DEPRESSIVE SYMPTOMS AMONG YOUTH: AN INTERVENTION PROGRAM

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01-275202-014

A thesis submitted in fulfillment of the

requirements for the award of the degree of

Masters of (Clinical Psychology)

Department of Professional Psychology

BAHRIA UNIVERSITY ISLAMABAD

SEP 2022

Approval for Examination

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Program of Study: Master of Clinical Psychology

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Dedication

Dedicated to all people who are struggling with symptoms of stress, anxiety and depression across the globe.

Acknowledgment

I thank Providence for providing me with natural and human resources which made it possible for me to complete the demanding task of thesis. I am also thankful to my parents, all the teachers since nursery class, and the playmates with whom I learned to face setbacks, win and lose yet continue and enjoy the process. I also owe my gratitude to every single human being that I have ever come across which left an impact on me including that which may initially or wholly felt that it was not pleasant. All the life experiences, interactions, and learning had made me the person that I am today.

I would like to express my profound gratitude to my honorable supervisor Dr. Noshi Iram Zaman, Senior Assistant Professor of the Professional Psychology Department. Dr Noshi has not only fulfilled the role as a principal supervisor, but also as an understanding teacher, spiritual mother, professional guide, graceful human being and a clinician with an eye for details and minutes. Her knowledge, teaching and clinical experience, feedback, guidance, discussion, consultation, suggestions, recommendations and pieces of advice has had an inestimable value and has helped me as an MS scholar, researcher, therapist, as a life time student and as a human being. When the going got tough, her encouraging and motivating presence and communication has shown light. Her professionalism and punctuality have been an inspiration. I also thank my co supervisor Dr Fahad Khan for bearing with me and for trusting me despite initial disappointment. His kind weekly Zoom meeting and knowledgeable discussions and guidance has made the process smooth and

feasible, in addition, efficient and effective. His training beside Dr Hooman Keshaverzi served me well to conduct the research. In the short duration, Dr Fahad has left a significant pleasant impression. I would like to mention my gratitude to the Head of Department Dr. Rizwana Amin, PG coordinator Dr. Wizra Chaudhary and all other teachers who taught me for instilling in me resilience and ability to handle pressure without which doing MS is not possible.

I thank my friends and classmates at the university who shared their irreplaceable humanity with me for the past two years, particularly Iqra, Somal, Anum and Mina which has made MS a worthy experience in the stream of life. Honourable mention include Amna Fazal; Humama Sajjad; Fatima Naqvi; Hania Fayyaz; Iqra Jabeen; Sila Kharonai; Mamoona Rafique; M. Harris Khan; Qubsha Munir; Rabia Rasheed; Khadija Khan; Saheefa Noor; Aasia Hussain and Syeda Farah.

Muhammad Talha

ABSTRACT

It was proposed that it will be a worthwhile endeavor to carry out a psychotherapeutic intervention in a group setting to test the efficacy of Traditional Islamically Integrated Psychotherapy (TIIP) for depressive symptoms among young adults. In this study, it is tested whether the symptoms improve. The research participants had some homogenous presentation of complaints which were present in both groups. The respondents were screened for selection with DASS-21. The respondents were separated into two groups randomly. Group 1 was given intervention based on TIIP with a particular focus on nafs (behavioral inclinations). In group 2, TIIP intervention was not given. The rest of the treatment was kept constant and made use of E-H and phenomenology. The respondents were assessed at intervals with brief symptoms inventory (BSI). The data provided by the study supports the efficacy of TIIP intervention for depressive symptoms among youth. The BSI scores of the majority of the respondents in the intervention group moved from clinically significant to clinically non-significant.

Keywords: Traditional Islamically Integrated Psychotherapy; depressive symptoms; nafs, brief symptoms inventory; Phenomenology

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LIST OF ABBREVIATION AND SYMBOLS

Abbreviation	Definition
TIIP	Traditional Islamically Integrated Psychotherapy
BSI	Brief Symptom Inventory
R	Respondent
DASS	Depression Anxiety Stress Scale
E-H	Existential-Humanistic

CHAPTER 1

Introduction

The depressive symptoms among youth have grown which impacts their physical, mental, social and spiritual health, moreover, they are not able to excel maximum in their academic, intellectual, leisure, familial, social and other life activities. Given depressive symptoms do not constitute a full-fledged disorder, hence, a person is not completely debilitated and can be seen as functional outwardly which further masks the gravity of the problem. It has academic, civic, economic and social costs to the family, society, country and the world at large. The overall wellbeing of a person is compromised without realization at the individual and collective which is a social problem too. The notion is that any problem which can be solved by the collective efforts of society is a social problem. Academics, mental health professionals, universities, sociologists, NGOs and government policy-makers et al. can be at the forefront of efforts to solve social problems such as depressive symptoms among young adults.

While there has been a steady increase in mental health services across the globe, it has also been observed that the mental health of people at the population level has not improved, in fact, there has been an increase in mental health crises not only in the first world, but also in third world countries. It is postulated that there are cross cultural differences; what works in one society may not hold the same reliability and validity in another society. It has been advocated that there is a need for programs and interventions which cater to the indigenous, local, national habitat - culturally, socially, religiously and are in line with the milieu of a person. It is expected that such programs and interventions are more likely to produce better outcomes. Lastly, that is likely to be the case that such interventions and programs will be cost effective compared to alternate options.

An overview and detail about the depressive symptoms and its impact on young adults will be described. The relevance and importance of religion and religion-based therapy - Traditional Islamically Integrated Psychotherapy (TIIP) has been highlighted. The state of mental health and research on university students in Pakistan with depressive symptoms have been cited. The history of therapy and mental health in the Islamic world will be touched in addition to the contributions by Muslim scholars. Development of the theory shall be summarized and a gap in the research literature shall be identified. The research aims, objectives, and questions shall be explained. The significance of the study shall be highlighted.

1.1 Background

Depressive symptomatology among youth is a great concern in the current era. This not only affects their social and academic functioning but is overall disastrous for their personal life. Khan et al. (2020) did a meta-analysis and found 42.66% of university students in Pakistan suffer from symptoms related to depression although they do not have a clinically full-fledged diagnosed depression. It adversely impacts the academic achievement and performance of the students. College and university students represent the young adults whose age range falls between 18 to 29. The average age of onset of depression is mid-20s, furthermore, before the age twenty is hit, first experience with depression has been noted. Fried and Nesse (2014) found depressive symptoms, in particular, sad mood and concentration problems interfere with the personal, social, familial, educational, occupational functioning in addition to the costs to the person, their family and peers and the society at large. Bernal-Morales et al. (2015) describe that adolescents and young adults are particularly prone to symptoms of anxiety and depression which adversely impact their academic performance and beyond.

Javed et al. (2020) carried out a comprehensive analysis of the current state of mental health in Pakistan. The authors found that for a population of 220 million, there are only 400 trained psychiatrists with limited facilities in few state run hospitals in the

country. Zadeh (2017) asserts that the field of clinical psychology in Pakistan faces challenges such as that of accreditation, and regulatory body, gaps in professional training and lack of public awareness. Furthermore, according to the Pakistan Psychological Association (Zadeh, 2017), that person is a clinical psychologist who has a PhD in Clinical Psychology which is also the international standard set by APA. In view of that, the number of clinical psychologists is less than that of the psychiatrists. Hence, there is a dearth of mental health professionals and the population bears the consequences of its lack, particularly the young as the stressors and demands on them are the highest compared to previous generations. Given youth are the future of the nation, there is a great need to alleviate their suffering and improve their wellbeing, where possible.

Twenge (2014) stated that in 2008, one in ten Americans, or twice as many as in 1996, used an antidepressant. Between 1988 and 2001, the number of students receiving treatment for depression and the number of students who were suicidal increased at the counselling center at Kansas State University. Moreover, the author describes that college counselling centers reported students with more serious mental health problems on the rise and twice as many as in 1997 were using psychiatric prescriptions. Twenge (2014) states that a popular definition of depression is having sad or helpless feelings practically every day for two or more weeks in a row, which 29% of teens reported having in a 2011 national study of teenagers.

Torous et al. (2019) stated 1 in 4 persons globally is likely to experience a mental disorder at some point in their lives. In addition, the authors described that those who suffer from depression make 3.94% of the world population. Furthermore, it was highlighted that to deal with such human suffering, a professional workforce is required which is not available and there is a meagre number of mental health professionals. Torous et al. (2019) identified that in developing countries - 76.3% to 85.4% people who suffer from serious mental disorders did not receive treatment within the last year. The authors emphasized the need for new solutions to close the treatment gap.

1.1.2 *Depressive Symptoms and Its Costs*

Depressive symptoms constitute a state in which a person has symptoms of depression but does not fulfill the full-fledged diagnostic criteria. Fried and Nesse (2014) suggest that depressive symptoms have adverse impact on academic, social, economic aspects of the person, and hence, the quality of life in general. Cuijpers and Smit (2008) stated that depressive symptoms cost the Netherlands 1.5 billion Euros per year which are comparable to the cost of depressive disorder that is 1.8 billion Euros. The authors also asserted that those who have depressive symptoms are at increased risk of developing major depression. Cuijper and Smit (2008) cited that a metanalysis of seven studies suggests that psychological treatment is effective for depressive symptoms.

Horwitz et al. (2020) report that numerous academic performance indicators have been favorably correlated with religiosity, however it is unclear if this correlation is real or merely coincidental. The authors argue that family background is one source of variability that could influence a child's level of religiosity and academic success. Furthermore, the authors assert that their study is the first to quantify the relationships between religion and short- and long-term academic success using sibling differences and that two primary conclusions come from their analysis. First, even when accounting for the fixed effects of family, adolescents who identified as religious had higher GPAs in high school. Second, 14 years after their religiosity was assessed, more religious adolescents finished more years of education because they had higher GPAs in high school. Our research indicates that young people's religious beliefs have both immediate and long-term effects on their academic performance. As a result, these beliefs should be more actively considered when theorizing about the factors that contribute to educational and economic stratification.

1.1.3 *Importance of Religion and Intervention - Traditional Islamically Integrated Psychotherapy (TIIP)*

Religion has been part of humanity since the Paleolithic's times and humans have prayed, performed rituals, and other related activities, inwardly and outwardly. It has served

humanity as a coping mechanism to deal with vicissitudes in life and to deal with testing times in life. Religion can be said to be a shield against factors which adversely impact wellbeing. Gallup Organization (2009) conducted a global survey on the importance of religion which included 114 countries – in each country, on average, based on a representative sample, 1,000 adults were interviewed either on the telephone or face to face. The organization found the global median to be at 84% for the importance of religion in daily life which is in line with its surveys in other years and in Pakistan's case, 92% of the population finds religion to be an important part of their lives. Furthermore, the United States is among the rich countries where the importance of religion is relatively high at 65%. It also found wide differences between countries for instance only 16% of the population considers religion to be an important part of their life in Estonia compared to the other pole – Sri Lanka and Oman, etc where 100% of the respondents deem religion to be an important part of their life. However, there is lack of awareness, and application regarding TIIP in Pakistan, and research is limited, if any. TIIP is likely to be effective in gaining acceptance within the populace of Pakistan given the religiosity of the population; given the research on Muslim population in the USA, it is likely to show promise for Muslim poulation elsewhere (Keshaverzi et al., 2020).

Keshaverzi et al. (2020) state that TIIP focuses not just on the removal of symptoms, but on the holistic conceptualization of the patient. Moreover, TIIP emphasizes the state of the therapist as it has been in the Jungian therapy and other experiential schools of thought. TIIP also keeps in view the psycho-spiritual equilibrium of the human psyche. A human body temperature at 98.6°F (37°C) is an example of homeostatic equilibrium. Rothman (2021) described that TIIP uses tafakkur (contemplation), muraqabah (meditation), muḥāsabah (introspective examination), body awareness, emotional tracking, dua or prayer, dhikar (a practice of remembrance) among others as tools for healing.

1.1.4 *Existential-Humanistic-Phenomenology*

Schneider and Krug (2010) assert that the four main goals of E-H therapy are to: (a) assist clients in becoming more present to themselves and others; (b) assist clients in

experiencing the ways in which they both mobilise and block themselves from being fully present; (c) assist clients in accepting responsibility for the creation of their current lives; and (d) assist clients in choosing or actualizing more expanded ways of being in their outside lives. These goals are achieved by clients' commitment to, desire for, and capacity for change as well as by therapists via their ability to attune to, endure struggle with, and vivify developing patterns. Even though E-H treatment is similar to, and even grounds, many other intense therapies, it stands apart because of its focus on present, struggle, and whole-body reactivity.

Neukrug (2015) reports that phenomenology enables a person to become conscious of how they interact or do not interact with various parts of life. By that, a new energy and zest for involvement are generated by actualizing and taking control of one's own experience.

1.2 History and Significance of Mental Health in Islam

The first psychiatric hospitals were built in the Islamic world as early as the 8th century and were called Bimaristan (Ibrahim, 2002). Some famous psychiatric hospitals were built in Damascus and Aleppo in 1270. Bimaristian hospital had their own ward dedicated to mental health. Rothman (2021) reported that 9th and 10th century scholars like At-Tabari, Ar-Razi, Ibn Sina, Al Balkhi, Al-Farabi did work related to psychotherapy and psychiatry;child development; depression; sociology and social psychology respectively. Early Muslim period scholar like Ibn Sirin did work related to dream interpretation; the list goes on.

Moffic et al. (2018) gives reference to the Islamic scholar Al-Ghazali who said that the conservation of mind and cognitive faculties is considered as one of the top five aims of Islamic law-making as a whole. Preserving religion, person, household and wealth are the other four aims of Islamic law making (the essentials of Islamic legal theory). Besides, it is said, no matter what, if something was considered to adversely impact one's cognitive capacities, for example, drunkenness, it was either discouraged or prohibited. Thus, it is no

surprise that learned Muslims considered charged poignant states for instance intense anger as an obstacle to sound mental judgment, for example, a judge cannot pass verdicts in a condition of anger. There is a basis to it in the Quran and Hadith for such comprehension.

Moffic et al. (2018) assert that the emphasis on physical, mental, and holistic well-being has its roots in Islamic culture, specifically the Quran and Hadith. The Quran and Hadith cover general concepts of health and disease, providing direction for how to advance in learning about the field of knowledge. The Prophet's (SAW) tradition opened up new paths for individuals looking for disease cures. There is a claim that a corresponding cure is brought about for each illness that God created. As a result, Muslims have dedicated themselves to the study of healing and medicine since the 7th century. In addition, it is mentioned that traditional Muslim thinkers and academicians looked at the health from the same lense as per the defintion given by World Health Organization (WHO) according to which health is "a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity". One example among a multiplicity of them is the instance of renowned al-Balkhi from the ninth century who publicly recommended and supported taking into account both physical and psychological aspects of health and striking a balance for well-being.

