings) and Muslim jurists' and scholars' rulings and ideas. These sources of Islamic principles are frequently ignored by therapists when dealing with individuals displaying cognitive behavioral difficulties such as depression, anxiety, personality disorder, communicative disorder and so forth. For example, many Islamic principles teachings, with regard to crisis, frustration, fear, sadness etc., have been neglected (Abu Raiya, 2009).

In this regard Malik Badri (1999) reported on this issue that, one of the problems of the Muslim world today is that it has become dependent on the West in all branches of modern knowledge. Human and social sciences include psychotherapy,

however, are closely connected with people, and are greatly affected by their behavior and relations, and their values and beliefs. Although some intellectuals claim that these disciplines are cross cultural, they have nevertheless become fundamentally Western in thought and outlook, even in application, since they were initiated in the West and cater for the Western vision of life. This state of affairs represents a danger to the Islamic culture and its spiritual, moral and human values which are left largely unobserved. Muslim psychologist should therefore take an independent line in the study of these disciplines and adopt an attitude of inquiry and criticism instead of passive acceptance. They should also explore the rich cultural heritage of Islam and draw from the extensive resources introduction available in the Quran, the Sunnah and the works of the outstanding people of this Ummah. Not only will provide ne useful data which can help them solve many problems faced in these disciplines but, more importantly, it will reduce the materialism, fanaticism and narrow - mindedness

Table 1.1
Rates of Depression in Islamic Countries

Sample	Authors	Year	Prevalence (%)
Qatari students	Bener, Ghuloum, Abou-Saleh	2009	44.4
	Bener, Ghuloum, Abou-Saleh	2011	59.4
Saudi students	Al-Gelban., et al	2007	38.2
	Al-Faris., et al	2012	48.2
Pakistani students	Husain, Creed, Tomenson	2000	44.4
	Khan1., et al	2006	70.0
Emirati students	Ahmadi, Kamel, Ahmed, Bayoumi	2008	23.30
	Ahmed, Banu, Al-Fageer, Al-Suwaidi	2009	28.6

Additionally, little literature exists in either academic or non-academic communities about the suitability of Islamic principles for treating, caring and supporting individuals who are suffering from depression (Quadri, 2006). Despite the existence of Islamic principles methods and processes for treating individuals with psychological problems, many Islamic principles psychologists still rely on treatment that lacks Islamic principles perspectives. This could possibly be due to too much respect for, and overdependence on, Western scientific discoveries, even though these Western sciences and findings are oriented toward non-Islamic principles cultures. This position was equally recognized by Elias (2005), who asserted that for Muslim helpers working with a Muslim population, training in religion and spiritual interventions is a must. This is because, as recognized and believed by many Muslims, Islam is a way of life which transcends ritual practices.

Finally, despite this dramatic increase in the prevalence of depression in Libya, Charlson et al. (2012) reported that “the few trained psychologists and psychiatrists have no experience of treating depression”. Likewise, Arie (2011) reported that “mental health services were almost non-existent. There are some psychologists [in the main cities], but they only worked before now on things like autism” (p. 423). Based on the foregoing, this research would contribute in developing a cognitive behavioral therapy with Islamic principles for Muslim individuals with depression. Specifically as mentioned above there is a need for an approach or model of psychotherapy that would suit the culture of the people in Libya.

1.6 Significance of the Study

This research is important because it attempts to design CBT with Islamic principles which might be effective and suitable for Muslims with depression. Similarly, the study would greatly assist therapists, especially Muslim therapists, in Psychotherapy with Islamic principles and provides facts about education and credentialing more religious psychotherapists as well as the quality and integrity of our training systems which historically have not done enough to address issues of religion and spirituality in the classroom. This study is the first attempt to integrate CBT and an Islamic perspective for treating depressed Muslim individuals. As such, the study could serve as a seminal study and indeed a foundation upon which further studies could be carried out to improve the use of CBT-IP. Moreover, the study attempts to contribute to advancing psychological knowledge, especially the theoretical arguments on alternative methods and processes of treating depressed individuals without completely depending on Western scientific orientations and findings. As well as this study is important because it provides an understanding of Islamic beliefs and the teachings of Islam can provide invaluable resources for the treatment of Muslim clients who are experiencing depression symptoms. In such a model it is essential to support clients in their religious beliefs, to strengthen their faith, correct their thoughts and beliefs (cognitive re-structuring and change their behaviours).