Moffic et al. (2018) states that in the sight of Almighty God, human beings are considered responsible for themselves, both socially and religiously. It is anticipated that a person will fulfill his duties towards himself, his family, his society and to Providence. A principal Islamic legal maxim is that it is obligatory for a person to fulfill anything which is necessary for fulfilling the mandatory task. Thus, it is not unexpected that learned Muslims have deemed and held in high esteem - physical as well as mental well being of the person as it is necessary to fulfill one's obligations. Furthermore, the authors mention that an overview of Islamic legal texts makes it clear that sufficient heed has been paid to the soundness of the mind and the importance of mental ability which runs through most of the chapters as necessary for being able to fulfill one's social and religious obligations which includes religious ceremonies, monetary deals, matrimonial agreements and others.

1.2.1 *Relationship of the Mind and Body*

Moffic et al. (2018) mention that to understand the interconnectedness between mind and body from the Islamic perspective, Al-Balkhi's account of disruption of the physical and spiritual is involved. Physical disease such as fever, sore head, and other suffering which impact parts of the body is experienced by the body, the soul also goes through diseases for instance annoyance, deep distress, angst, terror, alarm, and other mental suffering of similar vein. The authors assert that for al-Balkhi and the great number of Muslim thinkers ideas, creativity, discernment, and faculty of remembering is not only considered to be the outcome of psyche or mind which has a spiritual aspect to it, but also closely associated with soul. It is mentioned that the heart, the spirit, the ego, and the intellect were the four components that Al-Ghazali believed made up the soul.

Moffic et al. (2018) describe that in his book Timeless Healing, Herbert Benson, a key figure in the founding of Harvard's Mind/Body Medical Institute, severely criticised the way Western science treats the physical effects of faith and emotion. Herbert claimed that a strategy based on equilibrium for well-being should consider humans not just as emotional and intellectual beings but also as spiritual beings. He regarded those processes as the work of the soul. Similar claims were made by Abu Zayd al-Balkhi eleven centuries ago. Al-Balkhi tried to convince the doctors of his time in his treatise "Sustenance of the Body and Soul " that there is an unavoidable relationship between the mind and the body and that they should not practise their trade exclusively with the focus on the body. Al-perspective Balkhi's on wellbeing, which views a person as a composite of their body and soul, served as the inspiration for the psychophysiological attitude toward wellbeing in medieval Islam.

Moffic et al. (2018) describe that as the integration of mental and physical components of health has received more attention recently, such programmes that address the cognitive and physical aspects are being established. Furthermore, studies have provided evidence supporting the significance of the physical-mental relationship. For instance, emotional moods have an impact on how the immune system reacts to illness. Moreover, research has demonstrated that mental factors can influence heart diseases and

can promote unfavourable cardiac events. The decreased likelihood of developing high blood pressure, diabetes mellitus, and respiratory tract infections has been linked to positive feelings.

1.2.2 *Music Therapy in Islam*

Isgandarova (2015) mentions that the comprehensive research on music throughout the medieval Islamic era shows that innovations in many fields could not be stopped by a strict and harsh opposition to music. Ikhwan-Safa, al-Kindi, Abu Bakr Muhammad ibn Zakariya al-Razior Rhazes (864–925), Farabi, ibn Sina, al-Urmawi, Maraghi, Yusuf b. Nizameddin b. Yusuf al-Rumi al-Mawlawi, and others deserve special recognition for their contributions. Since the ninth century, these writers have added to our knowledge of music by analysing it from a philosophical standpoint. Ikhwan al-Safa, for instance, underlined the need to examine music within the context of morals as a whole.

Isgandarova (2015) reports that we should also mention that throughout the thirteenth and fourteenth centuries, various regions of Iran, Azerbaijan, and Anatolia saw a remarkable development of music. It should come as no surprise that several of the Muslim thinkers and scholars mentioned above who used music in their writings were either from Ottoman Turkey or Azerbaijan. The majority of these outstanding Muslim musicians and composers had ties to well-known Sufi chambers and worked to create music with a spiritual purpose. For instance, Mustafa Efendi, also known as Nayi Ali Mustafa Kevseri Efendi (d. 1770), was a Mevlevi Dervish. In his Mecmua-i Kevseri (Journal of Kevseri), also known as Kitab- Musikar, he was well noted for his attempts to update Turkish Music theory.

Sufie & Sidik (2017) discuss that the philosophy and viewpoints of the Greek civilisation serve as the main inspiration for music therapy, which was later modified by Muslim scholars using Islamic principles. The early Greek philosophy, which was further elaborated by al-Kindi and Ikhwan al-Safa', al-Razi, al-Farabi, and Ibn Sina (Avicenna),

although the latter rejected any connection between music and metaphysical aspects, related music to cosmology and astronomy. Despite having a wide range of opinions, this theory serves as the cornerstone for the use of music therapy in both physical and mental healing. In addition to philosophy, music played a significant role in Islamic culture's contribution to healthcare, especially in the form of spiritual care for the soul, which is based on religious aspects.

Isgandarova (2015) describes that Al-Urmawi conducted an experimental study on the effects of music on the camel, which had been thirsty for forty days, with the consent of the caliph, according to Nilgün Dogrusöz of Istanbul Technical University, in response to the threat to forbid music in all aspects of life. The camel was untied in front of the whole public in Baghdad, and then given water and Nevbet-i müretteb in the maqam of Zirgule. Al-Urmawi reportedly began singing, and the thirsty camel, instead of heading for the water, sat there listening to him perform while crying. Al-Urmawi even conducted the test three times in order to demonstrate the validity and dependability of the research; the findings were consistent each time. Al-Urmawi did that in the hope to demonstrate that music is a normal part of life and should not be outlawed in this way. Never before has such music-related scientific experiments been conducted.

Al-Faruqi defined music therapy as the art and science of combining sounds, vocal tones, or instrumental sounds to produce a variety of expressions that satisfy emotions, aesthetics, and the structure of the basis for belief systems held in the context of the Islamic civilisation, according to Sidik et al. (2021). This definition encompasses music's three core components: sound, voice tone, and instrument; capacity to arouse aesthetic and emotional responses; and ability to fulfill a specific purpose within a belief system. It is found that the concept of music therapy existed throughout the Islamic Middle Ages and fits under this criteria. The writers also state that the approach of music therapy, which extends beyond employing instrumental music and singing, includes the use of adhan (the call to prayer), the recital of the Quran, and the sound of water. These additional therapeutic techniques make advantage of the tonal, rhythmic, and melodic components of the sounds.

According to Sidik et al. (2021), sufi dervishes employed music in al-sama' ceremonies in sufi activity centres named khaniqah, ribat, and zawiyah throughout the Islamic Middle Ages. Al-sama' was used as a type of physical and mental treatment for the ennui (boredom and exhaustion) of life's vicissitudes as well as a remedy for the soul's longing to experience the Divine by members of a sufi fraternity (tariqa), under the guidance of a Sufi Sheikh or Master. As a result of its status as a wasilah (means of approaching Allah SWT through the sense of hearing), al-sama is an important ritual for sufis. It is also believed to be the wasilah for gaining mental peace and purging sin from the soul. Sufis believe that the actuality of al-sama' occurs when they experience fana' (self-annihilation or extinction while still physically alive) from worldly concerns and al-wajd (spiritual ecstasy in seeing the magnificence of the Divine secret).

Sidik et al. (2021) go through the benefits of using music therapy as a medical treatment. Ibn Sina and Ikhwan al-Safa list the following as some of the uses of music entertainment:(i) amuse, soothe, relieve, or reduce pain; (ii) strengthen body immunity (antibodies) to diseases; (iii) aid in healing; and (iv) divert attention from pain and calm down in order to hasten the healing process. It is obvious that the focus is more on calming down and alleviating discomfort than on complete healing. On this foundation, music therapy serves as an adjunctive therapy. Stress reduction and symptom relief are two additional benefits of music therapy. Additionally, the authors report that music therapy was used as a remedy in many mediaeval Islamic hospitals. The hospitals included those at Suleymaniye Sifahanesi, Bimarastan Fez (Sidi Frej), Edirne Sultan Bayezid II Darussifas, Cairo's Bimarastan al-Mansuri, Aleppo, Syria's Bimarastan al-Arghuni, and Damascus' Bimarastan Nur al-Din.

According to Sidik et al. (2021), the presence of these institutions showed that music therapy was widely employed throughout the Islamic Middle Ages' Seljuq and Ottoman periods. The application included singing, al-Qur'anic recitation, and the sound of flowing water in addition to instrumental music. For the performance of instrumental music, the use of a stage or a domed auditorium was favoured. To enhance the therapeutic

effect, some hospitals installed an acoustic system. A dome was built to reflect sound off its concave walls, which focused the sound in the centre and amplified it. This acoustic device assisted in distributing the music's sound throughout the facility. The hospital's garden fountain pool made it possible to use the soothing sound of running water as therapy, and it also provided a peaceful environment for staff members, patients, and visitors. Patients receiving music therapy typically have mental illnesses as well as psychological conditions like sadness, sleeplessness, and melancholy. The patients' amusement, anxiety reduction, and pain relief were the three main goals of this treatment. However, music therapy was no longer provided in these Islamic mediaeval hospitals by the 19th century AD.

1.3 Psychology, Religious Experience and Islamic Psychology

Rassool (2021) describes that although its beginnings can be traced to ancient Greece, between 400 and 500 years ago, with the emphasis being on philosophy, psychology is a relatively recent scientific field. Philosophers such as Socrates, Plato, and Aristotle discussed topics such as free choice vs. determinism, nature vs. nurture, attraction, memory, and consciousness in their philosophical discourse. Aristotle believed that each child is born with a "blank slate" (Latin: tabula rasa) and that knowledge is mostly acquired via learning and experience, whereas Plato felt that some types of knowledge are intrinsic or inborn. The issue of nature and environment variables was extensively contested. The "tabula rasa" phenomena served as the germ of the psychology school that would become known as behaviourism.

Rassool (2021) mentions that Marko Maruli used the term "psychologia" (or "psychology") for the first time in his book, Psichiologia de Ratione Animae Humanae, published in the late 15th or early 16th century (Krstic,1964). The word psychology was first used in the English language by Steven Blankaart in The Physical Dictionary which refers to “Anatomy, which treats the Body, and Psychology, which treats the Soul,” in 1694 (Colman, 2014). From a historical perspective, there are a few stages in the definition and study of psychology. The author elaborates that in the first stage psychology was stated as the “study of the soul or spirit”. In the second stage, it was stated as the “study of the

mind". In the third stage, it was stated as the "Study of science of mental life, both of its phenomena and their conditions." by William James while John B. Watson stated it as the acquiring of information which is helpful to regulate the behavior. In the fourth stage, psychology was stated as the study of human conduct, practical contact with and observations of facts and events in addition to being the study of complete behavior that includes consciousness and unconsciousness.

Rassool (2021) discusses that from the scientific study of human behaviour and experience to the study of the human mind, its functioning, and behaviour, to the study of awareness and unconsciousness, there are many different definitions of psychology in the literature. However, a sizable majority of psychologists reject the existence of the soul, and other psychologists contest the truth of the unconscious. It is asserted by the author that the work of William James (1902–1999) in The Varieties of Religious Experience is noteworthy because he issued a warning against separating religious experience from the scientific study of human behaviour. According to James, to attempt to define the world while leaving out all of the many spiritual attitudes and feelings of personal destiny—which are just as definable as everything else—would be like equating a printed menu with a filling dinner. He stressed three fundamental ideas: there are many emotions, viewpoints, and experiences that are religious in nature and important to human life; religious experiences can be described in the same way as any other human experience; and any description of human life that leaves out religious experience will fall short in illuminating human behaviour.

1.3.1 *Obstacles in approaching psychotherapy/counselling services*

Rassool (2021) elaborates that there are obstacles that Muslims and Black and minority ethnic (BAME) communities must overcome in order to receive mental health services, notably psychotherapy or counselling, and these obstacles are widely recognised. Individuals from BAME communities have recognised issues related to systematic or institutionalised racism and the dearth of BAME professionals as major hurdles to the availability of mental health care (Fernando, 2005). Underutilization of mental health

services may be caused by two main factors: inaccessibility (e.g., due to language barriers or insufficient service supply) and resistance to access (e.g., because the community wants to keep things private) (Weatherhead & Daiches, 2009). Strong religious convictions and the conviction that only God can provide relief are some of the obstacles that keep Muslims from getting professional help. Other obstacles include feelings of embarrassment or stigmatisation if they use services, as well as a "fear of stereotyping" by services (Weatherhead & Daiches, 2009). Lack of cultural awareness and religious inclusion in the treatment process and content are other obstacles. Additionally, there has been a need for infusing cultural metaphors and non-Western clients' stories into Western psychotherapy (Moodley, 1999). Muslims who strongly identify with Islamic values "are being counselled primarily with a Eurocentric worldview, which is anchored in the Judeo-Christian tradition and reflects the prevailing values of the greater culture," it is evident (Rassool, 2016, p.x). Racism and cultural insensitivity in counselling and psychotherapy given to Muslim clients in the West have been noted in the context of the ethnocentric nature and process of these therapies (Al-Roubaiy, Owen-Pugh & Wheeler, 2017). In a recent study, Moller, Burgess, and Jogiyat (2016) investigated the difficulties that second-generation South Asian populations in the UK have while seeking counselling. The authors have offered evidence of how barriers to obtaining counselling for psychological distress might be created by stereotypes of race and religious identity. These common misconceptions about counselling, counsellors, and clients among the populace served as possible obstacles to help-seeking.

1.3.2 *Problems and solutions in Islamic psychology*

Rassool (2021) argues that on a global scale, many educational institutions encounter significant obstacles in the integration of Islamic sciences in undergraduate, graduate, and continuing education programmes. The majority of countries place restrictions on educational institutions' ability to include Islamic studies in psychology, counselling, and psychotherapy programmes due to institutional and professional rules - in

their course work, psychology. Perhaps this is the reasoning behind why their curriculum uses the "Sprinkle" or "Bolt-on" techniques. Wherever it is feasible, Islamic psychology instructors must let their students know that there are other approaches to using psychology to analyse human experiences and behaviours. For psychology departments at academic institutions, offering more elective courses in Islamic psychology and psychotherapy would be an alternative to changing the content of undergraduate and graduate psychology courses.

1.3.3 *Human and Scientific Knowledge*

Richardson (2004) in his book - Faith in Science: Scientists Search for Truth reports his interview with Professor Kendler (2004), a pioneer of research in schizophrenic disorders and its genetics basis. The author quotes Professor Kenneth Kendler who argued that it is crucial that we avoid combining and mistaking the two types of information. In clinical psychiatry, one of the things that is attempted is to try to integrate the scientific knowledge we have about psycho-pharmacology, about neurotransmitters, and about brain function with the incredibly human knowledge that is gained about people as one sits with them in a counselling or psychotherapeutic endeavour. This has a lot to do with one's attempt to make sense of one's identity as a psychiatrist. In the beginning, Kendler (2004) found it difficult to combine the human knowledge he learned through working with patients in psychotherapy with the knowledge he learned from reading scientific research. Professor Kendler reports that a mid-twenties patient of his developed depression following a breakup with a love partner. She and Professor Kendler both came to the conclusion that her sadness was closely tied to the death of her father when she was seven years old after 80 or 100 hours of psychotherapy. Moreover, the romantic partner she chose was older and in some respects resembled her father, and she had never truly mourned. Besides, she was forced to confront a number of painful, self-deprecating memories and issues that she had not really fully resolved as a result of the end of that romance.