This study may provide some evidence for the importance of training therapists and counsellors in Islamic principle psychotherapy. Although provide a framework for

understanding what Muslim therapists need to know before working on Islamic principle psychotherapy issues, how to incorporate various religious and spiritual interventions into therapy, and an overview of essential ethical issues that therapists should be aware of when working with religious and spiritual issues in therapy. This kind of basic Islamic psychological study may help Muslim therapists to increase their knowledge, by understanding human behavior according to Islamic principle views, and protect them from the risk of practicing beyond their competency. In 2005, Richards and Bergin argued that the issue “seems not to be whether we should be educating and credentialing more religious psychotherapists, but somewhat, the quality and integrity of our training systems which historically have not done enough to address issues of religion and spirituality in the classroom” (p. 69).

1.7 Objectives of the Study

1.7.1 General Objective

This study aims to develop and evaluate cognitive behavioral therapy based CBT-IP on Islamic principles to help Muslims recover from their depression.

1.7.2 Specific Objectives

The specific questions of this study were:

1. To determine if there is a significant mean difference in depression by gender
2. To determine if there is a significant mean difference in depression by age
3. To determine if there is a significant effect of age on depression for males and females
4. To determine if there is a significant mean difference in depression before and after ICBT for participants in the experimental group
5. To determine if there is a significant mean difference in depression before and after being exposed to CBT for participants in the control group
6. To determine if there is a significant mean difference in depression before and after the experiment for participants in the waiting list group
7. To determine if there are significant mean differences in depression between the experimental, control and waiting list groups after being exposed to the interventions
8. To evaluate the protocol compliance in ICBT and CBT (qualitative data)

The Mental Health and Psychosocial Support (2010) reported that initially, the numbers of depressed patients in Libya visiting the outpatient clinic increased from 100 patients per month to 200 per month and continues to increase. Despite the Libya Health and Environment Report of 2010 there were no official statistics information about the depressed people like parentage, rate, prevalence and gender different. Due to lack or rare information the researcher believe that these objectives 1, 2, 3 may be helpful in shedding light on a few relevant aspects of depressed people in Libya and psychosocial support needs and capacities in Libya which can be updated and build upon in the future.

1.8 Definition of Terms

The definitions of key terms used throughout this study are presented in this section as follows:

Depression is defined as a mood disorder that has 21 characteristics, as follows: sadness, pessimism, past failure, loss of pleasure, guilt feelings, punishment feelings, self-dislike, self-criticalness, crying, suicidal thought or wishes, loss of interest, agitation, worthlessness, indecisiveness, loss of energy, changes in sleeping pattern, irritability, changes in appetite, concentration difficulty, tiredness or fatigue and loss of interest in sex (Beck et al., 1996). For operational definitions see Chapter 3.

according to Beck Depression Inventory- II is defined as a mood disorder that has 21 characteristics on the somatic, cognitive and behavioral as follows:

sadness, pessimism, past failure, loss of pleasure, guilt feelings, punishment feelings, self-dislike, self-criticalness, crying, suicidal thought or wishes, loss of interest, agitation, worthlessness, indecisiveness, loss of energy, changes in sleeping pattern, irritability, changes in appetite, concentration difficulty, tiredness or fatigue and loss of interest in sex, as measured by Beck Depression Inventory-II (Beck et al., 1996). Each item's score is based on a 4-point scale from 0 (rarely or never) to 3 (almost or always). The total scores range from 0 to 63. According to the manual, cut-off scores less than 10 show normal or minimal depression; 10-18 indicate mild depression; 19-29 indicate moderate depression, and scores greater than 30 indicate severe depression (for more details see 3.4.2).