Richardson (2004) reports that when Professor Kendler searched the scientific literature, he was startled not to discover any empirical proof that childhood deaths increase

the risk of depression in adults. Later, Professor Kendler conducted a study involving roughly 2000 women and was shocked to discover that there is no statistical correlation. According to statistics, divorce and other marital issues within a family do predispose to depression, however a parent dying young does not. There are two knowledge bases available here. In one, you sat with the patient, you gained the human knowledge that the loss of her father was a factor in her despair. Additionally, there is a sizable statistically sophisticated sample and meticulous methodological science that contradict it.Could that serve as a bridge between religious and scientific knowledge? You cannot use the scientific literature to refute the psychotherapy insight. They simply do not know the same things. Psychoanalysis has a real inability to distinguish between those two types of knowledge, which is part of what it represents. According to psychoanalysis, the knowledge we acquire during human interactions, when you can make notes with great accuracy but are unable to test them, can actually be thought of as a branch of natural science.

1.3.4 *Religion Comes Naturally to Humans*

V.S. Ramachandran, M.D., Ph.D., explores that could it be that the neurological circuitry that mediates religious experience is something that has specifically developed in humans? It is intriguing to wonder whether our inclination for such ideas may have a biological foundation since it is so pervasive in all communities around the globe (Ramachandran & Blakeslee, 1998). Bloom (2006) argues religion has received little attention from modern developmental psychologists, despite its substantial intellectual appeal and significant social impact. The author elaborates that however, in recent years, a growing corpus of study has examined kids' understanding of specific global religious concepts. The author argues recent research suggests that young infants inherently believe in mind-body dualism and supernatural agents, two core components of religious belief. That this bias in favour of creationism seems to be cognitively normal is one of the most intriguing findings in the developmental psychology of religion.

Bloom (2006) describes that everything, according to four-year-olds, has a purpose, even things like lions ("to go in the zoo") and clouds ("for raining"). While adults prefer a

physical explanation when asked why a group of pebbles are pointed, whereas youngsters choose for solutions that provide a practical purpose, such as "so that animals might scratch on them when they become itchy." The author says that based on these observations, Kelemen has hypothesised that infants are more prone than adults to "promiscuous teleology," which is the tendency to interpret the world in terms of design and purpose. Bloom (2006) expands that other studies show that children prefer explanations that entail a purposeful creator when they are asked directly about the origin of animals and people, even if the adults who reared them do not.

1.4 Rationale

The rationale is provided in three sets - contextual, methodological and theoretical gaps which is elaborated in the following lines:

1.4.1 *Contextual Gap*

Traditional Islamically Integrated Psychotherapy (TIIP) is an emerging psychotherapy which shows promise that is evident from case study done on Muslim clients in the USA. However, there is a lack of adequate research. Moreover, the research on TIIP, if any, is extremely limited in Pakistan. TIIP is an integrative therapy with religious orientation which corresponds to the culture of Pakistan. There is a rising mental health crisis both globally and especially among the Muslim youth. Moreover, there is tendency among the Muslim population not to seek mental health services. The current research is conducted on the young Pakistani population who are struggling with their mental health. The literature also shows more religiously inclined clients benefit more from religiously oriented psychotherapy. Present research will fulfill such gaps.

1.4.2 *Methodological Gap*

The goal of this study was to apply TIIP on a young population which has depressive symptoms in a combination of settings - individual and group. Moreover, it

aimed to improve their overall well-being and check whether TIIP shows efficacy in decreasing depressive symptoms among the youth under study in a Pakistani university.

1.4.3 *Theoretical Gap*

The result of the present research will cumulate the research on TIIP's efficacy in particular, and Islamic psychology, in general. It will assist to present an initial roadmap of how TIIP can be used in therapy, both in individual and group settings. Moreover, its focus is on the youth. There is a lack of research regarding that in Pakistan, hence, this study will fill that gap.

1.5 Problem Statement

The literature on young adults suggests that there is a high prevalence of depressive symptoms among young adults, which impacts quality of life and has economic consequences. Sabry (2013) found that many Muslims are reluctant to seek mental health services partly due to their religious doubts about the nature of the field. The literature of the efficacy of TIIP in different settings is limited, one of which is group therapy particularly for young adults with depressive symptoms.

1.6 Research Questions

- Is Traditionally Islamically Integrated Psychotherapy (TIIP) effective to relieve depressive symptoms among young adults in group therapy settings?

- Does the effect of healing of TIIP hold at the follow up?

- What is the feedback regarding TIIP intervention by the research participants and what it entails in the Pakistani context?

1.7 Objectives

The study shall attempt to address the following:

a. There is a lack of empirical evidence for group therapy intervention for young adults with depressive symptoms based on Traditional Islamically Integrated Psychotherapy (TIIP). The purpose is to add to the empirical evidence.

b. To test the efficacy of the specific therapy for the population under research.

c. To heal depressive symptoms of young adults and consequently increase their academic performance and overall functioning in general.

d. To make a small contribution to the literature related to the Traditional Islamically Integrated Psychotherapy (TIIP) and the wider field of Islamic psychology as Buddhist psychology contributed to the psychology with its west centric habitat.

1.8 Significance of the Study

The research will contribute to the emerging and growing Islamic psychology broadly, and particularly TIIP which is getting traction among Islamic psychologists worldwide. If the group therapy application of TIIP works out, it will add another component to TIIP that its application in a group setting for young adults with depressive symptoms is helpful. Within the Muslim cultures, that can be time effective and cost-effective therapy with appeal to the Muslim population.

CHAPTER 2

Literature Review

Awaad and Ali (2015) delineate that Abu Zayd al-Balkhi, a 9th century Muslim polymath wrote a book – Sustenance of the Body and the Soul whose OCD symptoms correspond to the modern DSM-V. Rothman (2021) highlighted that al-Balkhi suggested to patients of depression to focus on positive cognitions in the 9th century. Sabry et al. (2013) stated that Islamic scientists such as Al-Razi, Farabi, and Ibn Sina established scientific principles of that time for music therapy with reference to psychological disorders.

Rothman (2021) put forth that a therapist's vulnerability to misinterpret, misread, misunderstand, mismanage, or neglect crucial aspects of a client's life that might seriously impede adjustment or growth can influenced by their lack of knowledge of spiritual structures and experience, claimed Bergin and Payne in 1991. (p. 201). Consequently, it can be seen as best practise to at the very least respect, consider, and recognise a client's spiritual and/or religious inclination. But in acknowledgment of the potential value and clinical direction that religion and spirituality may bring to the psychotherapy interaction, some theorists and practitioners have created and employ spiritually centered treatments. (Pargament & Saunders, 2007).

Rothman (2021) reports that according to studies, therapies with a religious focus are more beneficial for clients who are more religiously motivated or whose symptoms and treatment objectives are related to religion. (Martinez, Smith, & Barlow, 2007; Worthington, Hook, Davis, & McDaniel, 2011). Keshaverzi et al. (2020) in their book gave practical examples of the use and application of Traditional Islamically Integrated Psychotherapy (TIIP). Furthermore, a case study was presented of a 16 years old client with South Asian and strict religious Muslim parents' background who has had symptoms of anxiety and depression, who was also a Hafiz yet had become an atheist. The book presented the successful utilization of TIIP with the former.

Keshavarzi et al. (2020) describe that in TIIP, Aql does the intellectual processing; ruh is the divine nature within the human being; nafs or self is dynamic with three stages; and the state of the soul has an impact and the state of the therapist matters. Munjiyat (virtues) are emphasized and utilized at first for the client to be more accepting of themselves, only then muhlikat (vices) are given heed. Inner work is necessary. Tahdhīb al-akhlāq (Reformation of Character) is part of the intellectual landscape of TIIP. Four virtues – wisdom, temperance, justice, courage are related. Rothman (2021) described that there are three main stages of nafs through which a human being fluctuates namely, Nafs alammārah bil su (soul that commands to evil), Nafs al-lawwāmah (self-reproaching soul), and Nafs al-muṭmaʾinnah (soul at rest). During the therapy process, usually, only the first two stages are engaged and most humans struggle with these two stages – the self-critical soul and the one who orders evil.

Rothman (2021) writes that as the practise of including spiritual and religious components into psychotherapy has become more prevalent, there has been a more recent and rising desire among Muslim service users in doing so. (Haque, Khan, Keshavarzi & Rothman, 2016). The emphasis on using Islam in treatment with Muslims has mostly centred on Cognitive Behavioural Therapy (CBT), which is one of the most well-known, empirically researched, and widely used approaches to psychotherapy at the moment (Cuijpers et al., 2014; Hans & Hiller, 2013; Stewart & Chambless, 2009). The author describes that describes that in their study on how to integrate religion and psychotherapy for Muslim clients, Abu Raiya and Pargament (2010) made a number of recommendations, including evaluating the relative importance of Islam in the client's life, their level of commitment to practising their faith, and how the clinician's approach should take into account these different levels of commitment.

Ghorbani et al. (2014) conducted research in Iran, the results which they yielded for each item with minimum alpha reliability of .5 and above were finally included in the fifteen item Muslim Experiential Religiousness scale. Khan et al. (2015) carried out research in Pakistan to see the application of Muslim Experiential Religiousness scale and

found it to be correlated with different markers of wellbeing in addition it predicted religiosity or lack thereof in the context of Pakistani culture. There is now a substantial research vacuum on the effectiveness of therapies and treatments that apply Islamic principles to psychotherapy with Muslim patients. (Beshai, Clark, & Dobson, 2013; Hamdan, 2008; Haque & Keshavarzi, 2014). Rothman (2021) reports that according to Geertz (1975), who examined Muslim cultures around the globe, each community modified Islam to fit its own local environment and historical context. Islam is not a thing that exists outside of human experience and is unaffected by it. How people really experience it shapes and gives it life. (Varisco, 2005). While the majority of Muslim societies are characterised by a collectivist worldview, numerous common methods of psychotherapy fall within the individualist school of thought. (Al-Krenawi & Graham, 2003).

Li et al. (2017) assert that few studies have looked at the relationship between Western laypeople from individualist cultures' subjective well-being (SWB) and their belief in free will. But no research has looked at this connection among individuals from collectivist cultures (e.g., Eastern Asian cultures). In order to investigate this association, they looked at two significant, independent cohorts of Chinese adolescents (N1 = 1,660; N2 = 639; high school students) in the study. A self-reported survey (Cohorts 1 and 2) and a forced choice question with two options regarding the existence of free will were used to gauge belief in free will (Cohort 2). Both cohorts of SWB measured both affective (positive and negative affect) and cognitive (life satisfaction) well-being. According to data analysis, both cohorts had higher life satisfaction and positive affect when they had a larger belief in free will. The authors argue that study offers proof in favour of the cultural generality of the advantages of free will belief on SWB.

In Islamic paradigm, free will and responsibility is embraced while a positive outlook and gratitude is encouraged. We human beings are a combination and biological make up of 50 trillion single cells as all of these cells are individual organisms that have a mutual co-operation with other existing cells for a collective survival. These cells have individual consciousness and individual reactions to the environment they are in. We human beings are a collective consciousness of all these cells. As a nation reflects the traits

of its citizens, our human-ness must reflect the basic nature of our cellular communities. Therefore, I am to conclude, like these cells, we are not victims of predetermines, but masters of our fates through free will. Each Eukaryote cell (containing nucleus) has the functional equivalents of our digestive system, nervous system and so on. And like humans, these single cells can also create memories and pass onto their daughter cells and induce behavioural responses to ensure a survival. This is 'Affinity Maturation' in cells that are invaded by measles virus. The cells adjust the shape and function against an invading hazard (Li, et al, 2003; Adams, et al, 2003). The cell learnt; created a memory; this is inherent intelligence (Steele, et al, 1998). In humans, life experiences can excite or stimulate telomerase activities like child abuse, domestic violence or even post-traumatic stress disorder. On the contrary, a positive outlook on life and gratitude can enhance the telomerase activity promoting a healthier life (Blackburn and Epel 2012, Stetka 2014). Even more, there were breast cancer patients who had peaceful and mindful meditation, and had a sustained and preserved telomere length. The control group with no interventions had reduced and shortened telomere length (Carlson, et al, 2014).

Kokkris et al. (2019) discuss that having free-will enable or constrain decision making? The existentialist hypothesis, which is based on the idea that free will is a source of suffering and doubt, would assert that being more indecisive is a decision-making barrier. The evolutionary hypothesis, which is founded on the idea that free will is a key component of social effectiveness, would, on the other hand, anticipate that free will helps decision-making by decreasing indecision. The evolutionary hypothesis is supported by the findings of five research papers that used diverse operationalizations of free will beliefs (measured and modified), multiple decision tasks, and various measures of indecisiveness (trait and condition). Lower indecision is consistently correlated with belief in free will. One restriction on this impact is that only those with a high level of self-concept clarity are affected.

Konrath et al. (2010) describe that the Interpersonal Reactivity Index (IRI) has four subscales: Empathic Concern, Perspective Taking, Fantasy, and Personal Distress. A cross-temporal meta-analysis of 72 samples of American college students who completed at least

one of these subscales between 1979 and 2009 (total N = 13,737) was done. Overall, the authors discovered decreases in the IRI's most characteristic empathic subscales: Perspective Taking and Empathic Concern both experienced severe declines. There were no changes over time in the IRI Fantasy and Personal Distress subscales. Additional research revealed that the reductions in empathy and perspective taking are relatively recent occurrences that are particularly prominent in samples taken after 2000.

Nishi et al. (2018) describe that using data from the Comprehensive Survey of Living Conditions in Japan from 2007, 2010, 2013, and 2016 (Total N = 2,159,005, all survey years combined), this study assessed trends in severe and moderate psychological distress as well as the use of mental health services among individuals (18 years old). Compared to 2007, the number of people experiencing severe distress increased slightly in 2016 (4.01%-4.15%, p = 0.02), while the number of people experiencing moderate distress remained largely unchanged (24.61%-24.69%, p = 0.61). Both those in severe distress (11.95%-15.76%, p 0.01) and those in moderate distress (2.60%-3.56%, p 0.01) steadily used more mental health services throughout this decade.

Sawyer et al. (2018) based on the study - *"Has the Prevalence of Child and Adolescent Mental Disorders in Australia Changed Between 1998 and 2013 to 2014?"*assert that in order to successfully address the significant public health issue posed by child and adolescent mental disorders in the community, new innovations in research, policy, and practise are required. This is because the prevalence of child mental disorders has not changed at a population level over time. Patel et al. (2018) discuss that "No health without mental health," however a noble objective, has been replaced with the notion that "no sustainable development without mental health." Mental health has been shrouded in mystery for far too long. The information gained over the last 20 years and new international and national commitments established during that time have the ability to change this situation. According to this Commission, mental health has to be reframed in light of this information and potential. To protect mental health and prevent mental disorders, immediate action is needed in addition to extending resources to recognise, treat, and support recovery for those with mental disorders. This activity places mental health at

the centre of sustainable development for all individuals, in all societies and countries. To realise this vision, major and urgent investments are needed at the global, national, local, and in other development-related sectors. Most importantly, achieving the SDGs' goals for mental health would need a concerted effort from all parties concerned. Therefore, we support a partnership to improve global mental health that includes significant global, national, and subnational mental health stakeholders, as well as full engagement from people who have firsthand experience with mental illnesses. According to the Lancet Commissioners on Global Mental Health and Sustainable Development, quick action to fully implement our recommendations will be necessary to meet the SDGs' health and numerous other aims.

Jorm et al. (2017) delineate that in community surveys, many people who were found to have common mental problems do not receive treatment. Closing this "treatment gap," according to modelling, should make such problems less common in the general population. Data from 1990 to 2015 from four English-speaking nations—Australia, Canada, England, and the US—were examined to determine the benefits of closing the treatment gap in developed nations. The authors reported that the statistics demonstrate that despite significant advances in the availability of therapy, especially antidepressants, the prevalence of mood and anxiety disorders and their symptoms has not diminished. Additionally, there were other theories put forth to explain this lack of improvement. The idea that rising risk factors have obscured prevalence declines brought on by therapy was not supported. However, there was little evidence to support the claim that because more people are aware of or ready to reveal prevalent mental diseases, improvements have been covered up by increasing symptom reporting. The fact that much of the treatment being given falls short of the minimal requirements of clinical practise guidelines and is not being targeted optimally to those who are most in need is a more strongly supported explanation for the lack of progress. Jorm et al. (2017) argue that a contributing aspect can also be a lack of focus on the prevention of common mental diseases. Health systems around the world are still grappling with the problem of lowering the frequency of prevalent mental diseases, which may need paying closer attention to the "quality gap" and "prevention gap." Additionally, there is a need for governments to keep track of results over time using

defined metrics for service delivery and mental illnesses.

In the later half of the twentieth century, with Malik Badri as its pioneer, the interest in Islamic psychology began. But there has been a lack of unified theory and model for treatment. That gap was filled with a book by Abdallah Rothman – Developing A Model of Islamic Psychology and Psychotherapy: Islamic Theology and Contemporary Understandings of Psychology. The research in the book was based in grounded theory which took separate opinions from Islamic scholars until the saturation point. Then, Islamic spiritual masters (Sufis) and Islamic psychologists were interviewed in-depth which included practising and non practising Muslims as well as those who are well versed in Islam and its spirituality. Moreover, those who incorporate principles and some techniques of Islamic psychology in their modern practice of psychology. Out of that, Islamic model of the soul was carved out.

Rothman (2021) highlighted that Islamic psychologists from four continents had a concensus that guilt and shame is part of Muslim cultures and hence their clients from that background become more prone to anxiety and depression. The author described he experienced the difficulty in finding Islamic psychologists or Muslim psychologists who incorporate Islamic paradigm into the Western practise of psychology. Moreover, Islamic scholars were reluctant and at first thought that they possibly could have something to say in relation to psychology. Furthermore, the author found both from his personal experience and from the observation regarding the participants that people do not like to be recorded especially at the beginning so he conducted most of his interviews in person which meant traveling across countries.

Rothman (2021) described that the principles of positive psychology namely empathy, active listening and self acceptance correspond to the Islamic paradigm. The author stated that the research participants had a consensus that fitrah is pure and has a direct connection with God, it has an imprint of God on every human being. It becomes stale as it engages in the dunya according to the Islamic paradigm and hence a veil can appear. According to the author, Qalb (the heart) is the house of consciousness in the

Islamic paradigm as in other spiritual traditions such as Buddhism and Judaism.

Liester (2020) explained that it has been reported for decades that recipients of the heart transplant acquire the personality characteristics of their donors. That includes changed preferences, temperament, identity and even memories from the donor's life. Leister stated that it is hypothesized that it occurs due to the transfer of cellular memory which has four types, namely, epigenetic memory, DNA memory, RNA memory, and protein memory. The article further described that another possibility which transfers memory is due to intracardiac neurological memory and energetic memory.

Rothman (2021) describes that a Muslim psychologist can either approach psychotherapy from a religious Islamic perspective, using the beliefs, philosophy, and religious edicts to inform treatment goals, or they can use their identity as Muslims and their familiarity with Muslim customs and practises to essentially offer perhaps more in-depth culturally sensitive therapy than a non-Muslim could. It is argued by the author that large number of Muslim mental health professionals adopt the former strategy, despite the latter attracting more and more interest and attention. Rothman (2021) argues that the teaching and practise of psychology in the academic and scientific world is founded on a materialist worldview that prioritises objectivity and has a neutral — some could even say atheist — approach toward religion and other types of human transcendence experience. Furthermore, the cultural phenomena that are founded on these notions make them accessible to multiple perspectives despite the fact that the bulk of Western psychology has established these standards from a single position. Lastly, speaking with colleagues who utilise similar strategies, such as existential psychotherapists who will challenge and apply alternatives to conventional diagnostic categories, may be quite instructive for Muslim therapists.

Schneider and Krug (2010) assert that practitioners of Existential-Humanistic (E-H) therapy use a number of techniques. Moreover, the strategies, however, are not tactics in the traditional sense; rather, they are positions or circumstances that might lead to deep change and experienced release. Lastly, the development of therapeutic presence, the

development and activation of therapeutic presence through struggle, the experience of resistance to therapeutic struggle, and the merging of the meaning, intentionality, and life awakening that can result from the struggle are some of the core intertwining and overlapping E-H stances.

Keshavarzi et al. (2020) consider therapeutic rapport and presence of the therapist as quite important for the healing process within the TIIP framework which is parallel with E-H perspective. Schneider and Krug (2010) mention that the development of intra- and interpersonal presence is at the heart of E-H transformation processes. Firstly, without presence, there may be an improvement in cognition, behaviour, or physiology, but not always in the feeling of autonomy or personal commitment that core transformation demands. Secondly, E-H treatment emphasises presence to what really matters, both inside the self and between the self and the therapist, to put it another way. Thirdly, and lastly, there are four fundamental purposes for presence cultivation: It brings people's grief back into focus (e.g., blocks, fears, anxieties). 2. It encourages the feeling of agency and responsibility-taking. 3. It makes individuals aware of the possibilities for transforming or overcoming that suffering. 4. It creates a close-knit therapeutic bond, which fosters development and transformation on its own.

Rothman (2021) elaborates that when Muslim psychologists attempt to assist their Muslim community from inside their academic and professional specialty, they often disregard the idea of an underlying paradigm. The discipline of psychology in the West undoubtedly has a lot to offer in terms of therapeutic approaches, cognitive developments, and behavioural research. The impulses, reasons, and even therapeutic goals can be very different, if not at odds with one another, if the underlying perspective is based on a worldview hostile to and devoid of the concept of God. Rothman (2021) laments that among Muslims like an anthropologist who does not sincerely embrace the strange practises and foreign beliefs of the locals because they are outside of their Western paradigm has a frequent inclination to approach efforts to explain psychology in the setting of Islam from the outside in. Similar to this, some researchers use a perspective referred to as social constructionism to analyse Muslim psychology, and in doing so, they omit a lot of

data that would be useful in comprehending their subjects. The social constructionist method to studying religious phenomena has drawn criticism for failing to adequately take into account people's religious experiences. It is necessary to develop more suitable methods of investigation that permit evaluation of fundamental motives from inside the Islamic theological worldview.

Rothman (2021) asserts that many viewpoints might be held on the study of psychology, or the nature of the inner experience of the human individual, based on the cosmological, existential, or just epistemological framework from which people are seen. There are several answers for why, how, and even whether humanity is what a certain theory states, therefore one cannot claim that their theory is objective and simply depicts human beings "as they are" in their present form. The author discusses that the bulk of the prevailing theories in psychology up to this point have been Western paradigmatic notions. Moreover, it may be prudent to accept a range of viewpoints on human psychology related to a particular paradigm of the human condition in a period when societies are made up of tremendously varied groups of individuals with widely differing paradigmatic perspectives. Furthermore, from an Islamic viewpoint, as with other spiritual traditions, the diagnosis and treatment of mental illness using just bodily and cognitive representations of the self without taking the soul into account is harmful and possibly destructive. According to the author, this viewpoint maintains that, in addition to biological and cognitive factors, there are other possible causes and experiences that are important components of the development process and should not be disregarded.

Rothman (2021) describes that the majority view in Islamic thought regards the body and soul as being connected and is based on a distinctively Islamic worldview drawn from the Qur'an. As a result, rather than being entirely distinct from the soul, the body is seen as a way of cleansing it (Al-Attas, 2001). The works of Iranian Shi'a philosopher Mulla Sadra, who lived in the 16th and 17th centuries, may serve as the best example of this particular Islamic solution to the "mind-body problem," which, despite some parallels to the Aristotelian paradigm, takes a different stance in this protracted philosophical debate (Rahman, 1975). According to Rothman (2021), Sadra did not see the body as being

manifestly distinct from the spirit, but rather as nothing more than the soul in its densest form. Moreover, when the soul debuts on earth and takes on a bodily form, its life is at its most vulnerable. The soul gradually begins to show itself over time, and at earthly death it eventually sheds the body (Kamal, 2016)

Ibn Sina, often known as Avicenna, was an early Muslim philosopher who is said to have contributed to a philosophical debate with his "floating man" experiment, according to Rothman (2021). Ibn Sina argued that there is no logical relationship between the soul and the body since a person would still be aware of themselves when dangling in the air without any physical sense perception of their body's limbs (Avicenna, 1952, 1959, 1975; Druart, 2000; Marmura, 1986). This viewpoint adheres to the Aristotelian paradigm and represents the materialist assertion of quiddity's primacy over existence (Druart, 2000). However, Ibn Sina's viewpoint on this does not represent the majority of historical Islamic thinkers, since some academics chose viewpoints that they felt were more closely in line with Qur'anic principles (Al-Attas, 2001).

"You would tread the same path as was trodden by those before you inch by inch and step by step so much so that if they had entered into the hole of the lizard, you would follow them in this also," Badri said in reference to the psychological state of Muslims, particularly at the time in the Arabic-speaking Muslim world, according to Rothman (2021). (Sahih Muslim 2669 a: Hadith 7 in Book 47.) In response to this "dilemma of Muslim psychologists," Badri is cited by Rothman (2021), who urges caution rather than a categorical rejection of psychology as a discipline. To do so, in his opinion, would be the same as tossing away the baby with the bathwater or mixing fine pearls with a bunch of trash. Any Muslim community would be deprived of access to a wealth of knowledge just because they are "Western" or "non-Muslim."
He lists all the benefits that Western psychology has provided, including psychometric testing, behavioural research, training, and several other important bodies of knowledge.

According to Haque (2008), according to Rothman (2021), "if a suitable viewpoint and notion of human nature is absent, any effort to describe human personality will be

faulty, imprecise, and sometimes deceptive. The assumptions and premises that form the basis of a hypothesis determine how valid it is (p. xvi). Mohamed (2008) begins the debate on how to create an Islamic personality theory by focusing on the Islamic idea of firah, or human essence. The Qur'an refers to God as the fair or as the creator of the heavens and the earth. The Arabic term firah, which is variously translated as "human nature," "primordial nature," or "innate predisposition," really means to burst out or arise (Murata & Chittick, 1998).

Rothman (2021) delineates that although there has not been much research on how different religions view the ego or "person," it seems that Buddhism has drawn more interest than Islam. Buddhism offers beliefs about the self and human nature that, in many ways, go counter to the traditional method of analysing personality. The author states that according to Padmasiri De Silva's description of the Buddhist view of the self in his book An Introduction to Buddhist Psychology, "the dynamic continuum is not bound to one life span but is impacted by multiple preceding lifetimes." In addition to the problem of recognising the holy or spiritual, western models do not properly match this paradigm since notions about the self are totally built on concepts that are not those of Judeo-Christian philosophy such as the subconscious mind, which still retains memories of childhood and a past existence, as well as the conscious mind. The idea that Buddhism has a fundamentally different perspective on understanding the nature of the human being is analogous to the belief that the Islamic worldview warrants its own unique framework of the self that is based on a religious philosophical paradigm. The author describes that four-term definition of the self is the framework that occurs the most often in the literature on Islamic psychology.

Al-Ghazali (2014) sometimes did not divide the spirit from the heart since it is the essence of the person that God breathed into the human being, according to Rothman (2021). Ruh is connected to its Semitic language cousin, ruach in Hebrew (Q 15:29). The "monarch" or central command hub of the other linked components, the qalb, is the heart of the system (Al-Ghazali, 2014). Al-Ghazali claims that a person's heart is the key characteristic that distinguishes them from other animals and defines their relationship with

God and the core of what it is to be a human (Ali, 1995; Bakhtiar, 2008). The heart plays a key role in the Islamic notion of the self or soul since it is believed to be the seat of human awareness and is closely linked to concepts about human nature from an Islamic viewpoint (Haque, 2008).

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According to Rothman (2021), Mohamed (2008) continues to impart ideas and conceptions of the Islamic viewpoint on human nature straight from prominent Muslim philosophers of the past, much as he did in his 1996 book Firah: The Islamic Concept of Human Nature. Mohamed (2008) asserts that the concept of tawhid, or the unity of God, serves as the foundation for the firah's religious component. According to this academic viewpoint, everyone is capable of seeing this unity because it is inscribed on every person's soul and because the firah is regarded to represent the condition of humanity when it is free from sin and separated from God. These facts led these religious authorities to the conclusion that humans naturally gravitate toward God and His unity, which makes it simpler for them to recognise God and place their faith in Him. People are encouraged to work hard and eventually turn back to God and their true selves by the prophets and religion, which serve to remind them of God's unity and their fi'rah (Al-Attas, 2001; Mohamed 1996, 2009).

Ibn Khaldun quotes the following two passages from the Qur'an (Mohamed, 2008) to demonstrate the idea that human nature is dual: "And directed him on the two paths [of good and evil] (Q. 90:10)" and "And the soul and that which fashioned it. And it was infused with both lasciviousness and a knowledge of Allah.. The one who purifies it is successful. The person who bury it [in sins] fails (Q. 91-7-10). Therefore, Ibn Khaldun maintains that the human being exists in a state of fluctuating tension between two opposing forces within his or her nature, namely one that is oriented towards animalistic urges and potentially sin, or covering over (kafara) the truth of its nature, and one that is oriented towards purity and a God-like state. This idea has parallels in both Christianity and some sufi-influenced elements of Western psychology (Richards, 2009). The more pristine, godlike nature is to completely embody the primordial stage of human nature as the

animalistic part of people is solely tied to their worldly manifestation in this life (Al-Attas, 2001; Dhaoudi, 2008; Mohamed, 2008).