Cognitive Behavioral Therapy (CBT) is a form of psychotherapy that “integrates theories of cognition and learning with treatment techniques derived from cognitive therapy and behavioral therapy. CBT assumes that cognitive, emotional and behavioral variables are functionally interrelated. Treatment is aimed at identifying and modifying the client's maladaptive thought processes and problematic behaviors through cognitive restructuring and behavioral techniques to achieve change” (VandenBos, 2007, p. 188).

Cognitive Behavioral Therapy-Islamic principles (CBT-IP) is a form of treatment based on CBT and aimed at depression symptoms reduction, through the identification and correction of cognitive and behavioral distortions using Islamic teachings and principles.

CHAPTER TWO

LITERATURE REVIEW

2.0 Introduction

This chapter reviews how the word ‘depression’ is used in many different ways and how depression is currently defined. The etiology and prevalence of depression are described. Then, the main psychological theories of depression are explained and critiqued. How to diagnose depression by the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV-TR, 2004)¹ is also presented. The second part of this chapter describes available treatments of depression as per modern treatment theories and the proposed Islamic principles therapy for depression.

2.1 Conceptions of Depression

Depression as a term is very difficult to define. In fact, in everyday communications, individuals usually use the term *depression* in several different ways. They often state that they are depressed when they have a bad feeling or sad moments during hard times or when there is a crisis. Normally, the length of this kind of depressed mood lasts a few hours or a few days (Brothers, 2009). Corey (2008) stated that depression is used by the public to

¹ The present study was conducted in 2010-2011. Therefore, DSM-IV-TR was used as a reference instead of DSM-5 as published in 2013.

express a variety of emotional responses which range from a simply noticeable and temporary mood to a deep damage or even a life-threatening disorder.

It is believed that the majority of individuals experience a sad feeling or a grief which appears as a normal human reaction to frustration. This is because the depressed responses are universal experiences which fall under the normal spectrum of feelings (Clark, Beck & Alford, 2009). However, in some cases the depressed mood is uncontrollable and that there are some psychological symptoms that may be associated with sadness (Jorm, Allen, Morgan & Purcell, 2009).

Beck and Bard (2009) stated that in fact, there are different opinions among clinicians and researchers who have written about the classification of depression. A first group sees no justification for using this nosological category at all. The nature and etiology of depression are subject to even more sharply divided opinion. A second group contends that depression is primarily a psychogenic disorder; others maintain just as firmly that it is caused by organic factors. A third group supports the concept of two different types of depression: A psychogenic type and an organic type.

Beck (2009) suggested that depression may be defined based on the following attributes:

1. A specific alteration in mood: Sadness, loneliness, apathy.
2. A negative self-concept associated with self-reproaches and self-blame.
3. Regressive and self-punitive wishes: Desires to escape, hide, or die.
4. Vegetative changes: Anorexia, insomnia, loss of libido.
5. Changes in activity level: Retardation or agitation (Beck, 2009, p. 8)

Depression is deemed as a kind of disorder of mood and is called an affective disorder, signifying the trouble of mood in all widely used categorization and diagnostic schemes. However, a mood disorder may be considered to be a typical mood condition experienced by many individuals most of their lives. Depressive disorders are associated with sad, guilty, regretful, exhausted, withdrawn moods; these moods influence the individual's everyday behavior. This disease is called bipolar depression when accompanied by mania and called *unipolar depression* when it is not accompanied by mania (Cochran & Rabinowitz, 2000).

The researcher adopts Beck's (2009) concept of depression for the following reasons. Firstly, the researcher believes that Beck's concept is very clear and can be measured. Secondly, Beck's concept has identified definitive symptoms, and his theory is considered comprehensive as it covers all the depressive symptoms. Thirdly, because of the current study based on Beck's theory of depression, so Beck's concept of depression is consistent with the main goal of this study. Fourthly, the content validity for Beck's concept of depression was established by numerous studies (Beck, Steer, Garbin, 1988; Mark, 2004; Groth-Marnat, 2009).