Rothman (2021) reports that Al-Ghazali distinguished three levels of the nafs: nafs al-ammrah bi-l-su, nafs al-lawmmah, and nafs al-mumainnah, based on received wisdom and scholarly interpretation of the Qur'an (Al-Ghazali, 2014; As-Shadhuli, 1994). In the Qur'an (12:53), the term "nafs al-ammrah bi-l-su" refers to a stage of development wherein the self "exhorts one to freely engage in pleasing impulses and instigates to commit evil" (Haque, 1998, p. 367). (Haque, 1998; Haque & Keshavarzi, 2014; As-Shadhuli, 1994) The nafs al-lawammah (Q 75:2) is described in the Qur'an as a "higher" level of awareness that seeks to make right judgments and directs one in that direction. The nafs al-mutma'innah (Q 89:27) refers to an even higher condition of being when one is securely rooted in what is right and moral, no longer inclined toward evil, and has attained the highest degree of tranquilly (As-Shadhuli, 1994; Haque, 1998; Haque & Keshavarzi, 2014). However, because the process of self-actualization and personality development is continuing and the soul is ever-evolving, the third stage does not imply that the person has gained perfection (Hamid, 2008). Rothman (2021) describes that these three stages of spiritual development are the most frequently stated and serve as the foundation of an Islamic psychological paradigm, despite the fact that many Sufi literature discuss more than three phases of the soul, occasionally five or seven (As-Shadhuli, 1994). (Haque, 1998). According to Islamic tradition, a person may attain the perfection of The Universal Man (al-Insan al-Kamil), also known as the Perfect Man, which is a manifestation of the divine light, also known as the "Light of Muhammad (nur-al-Muhammad)" at the pinnacle of his or her realisation of firah, or primordial nature (Mohamed, 2008; Nasr, 1991; Nicholson, 1984; Schimmel, 2011).

Murata and Chittick, who are cited by Rothman (2021), claim that the Sufis "attempted to bring about perfect practise and faith by fostering the inner characteristics signified, but not necessarily actualized, through right conduct and good thought" (1998). These interior attitudes and character traits, according to the Sufis, set the Prophet's personality apart. (p. 246). Ibn Abbas asserts that the Arabic word for "human" in the Qur'an (Q 20: 115), "insan," is derived from the word "nasiya" (to forget), and that this is

because the human is in a state of forgetfulness because he or she once knew their true nature in the pre-existence but forgot it once they entered this material world (dunya). It is further explained that this is because the human is in a state of forget (Al-Attas, 2001; Haque, 1998). As a result, forgetting is what causes people to wander from their firah state, and Islam's approach is to recall people for who they truly are (Al-Attas, 2001).

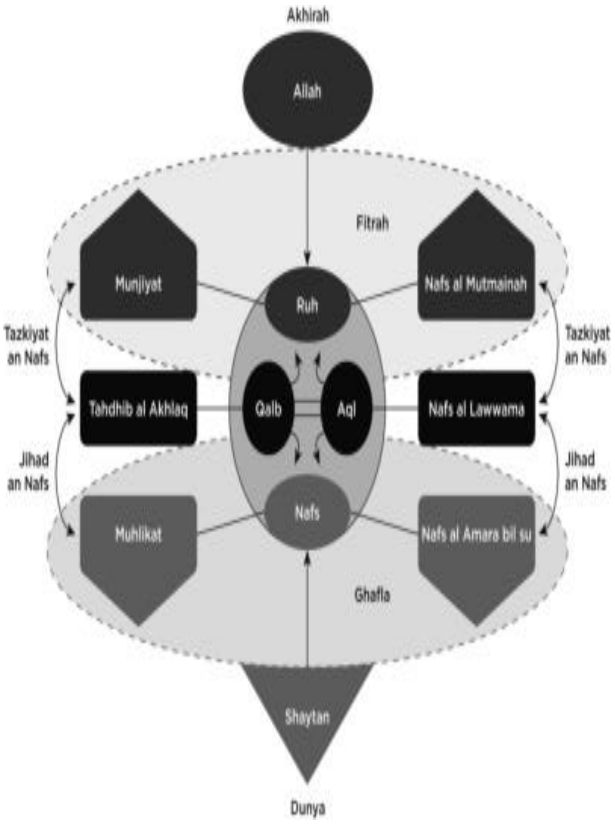
Rothman (2021) postulates that a constructivist or interpretive ontology and epistemology may appear to be at odds with the Islamic paradigm from a distance. However, constructivist approaches to social phenomena can unquestionably be said to have elements in the lived reality of Islam, which is thought to be embodied in the life of the Prophet Muhammad and extended through the scholarly tradition of the Muslim ummah (global community), as Muslims seek to understand how to apply religious tenets to daily life.

2.2 Theoretical Framework

TIIP is an integrative psychotherapy. It considers three sources of information as valid, namely, empirical, rational and revelatory. It is a holistic model and considers health on a spectrum. It taps into five dimension of human personality - aql (intellect); ihsas (emotions); nafs (behavioral inclinations); ijtimai (social); and ruh (spirit) and it believes all of these aspects have an impact on the metaphysical heart. Wisdom is the lost property of the believer, thus wherever he finds it, he is most entitled to it, according to the prophetic maxims (al-Tirmidhi, 1970, 2687; Ibn Mjah, 2007, 4169), according to Keshavarzi et al. (2020). The authors argue that awareness of how TIIP approaches modern secular psychologies requires an understanding of this prophetic heritage. The authors report that they consider TIIP as a movement that anybody can join as it is still a theoretical orientation to psychotherapy that is still developing, changing, and growing. Furthermore, the combined effort to contribute to this area of study will increase the scientific and clinical rigour of TIIP.

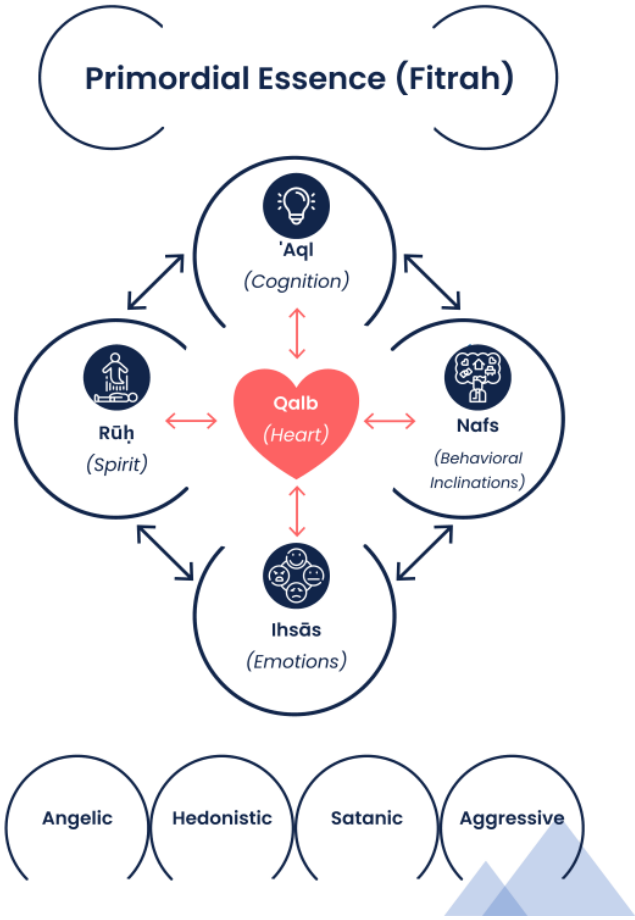
2.2.1 *An Islamic Model of the Soul (Rothman, 2021)*

Rothman (2021) reports that Al-Ghazali distinguished three levels of the nafs: nafs al-ammrah bi-l-su, nafs al-lawmmah, and nafs al-mumainnah, based on received wisdom and scholarly interpretation of the Qur'an (Al-Ghazali, 2014; As-Shadhuli, 1994). In the Qur'an (12:53), the term "nafs al-ammrah bi-l-su" refers to a stage of development wherein the self "exhorts one to freely engage in pleasing impulses and instigates to commit evil" (Haque, 1998, p. 367). (Haque, 1998; Haque & Keshavarzi, 2014; As-Shadhuli, 1994) The nafs al-lawammah (Q 75:2) is described in the Qur'an as a "higher" level of awareness that seeks to make right judgments and directs one in that direction. The nafs al-mutma'innah (Q 89:27) refers to an even higher condition of being when one is securely rooted in what is right and moral, no longer inclined toward evil, and has attained the highest degree of tranquilly (As-Shadhuli, 1994; Haque, 1998; Haque & Keshavarzi, 2014). However, because the process of self-actualization and personality development is continuing and the soul is ever-evolving, the third stage does not imply that the person has gained perfection (Hamid, 2008). Rothman (2021) describes that these three stages of spiritual development are the most frequently stated and serve as the foundation of an Islamic psychological paradigm, despite the fact that many Sufi literature discuss more than three phases of the soul, occasionally five or seven (As-Shadhuli, 1994). (Haque, 1998). According to Islamic tradition, a person may attain the perfection of The Universal Man (al-Insan al-Kamil), also known as the Perfect Man, which is a manifestation of the divine light, also known as the "Light of Muhammad (nur-al-Muhammad)" at the pinnacle of his or her realisation of firah, or primordial nature (Mohamed, 2008; Nasr, 1991; Nicholson, 1984; Schimmel, 2011).



2.2.2 *Traditional Islamically Integrated Psychotherapy (TIIP)*

Keshavarzi et al. (2020) describe that in TIIP, Aql does the intellectual processing; ruh is the divine nature within the human being; nafs or self is dynamic with three stages; and the state of the soul has an impact and the state of the therapist matters. Munjiyat (virtues) are emphasized and utilized at first for the client to be more accepting of themselves, only then muhlikat (vices) are given heed. Inner work is necessary. Tahdhīb al-akhlāq (Reformation of Character) is part of the intellectual landscape of TIIP. Four virtues – wisdom, temperance, justice, courage are related. Rothman (2021) described that there are three main stages of nafs through which a human being fluctuates namely, Nafs alammārah bil su (soul that commands to evil), Nafs al-lawwāmah (self-reproaching soul), and Nafs al-muṭmaʾinnah (soul at rest). During the therapy process, usually, only the first two stages are engaged and most humans struggle with these two stages – the self-critical soul and the one who orders evil.



2.2.3 *Biopsychosocial model*

Ruffalo (2021) describes that biopsychosocial model has also been called George Engel's pluralistic model of mental disorder. As of 2021, it is the main theoretical model used in the US. According to this model, mental illness and medical illness is the outcome of dynamic interaction between physiological, psychological and social factors in human life. Take the case of depression, a person may have a genetic predisposition that will be compounded by maladaptive core beliefs and resultant behaviors. In addition, family and social support apart from socio-economic standing of the person will also matter to predispose a person to depression. Culture, fashion, and current trends also play their part in the mental health of the person. Available evidence also suggests that a combination of pharmacological treatment and psychotherapy yields the best results which is in line with the paradigm of biopsychosocial model.

2.2.4 *Prochaska model*

Glordano (2021) reports that The Transtheoretical Model (TTM) is also known as the Stages of Change Model. According to this model, there are five stages of the change process namely, pre-contemplation, contemplation, preparation, action, and maintenance. Needs of the person vary in different stages. Going back and forth between stages is common. It asserts change is not an event, but a process which takes time. By understanding the process of change, and the patience and effort required in it, we can be more kind to ourselves and others. It is based on the research conducted by Prochaska and DiClemente in the 1980s which showed that those who successfully transitioned into former smokers went through a number of stages over time. To know, there are stages prior to the action is an important finding of the model. The time in the change process varies from person to person.

In the first stage of precontemplation, a person is unaware of the need for change and does not intend to make any change in the next six months. At the second stage, a person realises the need to change but is in doubt whether the change is worth it or not. At this stage, an individual may consider making a change in the next six months, but is not ready for action. The third stage is that of preparation in which an individual commits to change and is all set to take action within the thirty days. At the fourth stage, action is taken which is intrinsically motivated by the individual, the undesirable behavior is modified. This stage can last for six months as it takes time to solidify action based on behavioral modification. The final stage is maintenance which continues indefinitely. The individual is focused to prevent relapse and to make the behavioral change integral part of their life. Despite varied life circumstances over time, people learn and continue to maintain the behavior change.

2.2.5 *Feelings-as-Information Theory*

Lange et al. (2012) report that the idea of feelings as information describes how

subjective experiences, such as moods, emotions, metacognitive experiences, and physical sensations, affect judgement. Moreover, it makes the assumption that people utilise their emotions as an information source with various emotions offering various kinds of knowledge. In addition, sensations brought on by the object of assessment, however, offer accurate information, whilst feelings brought on by an unrelated influence can mislead us. The authors describe that the same rules apply when using feelings as a source of information as when using any other type of information. Furthermore, most importantly, when they (correctly or mistakenly) ascribe their feelings to another source, people do not rely on them, diminishing their informational value for the task at hand. It is argued by the authors that inferences from sensations are contextually sensitive and changeable since they depend on the epistemic question that they are used to answer. Lastly, feelings provide us with information about the nature of our current circumstance in addition to serving as a basis for judgement, and our mental processes are adjusted to suit the demands of the scenario.

2.2.6 *Need-to-Belong Theory*

Lange et al. (2012) refer to Roy F. Baumeister and report that one of the most potent, common, and significant human impulses is the need to establish and maintain at least a minimal number of social ties. The authors describe that it influences how we feel, think, and act. Additionally, it makes clear that one's sense of self-worth is an internal sign of how likely they are to make good relationships. Additionally, different methods of satisfying the need to belong may explain gender differences in personality and roles and even reinterpret the history of gender politics if it is assumed that women prioritise close, intimate relationships while men are more interested in larger networks of weaker ties. The authors point out that research on rejection have shown that suppressing the urge to belong has significant and oftentimes puzzling repercussions, such as an increase in violent and destructive behaviour and a reduction in collaboration, helpfulness, self-control, and logical thinking. It is reported by the authors that studies on emotional numbness caused by lab rejection have raised questions about the fundamental purposes of emotion and how emotion influences behaviour. Lange et al. (2012) mention that culture, the highest form of

human accomplishment and the manifestation of social life, requires a sense of belonging. Lastly, it is described that this observation provides a strong foundation for understanding human nature and several uniquely human characteristics.

CHAPTER 3

RESEARCH METHODOLOGY

3.1 Research Epistemology

The present research is primary as the data has been collected first hand and then has been analyzed using both qualitative and quantitative methods of research - mixed method research.

3.2 Research Design

This research approach is based on small-N designs - single-case experiments. Barker et al. (2016) describe that a potentially interesting technique to combine science with practice is through small-N designs, such as systematic case studies and single-case experiments, which allow therapists to incorporate formal research methods into their daily work (Hayes et al., 1999; Kazdin, 2011). Moreover, from the perspective of the practitioner, small-N research has several benefits, including the fact that it is typically affordable, does not take up a lot of time, and—most importantly—that its underlying philosophy is frequently agreeable to practitioners because it takes into account individual uniqueness and complexity. Graham (2012) describes that ten or fewer participants are typically the focus of small-N designs, whose behaviour (outcomes) are routinely assessed and contrasted over time. *"It is more useful to study one animal for 1000 hours than to study 1000 animals for one hour"* — B. F. Skinner (quoted in Kerlinger and Lee (1999))

Smith and Little (2018) argue that the collection of larger participant samples is one suggestion for resolving the replication dilemma. The authors contend that this suggestion overlooks a crucial point, namely that improving sample size will not make up for psychology's deficiencies in robust measurement, robust theories and models, and robust experimental control over error variance. In contrast, there is a long history of

psychological research that tackles each of these shortcomings which uses small-N designs that consider the individual participant as the replication unit, and yields results that are reliable and simple to duplicate. From the perspective of inference, the approach of fitting models at the level of each participant has one particularly significant repercussion: the individual is now the replication unit rather than the group (Smith & Little, 2018). As a result, a small-N design that reports measurements and model fits for, let's say, three, six, or ten participants is actually presenting data from three, six, or ten independent replications of the experiment (Smith & Little, 2018).