2.2 Prevalence of Depression

There is a considerable variation in the estimate of the prevalence of depression. There are different ways in which it is defined and differing measurement procedures that are usually used. The prevalence of depression is

determined by considering certain factors such as age, gender, culture, socio-economic status and, educational background (Licinon & Wong, 2005; U.S National Research Council, 2009).

The depressive disorder rate appears to differ with age. For example, depression may be expressed differently among children, adolescents and adults and that the rate of the depression increases dramatically among adolescents (Clark, Beck & Alford, 2009). According to DSM-IV-TR, the difference between genders often begins at mid-teenage years and continues to adulthood. Furthermore, the National Population Health Survey conducted a study in Canada and reported that the highest rate of depression varied from 1.4% to 9.1% for the first experience among youth whose ages ranged from 12-24. Moreover, the lowest rate of depressive disorder was estimated from 1.3% to 1.8% among individuals aged from 65 and above (Glickens, 2006). Other studies have also showed similar findings. Depression has been found to be highly common among adolescents with the prevalence rate ranging from 3% to 8% (Mirza, 2004). It was also found that 15% to 20% of teenagers through the course of this sensitive stage experienced depressive disorder (Cuéllar & Paniagua, 2000; Shirk, Kaplinski & Gudmundsen, 2009). 7.7% of depressed teenagers were associated with serious social difficulties such as poor academic attainment, peer problems, excessive use of drugs and alcoholic drinks, and suicide (Weinstein, Parker & Archer, 2002).

Depression appeared to be frequent in females compared with males. Epidemiological studies showed that the prevalence of depression was estimated from 2.6% to 5.5% among males and 6.0% to 11.8 % among females

(Loue & Sajatovic, 2008). In addition, DSM-IV-TR reported that there is a possibility during one's lifetime to experience depression which is estimated to range from 5% to 12% for men and 10% to 25% for women. At any given period of time, it was found that 2% to 3% of men and 5% to 9% of women suffer from major depression (Clark, Beck, Alford & 2009; Loue & Sajatovic, 2008; Millon, Blaney & Davis, 1999).

U.S National Research Council (2009) reported that, in general, depressive disorder prevalence rate is much higher among single or divorced individuals than among married individuals. As for women, it was found that depression is higher among widowed and divorced women or separated mothers than among their married and single counterparts.

The International Consortium of Psychiatric Epidemiology of WHO (2002) reported that depression symptoms are more prevalent among the deprived than the wealthy. Depression symptoms were estimated to be 4.9% with relatively higher prevalence among individuals whose educational level was below the college level (Hyman, 2001).

At mental health centers, the individuals who suffer from depression were diagnosed with the negative effect of depression more than any other individuals with other types of illnesses. In fact, depression is ranked as the second most prevalent disorder for admission to mental hospitals in the United States. The depressed individuals who do not consult mental hospitals have been estimated to be 5 times more than those with schizophrenia worldwide (Beck & Bard, 2009).

2.3 Etiology of Depression

Several risk factors, that are likely to cause or lead to the depressed mood in adults, appear as a result of the interaction between the demographic, neurochemical, and psychological factors (Dobson & Dozoi, 2008). These three main factors influence cognitive and health conditions, as well as they may increase or contribute to the etiology of depression (Miller, 2009). Depression theories, which look into the causes of depression, usually emphasise a single risk factor as biological, psychological, or social factor. However, for a more promising approach, one may look at the possibility of considering multiple-risk factors for depression (Palazidou & Tiffin, 2003).

2.3.1 Biological Factors

The biological factors of depression among adolescents and adults vary, depending on several risk factors that cause or increase depression. The biological factors include neurobiology, hetero-genetics, and hormones. For example, “Biological theories involve the thyroid and neuroendocrine axes, the activities of noradrenergic and serotonergic biogenic amine systems. Hormonal disturbances have been observed in major depressive disorders including low levels of melatonin, elevated glucocorticoid secretions, and blunted growth hormone and thyroid stimulating hormone” (Moss, McGrady, Davie & Wickramasekera, 2003, p. 377).