3.3 Research Approach

This study aimed to see the efficacy of TIIP in group therapy setting for Pakistani youth at a university. It aimed to examine any difference at the start and end which were monitored at intervals during the process. For that, a survey (BSI) and clinical interviews based in phenomenology were conducted. Adawi (2018) describes that Derogatis created the Brief Symptom Inventory (BSI) in 1975, which is a crucial standardized screening tool for evaluating mental diseases and psychological distress quantitatively. Neubauer (2019) describes that phenomenology is ideally situated to assist researchers in health professions education (HPE) in learning from the experiences of others as a research tool. The author asserts that the study of a person's actual experiences in the world is the main goal of the qualitative research method known as phenomenology. Even though it is a potent investigative strategy, HPE researchers frequently find this methodology scary due to its nature.

3.4 Research Strategy

This mixed method research adopts survey method (Brief Symptom Inventory - BSI) and clinical interviews as a means of data collection and treatment. Allen and Becker (2019) describe that in a special kind of interviewing known as a clinical interview, a

clinician and a client converse verbally and nonverbally face-to-face with the aim of acquiring data essential for the client's diagnosis and treatment.

3.5 Population and Sampling

A sample of 8 participants, 2 males and 6 females were recruited from the Bahria University, Islamabad from two departments - department of professional psychology and department of humanities and social sciences. Eight (8) participants were recruited to account for the attrition rate. Participants ranging from three to fifteen are acceptable for group study and therapy.

Random sampling was employed. Brown (2010) delineates that simple random sampling is a technique for choosing a sample size, n, such that each of the N has an equal chance of being chosen from the population of N elements.

3.5.1 *Inclusion Criteria*

As per the Erik Erikson age ranges, young adults within the age range of eighteen to thirty-five (18-35) were included. Only those participants who manifested depressive symptoms were included. Only Bahria university students were included in the study.

3.6 Procedure

Initially a Google form was created for DASS-21 for screening the research participants. There are 14 departments and an even greater number of programs hence in person collection was not possible due to time and resource constraints for the researcher. Scoring of DASS-21 for depression subscales includes; normal = 0-9, mild=10-12, Moderate =13-20, Severe =21-27, Extremely severe= 28-42**.** For Anxiety**,** Normal range= 0-6, Mild = 7-9, Moderate = 10-14, Severe =15-19, Extremely severe= 20-42. Stress scores ranging from Normal = 0-10, Mild = 11-18, Moderate = 19-26, Severe = 27-34 and Extremely Severe=35-42. One hundred and six (106) responses were received. Those

respondents who showed at least mild symptoms of anxiety, stress and depression were contacted. A short meeting was done with the interested respondents which debriefed them about the research. Those who showed further initiative and interest to be research participants were told about the consent form which was verbally explained to them; any query asked was answered and were given the paper to give their consent or lack thereof. Those respondents who did sign the consent form were given time to come for a detailed session in which demographic details and history was taken. Random sampling was employed for that purpose.

The selected research participants have had some commonalities. For group psychotherapy, they were further divided into two groups (control and experimental) using simple random sampling - into even and odd groups. Brown (2010) delineates that simple random sampling is a technique for choosing a sample size, n, such that each of the N has an equal chance of being chosen from the population of N elements. R1, R3 and R5 were included in the experimental group and R2, R4, and R6 were included in the control group. This data was collected from the Bahria University students based on random sampling. The participants were sought from young adults (18-35) at Bahria University.

For group therapy, trust, motivation, expectations and attitude were kept in view. To monitor progress, at intervals, the research participants were given a Brief Symptom Inventory (BSI) which is a briefer version of Symptoms Checklist-90 (SCL-90) which taps into nine dimensions: Somatization; Obsession-Compulsion; Interpersonal Sensitivity; Depression; Anxiety; Hostility; Phobic anxiety; Paranoid ideation; and Psychoticism.

3.6.1 *Trauma Conceptualization and Treatment Focus*

Keshavarzi and Khan (2020) describe that TIIP paradigm conceptualises by using ontological components of spirit, behavioural tendencies, cognitive abilities, and emotions in humans. All of the aforementioned are impacted by a trauma event for an individual. The spirit is negatively impacted by most traumas since they are in direct opposition with our fundamentally good nature and are unnatural and immoral (e.g., someone being killed,

sexual abuse of a child). Traumas typically involve intense circumstances that happen quickly and unexpectedly. Without sufficient cognitive training through resilience, a person may struggle to make sense of their environment and may start to think incorrectly. These ideas could cause underlying emotions to worsen and secondary emotions to emerge, along with spiritual incongruence (sadness turning into anger, development of shame or anger, etc). Numerous things can occur if the nafs is not in accordance with divine decision. Nafs uses inclinations in behaviour to take action. Negative thoughts and feelings aimed towards oneself may cause self-harming behaviours, avoidance of talking about and dealing with the trauma, and dysfunctional interpersonal connections.

3.6.2 *Existential-Humanistic and Phenomenology*

Schneider and Krug (2010) postulated that Tom Greening (1992) elaborated on Yalom's theory by seeing the givens as existential aspects or dialectics (e.g., life and death, freedom and determinism, meaning and absurdity, relatedness and separateness). As paradoxical dialectics, Greening argued, each challenge forces us to respond. We do so in one of three ways: (a) through a simplistic overemphasis on the positive aspects, (b) through a simplistic overemphasis on the negative aspects, or (c) through a confrontation, creative response, and transcendence of the dialectic. According to Greening, the ability to accept and react creatively to all four existential dialectics is a sign of psychological health or maturity from an existential standpoint.

van Deurzen and Arnold-Baker (2019) assert that phenomenology is not just a technique to rival with statistical analysis. It is a way of life and you cannot practice it unless you under- stand its spirit and adopt its philosophy. Practising phenomenology teaches you to sharpen your capacity for observation and self-observation. It demands that you immerse yourself in your sensory experience and become reflective about your affective life. We have to learn to master the way in which we experience and perceive the world and our own consciousness more and more clearly.

3.7 Research Ethics

The research topic and all its ingredients were approved by the HEC approved university which fulfills the ethical obligations to proceed with the research in addition to the approval from the departmental ethics committee.

3.7.1 *Informed Consent*

Research participants were briefed about the research. Subsequently, the study subjects were contacted for their informed permission. The participants were brief about the time it may take to complete the process; their commitment to the process if they agree to participate, at the same time, their freedom to leave if they want to; the protection and confidentiality of their data and information which will be ultimately destroyed, in both forms, soft and hard; the need to audio record; pros and cons of their participation; lack of any monetary benefit; their investment of time and energy and no assurance of results - it can be either - benefit or no benefit while the potential harm being no benefit despite investment of time and energy; their autonomy and freedom to weight the benefits and outweighing costs and then make a decision. Any question any participant asked was answered. At the signing of informed consent, they were asked again if they have any query or doubt or concern which needs to be addressed.

3.7.2 *Principles for Research Ethics*

The ethical principles of carrying out research have been observed - only professional relationship with the research participants within the bounds of professional boundaries; following of informed consent rules; and respect for and protection of confidentiality and privacy; discussion with the principal and co-supervisor; and due diligence related to the research process.

CHAPTER 4

RESULTS

The purpose of the study was to test the efficacy of TIIP for the young adults with depressive symptoms in a Pakistani university setting and the impact of an intervention on their overall well-being. BSI was used to monitor the progress of the research participants. Group therapy based in TIIP coupled with phenomenology was used to heal the depressive symptoms of the research participants. The study examined how TIIP in group therapy setting can be applied and whether it entails efficacy for the population under research, if so, how that improves overall wellbeing.

Common Complaints Among Respondents (Both Groups):
Anger, sadness, interpersonal issues, low self-esteem, lack of direction and emotional regulation, body image issues, trouble with attention and concentration.

Homogeneous Presenting Complaints of EG (That one apply intervention on): An Example

Experimental Group	**Control Group**
Anger, sadness, interpersonal issues, low self-esteem, lack of direction and goals, emotional dysregulation, body image issues, trouble with attention and concentration	Bullying by peers, perfectionism, existential crisis, fear and paranoia, problems in social interaction etc

Table 1

Socio-demographic Characteristics of sample (N= 07)

Characteristics	Categories	*f*	%	*M*	*SD*
Age	18-24 years	7	100.0	20.86	2.193
Gender	Male	2	28.6		
	Female	5	71.4		
Birth order	First	2	28.6		
	Second	4	57.1		
	Last	1	14.3		
Program	BS	6	85.7		
	MS	1	14.3		
Marital status	Single	7	100		
Occupation	Student	7	100		
Area	Urban	4	57.1		
	Rural	3	42.9		
Ethnicity	Urdu speaking	2	28.6		
	Pashtun	4	57.1		
	Punjabi	1	14.3		
Languages	Urdu	2	28.6		

	Pashto	4	57.1
	Punjabi	1	14.3

Table 2

Research participant's depression, anxiety and stress scores after screening

Research Participant	DASS-21 Score
R1	102
R2	80
R3	84
R4	70
R5	100
R6	64
R7	80

Table 3

Brief Symptom Inventory Scores at Intervals

Research Participant	BSI Scores
R1	1st BSI: 128/53= 2.41 2nd BSI: 191/53= 3.60 3rd BSI: 82/53 = 1.54 4th BSI: 59/53 = 1.11 (clinically non-significant)
R2	1st BSI: 103/53= 1.94
R3	1st BSI: 139/53= 2.62 2nd BSI: 136/53= 2.56 3rd BSI: 102/53= 1.92
R4	1st BSI: 103/53= 1.94 2nd BSI: 94/53= 1.77 3rd BSI: 80/53= 1.50
R5	1st BSI: 138/53= 2.60 2nd BSI: 120/53= 2.26 3rd BSI: 153/53= 2.88 4th BSI: 36/53= 0.67 (clinically non-significant)
R7	1st BSI: 79/53= 1.49 2nd BSI: 34/53= 0.64 (clinically non-significant) 3rd BSI: 15/53= 0.28 (clinically non-significant)

Table 4

Clinical Observations based in Phenomenology and Existentialism

Clinical Observations	Clinical Interview and Explanation
Loneliness	Want for nurturance, care and close relationships Lack of boundaries and trust Potent need to form relationships Hoping against hope the other loves; gullibility Rejection of others Self-effacement
Anxiety	Resistance to change Fear of change Nightmares related to fear Fearful for the safety for herself and the family Fearful to process emotions, experiences and thoughts
Isolation	Fear of Loss Fear of Isolation Fear of unwanted experience's repetition Feeling unsafe and unconnected
Freedom	Want for independence Urgency to gain independence Intensity for autonomy Absurdity or meaninglessness Prone to accidents Unconcerned about health in the presence of

	constrained environment
Responsibility and Angst	Confusion Independence vs care Individual goals vs concern for family
Nihilistic posture	Exaggerated reliance on reason Blind faith to escape reality
Vicious cycle (repeating parents' patterns)	Anger Smoking behavior Lack of boundaries Mistrust Arguing; verbal fights; not setting boundaries Passive rebellion against parents

CHAPTER 5

DISCUSSION

The purpose of this research was to evaluate TIIP's effectiveness vis-a-vis stress, anxiety and depression in a group psychotherapy setting. The likely reason for the results that have been shown shall be explored in the following lines. R1's initial score on BSI was high. Her history and pattern showed she got into four intimate relationships over a short period of time to make up for the love and nurturance that had been missing from her parents. The strained, argumentative, and maladaptive fighting pattern of her parents made R1 distressed. Her possible child abuse further exacerbated her issues. Due to all that, R1 developed maladaptive schemes and behavioral patterns which resulted in interpersonal and other troubles in her. Trauma results in normal disruption of normal cognitive, spiritual, physical, emotional and behavioral inclinations (Keshaverzi and Khan, 2020).

R1 showed impulsivity and low distress tolerance. By using 6Ms i.e. musharatah – goal settings, muraqasha-self monitoring, muhasabah-self evaluation, muaqabah-consequences, muatabah-self reprimand, mujahadah-exertion, her discipline and routine improved, and as a result her academic performance as well efficiency of performing academic tasks improved; R3 and R5 reported the same. However, R1 showed insight about her issues and her awareness of how that connects to her parents, and life patterns. R1 did not see any boundaries in her family and she herself showed a complete lack of boundaries. The sudden rise in BSI score was due to traumatic incident involving sexual assault in which her slight consent was involved (4/10 as reported by R1). Nonetheless, it caused physical, emotional, personal and social disruption. Keshaverzi et al. (2021) in their book gave practical examples of the use and application of TIIP. Furthermore, a case study was presented of a 16 year old client with South Asian and stricit religious Muslim parents' background who has had symptoms of anxiety and depression, who was also a Hafiz yet had become an atheist. The book presented the successful utilization of TIIP with the former. That case study as a model was employed with R1, R3 and R5.

Cognition, behavioral inclination, emotions, spirit and social aspects within the domain of TIIP were tapped into. R1 took regular individual and group therapy sessions and connected to her spiritual side as well as the family which was previously missing in her life. Participating in both group therapy and individual psychotherapy is beneficial for many individuals (APA, 2019). Your chances of achieving significant, long-lasting improvements may be increased by taking part in both forms of psychotherapy (APA, 2019). Subsequently, she started organising her things and room; engaged in physical activity; played with the child of her elder married sister; did journaling; processed emotions and feelings; accepted what has happened; intrinsically engaged in Islamic rituals and litany. Having vacations also likely contributed to her peace of mind as it allowed her to sit with herself.

R3 has loving parents and her life is smooth, however she has not gotten over the incident from the past few years when there was an attempted kidnap on her near her horse. Moreover, she showed anger issues for which she had a genetic predisposition. R3 admits to struggling with verbal and physical affection like her mother while she smokes like her father; smoking is her comforting behavior beside binge watching when looked at from the perspective of TIIP. Use of 6Ms improved her well being and academic performance. It also shows working on her behavior automatically improved cognitive and emotional well being. However, her improvement is not as significant unlike R1, one possible and solid reason for that seems to be that she has not been regular in individual and group psychotherapy sessions; she showed avoidance; her lack of adequate efforts to bring in change also showed lack of adequate motivation to change. Motivational interviewing showed she did not want to lose the benefit of the current state of affairs which must be lost in order to gain the benefit of the change. R3 did not show readiness to process what troubles her, it has only been in bits and pieces.

R4 has genetic predisposition towards anxiety and depression. It was triggered and exacerbated by an incident at the university. He made an inappropriate joke with a female classmate (asking her to sit on the bottle) which was spread to the class and he lost friends. R4 reflected that he did not respect and set boundaries and realized his mistake. R4 also had

unresolved grief from the death of father back in 2018. During the process, R4 also experienced the loss of his young adult elder brother to a drug overdose (his sibling had been in the rehab too few weeks before his death; he regularly used to it). The therapist, an only child, also lost his first cousin his own age (young adult) to lung cancer who was also a friend and kinda sibling. The therapist made use of appropriate self disclosure, unconditional positive regard, non judgement. R4 also made good use of individual and group psychotherapy sessions which is reflected in his results. R4 particularly appreciated and found the self disclosure helpful and healingful.

Existential-phenomenological awareness and interest in philosophy by both R4 and the therapist in addition to their connection also likely facilitated the healing process. From an existential-phenomenological standpoint, van Deurzen and Arnold-Baker (2019) report van Deurzen's clinical practice is that in order to find the person she is with and their emotional resonance and point of vulnerability, she looks for a connection with them. One, her observations usually start after she has calmed herself enough to concentrate on the other instead of on herself. Two, before she commences to talk, she attempts to detect their primary worry and try to comprehend their position and mode of existence. Three, her comprehension is initially shaped by her senses, then it is polished by her emotions and responses, and finally it is rectified and corrected by contemplation, as well as by her verbal exchanges (with the client) and the mental pictures she is creating and expressing.

Schneider and Krug (2010) mention the four givens of human life that Irvin Yalom (1980) identified are death, freedom, loneliness, and meaninglessness. Yalom highlighted that the design and quality of our lives depend on how we respond to these givens. When we face mortality, for instance, we also have to deal with the urgency, intensity, and seriousness that death inspires. We come into touch with and become conscious of our wants for relationship or its opposite, solitude, to the degree that we face isolation. The authors describe that according to Yalom, the nature of a person's existence is closely correlated with the kind and variety of their connection to their circumstances, as well as the priorities they set for integrating, exploring, or coexisting with those circumstances.

Schneider and Krug (2010) examine how difficult it is to answer to each of the givens: 1. Because we are conscious that we are alive and that we will die, life (and death) pushes us to act. An overemphasis on being alive, optimism, and death denial, as in death-defying endeavours, is one answer. Another reaction is to be negative, death-obsessed, prone to accidents, and unconcerned about one's health. The third option is to face the dialectic and live completely in the present while realising that, as Camus said, there is no future and that we must choose life even though we shall die. 2. We are challenged by meaning (and absurdity) because our potential for consciousness and meaning-making is constrained. One reaction is an exaggerated reliance on reason, intuition, or blind faith, as in the case of true believers who are dependent on cults, ideologies, or gurus. The outcome is a drive to action via drugs or death to escape awareness. Another reaction is an anti-intellectual or a militantly atheistic or nihilistic posture. Choosing and acting while staying open to revision is a third, more original response: facing the absurdity and, in spite of it, creating gratifying personal meanings. 3. We face problems from freedom (and determinism) because our freedom is limited. One answer is to declare unrestricted freedom, regardless of how it affects other people. Another reaction is the surrender of one's freedom, which may manifest as, for instance, drug misuse, codependency, and self-enslavement. Exploring options while keeping the social and physical environment in mind is a third and more inventive strategy. 4. Because we are social creatures who were created, born, and reared in connections, community (and aloneness) presents difficulties to us. We are distinct bodily and psychic beings at the same time. Denial of solitude, excessive organisation participation, unselfish service, and close connections are some responses. Another reaction to loneliness is resignation to it, or rejection of others, snobbery, or self-effacement to lessen the likelihood of rejection. The third and most innovative reaction is the desire to reach out to another person in spite of the potential for rejection in a society where one is likely to be considered as an object.

R5 showed similarity in her background, presentation of complaints, patterns and experiences. Like R1, she also suffered child abuse and developed similar sort maladaptive schemes and patterns. It also came to light that to deal with the distress of facing her mother during vacations, she remains stuck in bed but that happens only in vacations every year

while when the school, college or university is open, she is fine. R5 and the therapist found her home environment to be one of the significant factors causing mental health issues beside her experiences, divorce and subsequent early death of her mother and the harshness of her stepmother. Father's lack of connection and communication gap further complicates the problem. It was discussed in detail how R5 can make a case for herself with her father to allow her to do the job, move in with a couple that her father knows. That plan did not come through however eventually that exploration ultimately led to a breakthrough - an opportunity of studying abroad has been offered by a foreign university which has given R5 hope and enthusiasm and is likely the primary contributor for the ultimate result. R5 is being helped in the visa and accommodation process by both her father and stepmother. R5 also made use of individual and group psychotherapy sessions however in between she was unable to take sessions due to vacations which is reflected in her results. Like R1, different aspects of the psyche within the domain of TIIP were tapped into beside 6Ms. E-H was also utilized.

R5 is a dramatic example of how even when there is a hope of change of environment and resolution of interpersonal conflicts that one is faced with, how that can improve one's well being. Szasz (1960) argued that conflicts in interpersonal relationships are inevitable due to the great range of human values and the ways by which they may be achieved, as well as the fact that many of these factors are still largely ignored. In fact, stating that there is tension, strain, and discord in all human relationships—from mother to kid, husband and wife, to country and nation—is only stating the obvious. However, even the apparent might be misunderstood. I believe that is the situation here (Szasz, 1960). Because it seems to me that we have failed to acknowledge the obvious reality that human connections are essentially complex and that even making them somewhat harmonious needs a lot of patience and effort—at least in our scientific theories of conduct (Szasz, 1960). Furthermore, it is contended that the concept of mental illness is now being used to hide certain issues that may currently be present in people's social interactions but are not always insurmountable. If this is the case, the idea serves as a cover because it offers an impersonal, immoral "thing" (a "disease") as an explanation for issues with life rather than drawing attention to competing human wants, ambitions, and ideals (Szasz, 1959). In this

regard, we should remember that, not so long ago, men's social-living issues were attributed to demons and witches. The true successor to the beliefs in demonology and witchcraft is the belief in mental disease, which is seen as something other than a problem with how well people get along with one another. In the same way that witches existed or were "real," mental illness exists or is "real."

Schneider and Krug (2010) discuss that leading E-H theorists' ideas of psychological health are centered on the polarities of freedom and destiny or restriction, as well as the task of responding to these polarities. James Bugental (J. F. T. Bugental & Sterling, 1995), for instance, emphasised the self as corporeal, but changing; choiceful, yet limited; solitary, yet connected, drawing on a similar dialectic. No matter how we choose to conceptualise it, according to Bugental, we are always undergoing change (see also the ancient Greek philosopher Heraclitus). Our task, said Bugental, is to accept that shift, sift through its many components, and draw a meaningful and practical conclusion from it.

R7 came in with confusion about her career, education and the affairs at home. One of her primary concerns had to do with spirituality; she was not offering her prayers and not feeling guilty about it. She also struggled to manage things. R7 also expressed concern for her parents and the financial constraints. R7 had a big task at hand which when achieved gave her relief. The therapist and R7 discussed job exploration, aspects of life, only the spiritual element of TIIP, responsibility and purpose and other relevant discussions. Among all participants, R7 showed highest motivation, and compliance. The therapist felt as it has been that when I am truly helping a client, there sometimes seems like a I-thou llink between us, as Carl Rogers once told Paul Tillich, "I feel as though the forces of the cosmos or forces are functioning through me" (Kirschenbaum & Henderson, 1989).

Schneider and Krug (2010) report that E-H treatment is applicable to a wide range of clientele and session lengths. Despite having a reputation for being elitist, E-H practise has been used with corporate professionals, drug addicts, members of racial and ethnic minorities, homosexual and lesbian clients, and mental inpatients (O'Hara, 2001; Schneider, 2008; Schneider & May, 1995). Additionally, several practise orientations have separately

arrived at and embraced the E-H concepts of presence, I-Thou connection, and bravery (e.g., see Bunting & Hayes, 2008; Stolorow et al., 1987). Schneider and Krug (2010) state that the idea of psychological health may be stagnant and based on societal norms, which may not accurately represent the experiences of unique people (see Becker, 1973; Fromm, 1941; Wheelis, 1958).

R7 made use of her choice, autonomy, introspection, and took responsibility within the constraints of her given options and explored leading to an initiative which was not taken before. Schneider and Krug (2010) describe that the E-H perspective of functioning is based on three interrelated dimensions: freedom, experienced reflection, and accepting responsibility. Despite the fact that E-H theorists virtually always emphasise all three of these aspects, they do so in various, distinctive ways. For instance, May (1981) placed a strong emphasis on freedom and what he called destiny. May defined freedom as the power to make decisions within the boundaries of one's environment and one's own self (such as cultural boundaries). Freedom also entails responsibility because, as he put it, if we are given the freedom to make our own decisions, should not we be expected to do so? Therefore, what gives life meaning is the dynamic interaction between the opposing polarities of freedom and fate (May, 1981). May highlighted that freedom and destiny, as well as talents and constraints, can only be fully illuminated, in-depth investigated, and effectively modified through conflict.

Schneider and Krug (2010) assert that clients start to create new, more aligned life pathways as they begin to remove obstacles from what matters most to them. These avenues can manifest as a brand-new position, a task, or a connection. However, they can also go beyond definite objectives to embrace the freedom to accept life itself—in all its stark possibilities. Awe, or the humility, amazement, and/or feeling of adventure toward all that exists, often characterises this new connection to existence. The similar journey, although at an early stage, is what clients go through at the start of therapy. In other words, clients develop the ability to go effortlessly from utter dread to flowering wonder—from humiliation to audacity—from the very beginning, and this pattern, in a sense, serves as the foundation for clients to feel awe, or the maximum capacity to live.

5.1 Treatment Specific to Experimental Group

Nafs (behavioral inclinations); ihsas (emotions); aql (cognition); ruh (spirit); and ijtimai (social) aspects of a human being were discussed with the respondents within the framework of TIIP and standard questions were asked which were accompanied by exploration. The state of nafs was discussed and how a human being fluctuates between being someone who indulges in comforting and instant gratifications impulses; feels guilt and accountability for shortcomings and wrongdoing and how it gets glimpses of a state in which tranquility is experienced as one is in equilibrium and doing things correctly in certain aspect.

Goal-setting or stipulation, self-monitoring, self-evaluation, repercussions, self-reprimanding, and exertion are the six Ms (in Arabic) for routine and discipline which were tapped into for emotional regulation and were briefed and discussed. Related questions were answered. Change of behavior leading to change in thinking and change of environment bringing change in behavior was looked at.

Holistic conception of the person and health - a state of physical, mental, social and spiritual wellbeing was explored. It was discussed how health is on a continuum rather than a dichotomous category of healthy and ill. Balance in personality, psyche and behavior was looked at as a mark of health as a general rule of thumb; inadequate or excesses in personality, psyche and behavior even if they seem good lead to unwanted consequences healthwise and vice versa. Humanity struggles with the reaching balance and how that is the struggle of each human being in the world and how that can help.

Impact of past incidents and being in its shackle and its impact on academic performance and on life otherwise was discussed which was ended with hopeful possibility of Post traumatic growth. Flashbacks were explored as a special and powerful memory but a memory which has passed. The importance of giving a message to oneself: you have survived. Limbic system, amygdala and trauma were talked over. Processing the trauma at

their own pace was respected. It was examined how gradual exposure and emotional processing can be helpful. Moreover, how and why it is healthy, adaptive and rational to forgive one's limitations and take small steps towards healing. Appreciation for gradual exposure and engagement in games and social activities was highlighted.

5.1.1 Treatment for Both Groups

Aspects of life namely, academic; personal; intellectual; career; family; society; entertainment; transcendent; financial were looked at. It was discussed that it is important to allocate one's daily or weekly time to each of these aspects of life as per the order of importance of each aspect for the individual. Inadequacy and excesses leading to unwanted outcomes was highlighted and balance or equilibrium as is humanly possible was emphasized. The importance of humility; the trap of marginal thinking; the idea that one ends up paying the full price anyway; an unending stream of extenuating circumstances; and the idea that it is easier to follow values and principles 100 percent of the time than 98 percent of the time. Taking inspiration from relevant individuals was discussed be it Nadia Murad for sexual abuse and trauma; Jeffrey Lang for dealing with alcoholic and angry father who fought with his mother; Man's search for Meaning by Victor Frankl for not losing hope in testing times; and self-disclosure about meeting with the child of a living holocaust survivor.

Reciprocal inhibition was explored in which one does the opposite of one's inclination and indulgence behavior, i.e, fasting in place of binge eating; resisting the temptation to be lazy and instead do physical and mental activity. Moreover, the benefit and practice of mindfulness about one's thought, body, and feelings was looked into. Deep breathing and guided imagery to feel calm and deal with anxiety and stress was practiced. Lack of adequate and excessive guilt was looked at in comparison to healthy guilt which increases the probability of not repeating the undesirable behavior. Grounding technique, in other words, use of five senses to bring oneself to the present moment was rehearsed. The importance of similar sleep and wake up time was discussed, in addition, the importance of sunlight was highlighted.

Physical illnesses were ruled out. Genetic predisposition was looked at. Inadequate levels of vitamin D; folic acid in the population and lack of adequate iron in females was mentioned as one of the reasons for feeling tired. The impact of what we eat with regards to not only physical health but also mental health was emphasized; impact of nutrition on emotions and moods was examined; the field which studies that is known as nutritional psychiatry. Distress tolerance skills and acronyms were talked over. Motivational interviewing was done to deal with the confusion; the pros and cons of both the current state of affairs - status quo and the pros and cons of making the change were discussed.

Lack of adequate and healthy boundaries with friends, parents and in general was looked at as one of the issues causing interpersonal and personal troubles. The influence of parents, their parents, childhood experiences, upbringing and a similar pattern found in oneself was related. It was agreed upon that awareness of the problem and issue can create the enlightenment and struggle to overcome the maladaptive patterns and break the vicious cycle which cannot be broken unless one is aware, admits it and consciously makes an effort to face it, fix it and move past it.

The possibility of writing one’s autobiography was discussed. Self-fulfilling prophecy vis-a-vis how our expectations influence our behavior consciously and unconsciously, how that impacts our toil and resultantly, what outcomes we are more likely to produce was looked at. It was also examined how paradoxical intention can help one to fall asleep.

Dialogue was used as a therapeutic tool. Therapy from a phenomenological point of view has been adopted. Neukrug (2015) cites Emmy van Deurzen who argues that philosophical therapy with a strong dialogue foundation is phenomenological therapy. Moreover, instead of making use of psychodiagnostic classifications or other theoretical ideas, it moves along through thorough description and seeks to investigate people's struggles with living as they actually experience them. Furthermore, it encourages a person to compare their issues with the bigger picture of the human experience in order to attain

understanding. Additionally, instead of making recommendations or providing interpretations or explanations, it focuses on describing goals, meanings, values, conflicts, and paradoxes.