Functional brain imaging studies have shown changes in cerebral blood flow and metabolism and change in brain structure, including periventricular vascular change, when depression occurs later in life. These changes are not characteristic of or present in all major depressive disorders. Moreover, there is agreement among researchers that mood disorders are associated with the dysregulation of biogenic amines, particularly norepinephrine and serotonin (Hankin, 2008; Licinioni, Li Wong, 2005; Rozanski, Blumenthal, Davidson, Saab, Kubzansky, 2005). Dysregulation of the dopamine, acetylcholine, and gamma acid systems has also been found in mood disorders (Rozanski et al., 2005).

2.3.2 Psycho-Social Factors

Psychosocial factors include an extensive variety of conditions; however, four main psychosocial risk factors will be outlined below. They revolve around negative life events, vulnerability, social factors, and personality. First, negative life events may be considered as predisposing factors or trigger factors that may influence the form and severity of depression, but play no straight etiological role. In 1960s and 1970s, it was found that there is an important relationship between life events and depressed disorder; instances of stressful life events include divorce, retirement, bereavement, and depressive disordered childhood (Licinioni & Li Wong, 2005; U.S National Research Council, 2009).

Second, the theories of diathesis-stress, which explained stressful events, indicate that stressful experiences predispose depressive disorder in individuals who are vulnerable to biological, psychological, and interpersonal characteristics and circumstances (Palazidou & Tiffin, 2003; U.S National Research Council, 2009). In addition, Lakey, Sarason and Sarason (1997) reported that personality can be influenced by the social environment in a way that contributes to developing or maintaining depression.

Third, a social factor can be the loss of or lack of social support. Some researchers have found that this is linked with depressive symptoms. Palazidou and Tiffin (2003) indicated that the severity of depression among the depressed individuals is influenced by protective social ties and mental health. Lakey, Sarason and Sarason (1997) stated that several clinicians and researchers supposed that the individuals with certain positive thinking characteristics are at reduced risk for developing depressive symptoms. In this context, Lakey, Sarason and Sarason (1997) indicated that individuals' positive thoughts play an important role to influence the social environment in ways that contribute to the alleviating of depression.

Finally, psychosocial risk factors such as low socioeconomic status and lack of social support have all been reported to be associated with poor antidepressant treatment outcome (Licinioni & Li Wong, 2005). Although negative life, stress and social factors have been discussed as separate entities, they frequently cluster with psychological factors such as low self-esteem and low self-confidence. For example, individuals who experience work strain tend to report higher rates of depression compared to those who do not have strain

(Rozanski et al., 2005). The strong overlap and interaction between negative life events and vulnerability factors suggests that any life situation that has the power to evoke chronic negative emotional reactions may promote depressed mood. Becker and Kleinmar (1991) reported that more than 90% of females who had an onset of depression have experienced a severe event or major difficulty in the previous 6 months; and those who had low self-esteem and high matrimonial disputes were especially likely to become depressed after stressful events.

2.3.3 Medical Disorder Factor

Chronic diseases are universally considered to be a trigger factor for depressive disorder (Licinon & Li Wong, 2005). On the other hand, depressed feelings have been found to be a normal reaction among individuals with several medical illnesses (Johnson, 2004). In terms of statistics, the percentage of medical illnesses among primary care patients who suffer from depression is approximately 0-5%. In general, 10-14% of medical patients suffer from depression. The depressed mood among the patients who suffer from myocardial infarction is estimated to be 50%. It is approximately 25% among the patients who have cancer. 10-27% of post-stroke patients may also experience depression (Licinon & Li Wong, 2005; Johnson, 2004). Overall, there are a number of contributing factors to depression; however, the biological, psychological and medical factors play a more significant role in the etiology of depression.