An attempt was made to reduce, if not solve problems in living which is arguably one of the reasons which brought respondents to participate in the research and continue. It is obvious in all respondents that all have trouble in getting along with some significant persons in life or there is a communication gap or there is strain which weighs heavily on their psychosocial well-being. In other words, it is not so much the mental illness, but issues in living which are causing suffering and disruption in optimum function. That is in keeping with the aforementioned claim made by Thomas Stephen Szasz, a psychiatrist and academic who was born in Hungary and spent the most of his career teaching psychiatry at Syracuse, New York's State University of New York Upstate Medical University.

Respondents in both groups had issues with anger hence following knowledge regarding anger was utilized with the respondents. It has been reported that Professor Brad J. Bushman (Ohio State University) has researched aggression for three decades (Canadian International Institute of Applied Negotiation, 2022) . It is argued that (i) People who have good self-control are successful in majority cases. Those who end up committing violent crime usually have poor self-control. (ii) There are three responses to social rejection - trying harder; anger and aggression; withdrawal. (iii) During anger, it is important to look for the following in oneself: grandiose inflated ego; narcissistic tendencies. (iv) Being thin skinned and easily offended can lead to anger and aggression. (v) Anger when it is stuffed inside or vented out - both are considered maladaptive because both have cardiovascular consequences. Some solutions and adaptive dealing suggestions are made.

It has been discussed that one becomes an angry, aggressive person by practice, practice, practice (Canadian International Institute of Applied Negotiation, 2022) . During anger, one may hit, kick, swear, shout, scream. In a state of anger, one ruminates. That keeps angry feelings and leads to aggressive thoughts. Some recommendations to deal with anger effectively are: (i) One needs to delay responding; "Count to ten, if you are angry. If

you are very angry, count to 100." - Thomas Jefferson. (ii) Self-control is important in anger. See the situation with self-distancing - from a third person perspective, as a watcher. (iii) To calm down the aroused physiological state due to anger - one can try to use non dominant hand; sit up straight; try to speak complete sentences; instead of leaning forward, lean back (in anger, it's natural to lean forward); do something incompatible with anger - watch or read something funny and help somebody in need or kiss or hug somebody; do reframing - changing the perspective.; to engage attention in different directions - one can work on a puzzle, read a book; listen to calming music; take a bath; do deep breathing; do meditation and yoga. (iv) When you practice muscle, it becomes stronger. By practicing to deal with anger using adaptive ways, over time, it will become easier to utilize adaptive ways of dealing with anger. (v) In a state of anger, one is prone to the superiority complex of being right and the other person being wrong. It is important to be mindful of that. (vi) There's a thing such as hangry - low levels of glucose are associated with anger. Couples were given voodoo dolls and allowed to stuff pins to show how angry they were - they stuffed more pins when they were hungry and hence with low levels of glucose. Hence, it is vital to avert low glucose levels. Diabetic symptoms are a risk factor for aggression.

Sleep issues was another common problem which was found to be pervasive among respondents in both the groups thus following knowledge regarding sleep was utilized with the respondents. It has been stated by Suzanne M. Bertisch, MD, MPH at Harvard Medical School that for one of her clients tried exercises, transcendental meditation, and reiki massage did not work while medicine made her feel worse (Osher Center for Integrative Medicine, 2018). So she tried her behavioral therapy with experiments in a way over a period of 5 months which has largely cured her. Bertisch described comorbidity and explained neurobiological model of insomnia in addition to 3p model - predisposing (female, age, family history, etc.), precipitating (different environmental stressors), and perpetuating (habits/routine/ lifestyle which interferes with natural sleep cycle) (Osher Center for Integrative Medicine, 2018). Voluntary actions to influence involuntary physiological processes which help to sleep are emphasized (Osher Center for Integrative Medicine, 2018). Moreover, sleep-wake regulation brain systems are discussed. Additionally, lifestyle treatment, CBT-I, homeostasis process and circadian process are also

highlighted, mindfulness practice and mind-body practices are touched. The client (also a faculty at Harvard Medical School) mentioned she also consulted a sleep psychologist as an aid and that to say insomnia is horrible is an understatement. One duo according to her which helped her particularly was to restrict time on bed except for sleeping and to sleep and wake-up at the same time 7 days a week, which is incredibly tough to practice but she did it for her own good. Moreover, the client said she experienced insomnia for the first time in her 40s back in 2015 and she thought maybe it is genetic given her brother experienced it in his adolescence. Bertisch acknowledged that if she comes across a complicated case - someone who has insomnia; anxiety; PTSD; and other issues; she refers to someone suitable before she can handle the case as she is a sleep researcher and not a psychologist (Osher Center for Integrative Medicine, 2018).

Stress and struggling to manage it was another common problem that was found to be ubiquitous among respondents in both the groups thus following knowledge regarding stress was utilized with the respondents. Stress and its effects on the brain, body, and mind were discussed. Moreover, how it can be helpful and how it cannot be. Life situations and the Yerkes-Dodson law are covered. The effect of our perceptions and thoughts on stress levels is talked about with the client. It has been reported that stress is a constant (Rabin, 2020). To reduce sadness and increase joy in life, we may alter the way our brain reacts to stress. It is suggested to use stress coping techniques more frequently than simply when you are under stress. Use them all day long instead when one is joyful. One's mind will be trained to link the tactics one utilizes to positive feelings as a result. Then, because one's mind will identify the relaxation techniques with being relaxed, they will function more quickly and effectively when one utilizes them while one is under stress. Remaining committed to one's aim of maintaining good health and serving as a positive role model for those one cares about. All of that requires practice and learning.

The client and the therapist talked about the following: When one feels upset and furious, it is necessary to drink water, take deep breaths, and leave the area. Remember the times your stress management strategies came in handy (Rabin, 2020). Besides, increase their use. Moreover, on a sheet of paper, express your annoyance and rage and then rip the

paper off. Learning to unwind would not diminish your productivity or have a negative impact on your work. In fact, becoming more relaxed can improve your ability to interact with others, make you calmer, and more effective in daily life (Rabin, 2020).

It is stated that one of the reasons for depression may be stress because the chemicals released during times of stress alter how the brain cells in the region of the brain linked to depression operate (Rabin, 2020). Moreover, stress chemicals harm memory-related brain cells. Additionally, one's capacity to focus and think clearly is hampered by stress hormones, which may explain why one occasionally says things one later regret when one is under stress. Furthermore, the possibility of stress and its effects on pain were discussed: Your feeling of pain is increased by an increase in stress hormones. Besides, aches and pains will hurt more intensely when the levels of the stress hormone are high. The author describes that pain will be less painful when the levels of stress hormones are low. The discomfort of childbirth is one instance. Deep breathing reduces the concentration of stress hormones by increasing blood oxygen levels. Deep breathing is a crucial element of the Lamaze program, which helps pregnant women become ready for delivery. The objective is to lower the level of norepinephrine, a stress hormone that, when increased, heightens pain perception. Less norepinephrine means less pain (Rabin, 2020).

The client was made to feel relaxed via guided visualization. The client was at ease and pleasant when the following topics were covered, and it became clear to the client how important stress management was. It has been postulated that blood arteries become smaller as a result of stress chemicals, which raise blood pressure (Rabin, 2020). Moreover, a stroke may result from a surge in blood pressure. Furthermore, stress hormones speed up the process by which cholesterol deposits build up in and restrict the blood arteries of the heart. Lastly, blood platelets clump up and adhere to one another as a result of stress hormones, which may block blood vessels and result in a heart attack.

The fact that the client worries a lot and that stress weakens the immune system can make one more susceptible to recurring illnesses, it was discussed with the client. It has been asserted that stress hormones reduce the body's capacity to fend off infectious diseases

(Rabin, 2020). One, stress hormones cause illnesses including psoriasis, multiple sclerosis, rheumatoid arthritis, ulcerative colitis, and Crohn's disease to become more active. Two, asthma and irritable bowel syndrome are two conditions that are made worse by stress hormones. To calm the client down, guided visualization and deep breathing were used. Further conversation about stress was had as the client became more at ease. Three, to lose belly fat, proper exercise, a balanced diet, and a limited intake of junk food is needed and were discussed. Lastly, it was made known that stress hormones play a role in central obesity (abdominal fat), which increases the risk of diabetes.

It has been argued that stress hormones impair our capacity to think clearly, which makes it difficult to make smart food choices (Rabin, 2020). Additionally, stress hormones hinder the body's capacity to heal wounds. Besides, stress hormones raise blood sugar and raise the risk of having trouble controlling diabetes. Furthermore, telomeres, which are the protective elements (the little caps on the ends of your chromosomes) that stabilize the chromosomes, were discussed with the client. The author describes that telomeres get shorter each time a cell divides. It is further put that cells will cease dividing and tissues and organs will deteriorate if the telomeres get too short. It is also said that cortisol, one of the stress hormones, will cause telomeres to shorten for which there are few points to be noted. One, short telomeres have been linked to an increased risk of cancer, dementia, and a shortened life span. As a result, stress will be linked to shorter telomeres and a higher chance of developing disease. Two, telomere lengthening will be linked to practices and methods that reduce the levels of stress hormones. Three, telomeres are undoubtedly a factor to consider when considering how to improve your capacity for stress management. Lastly, it is wise to be aware of this and perhaps give it some thought (Rabin, 2020).

It was mentioned that a certain degree of stress is normal, necessary, and occurs occasionally. However, it only starts to negatively affect health when it continues for weeks or months (Rabin, 2020). It is reported that prolonged stress (chronic stress) may result in a long-lasting rise of cytokines in the blood - the same substances that cause inflammation (Rabin, 2020). Additionally, the detrimental effects of elevated cytokines on health include: chronic fatigue, low energy, slow walking, decreased strength, feeling weak, decreased

desire to engage in physical activity, increased risk of cancer, heart disease, type 2 diabetes, osteoporosis, and depression. It has also been stated that elevated levels of inflammation also predict a shorter lifespan and worse health, and they are linked to depression. It is argued further that individuals who are physically active, socially engaged, pleasant, and capable of managing stress have lower levels of inflammation. Lastly a diet rich in fruits, vegetables, and nuts also helps keep the chemical linked to inflammation at low levels. That is important because inflammation levels in the body must be kept low for long-term mental and physical wellness.

It has been asserted that it will be less likely for stressors to influence your health if you learn basic buffering techniques (Rabin, 2020). One, Religion (and/or Spirituality): Having a spiritual inclination or a belief system in a religion that enables you to unwind and calm yourself when under stress. Two, expectations (optimism): If you have expectations that everything will work out for the best, any setbacks would not change your fundamental conviction that you are a decent person. Three, having a sense of humour, which allows you to laugh at yourself and find humour in events, is what makes you laugh (remember the old saying that laughter is the best medicine). Fourth, friends (social support): Having a dependable and enjoyable social support network. Fifth and lastly, exercise (physical fitness): Getting regular exercise rather than sitting still all day.

5.2 Limitations of the Study

The constraints of the study include data; data was collected from a university situated in the capital territory of Pakistan - Islamabad. Furthermore, the respective university typically has students from middle and upper middle-class backgrounds which is the case with the research participants. Moreover, instead of an in person data collection, an online Google form was used as a screening tool via DASS-21. There are 14 departments and an even greater number of programs hence in person data collection was not possible due to time and resources constraints for the researcher. Theoretically, the age group was limited to eighteen (18) to thirty-five (35) years old; practically, it included participants within the age of 18-25. The outcome and conclusions drawn from the study cannot be

generalized to the population beyond these demographic features.

The current study made use of Brief Symptom Inventory (BSI). Rath and Fox (2018) report that The Symptom Checklist-90 (SCL-90; Derogatis et al. 1973) was shortened to the 53-item BSI (Derogatis & Melisaratos 1983), which assesses nine aspects of emotional-behavioral functioning: somatization, obsessive-compulsive, interpersonal sensitivity, depression, anxiety, hostility, phobic anxiety, paranoid ideation, and psychoticism. Furthermore, the authors assert that the BSI has the advantages of being quick to complete and useful for repeated assessments. Additionally, the measure is said to be sensitive to moderate to severe psychological distress, making it applicable to a wide range of people. Nonetheless, this study used self-report measures. Self-report measures have the advantage of being convenient; inexpensive; time efficient; privacy and anonymity which can lead to upright responses. However, self-report measures are prone to response and sampling bias in addition to individual differences in the introspective ability.

5.3 Future Research Directions

The current study showed that TIIP holds promise that it has efficacy to decrease depressive, stress and anxiety symptoms for the young Pakistani population in an urban area who are undergraduate students. Moreover, it is effective even with the population which is not particularly religious or has religious doubts or has religious beliefs and practices which show flux and volatility. Future studies can look into different demographic variables with respect to age, education, socioeconomic background in varied settings - individual setting as opposed to group psychotherapy setting. It can also be seen whether future studies with similar or different demographics replicate the results of the study or show a variance. The current study was conducted in the capital city. In other geographical regions of Pakistan such as Baluchistan, KPK, Sindh and autonomous areas - Azad Kashmir and Gilgit Baltistan, and possibly Punjab - studies can be conducted to see the outcomes; whether they are parallel with the current study; cumulate evidence; or show separate results owing to distinct demographics and because of variance in provincial culture; religious connection and practice; ethnic norms, and mores; and attitude towards

mental health and its services. Lastly, a longitudinal study can be conducted in case of ample time and resources which was not possible for the current study to cater to.

5.4 Implications

The current study has pragmatic implications. One, the study shows the efficacy of TIIP psychotherapy in group psychotherapy settings for young adults who have symptoms of stress, anxiety and depression in an urban area. Two, the study shows that by employing TIIP which is an integrative psychotherapy, the symptoms of stress, anxiety and depression can be curtailed which will lead to an improved overall wellbeing. By improving the well-being and decreasing the symptoms of stress, anxiety, and depression, academic, social, economic costs can be saved. At the same time, the productivity of the individual can be increased by a reserve of energy which was being exhausted due to symptoms of stress, anxiety and depression. Life has challenges, and sometimes, stress, anxiety and depression cannot be averted, however, if it is treated adequately, its consequences can be reduced. Three, the results of the study suggest that if similar measures are taken at other urban universities with the same demographics, it will have a positive impact on the wellbeing of the young adults there who are struggling with symptoms of stress, anxiety and depression.

TIIP is a culturally relevant psychotherapy in Pakistan due to its basis within the religion of Islam which is simultaneously encompassing of Western and other psychotherapeutic insights, techniques which have been found to be helpful whether its basis be empirical such as CBT or clinical such as psychoanalysis by Sigmund Freud. However, TIIP is mindful of epistemology, ontology and philosophical assumptions which are in line with the beliefs and practices of the majority of Pakistanis. If the current study is replicated, and expanded, gradually, it can save personal, social, academic, economic and other costs to society. Furthermore, if the current findings get the attention of academics, and relevant stakeholders who can employ this at the population level, it can have the impact of improving overall wellbeing and productivity for people with the demographics under study. There is a possibility that TIIP can be employed as a preventive measure for the educated younger population so that the problems can be addressed before they become

rooted.

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ANNEXURES-A

Informed Consent

I am Muhammad Talha, a Post graduate student of MS Clinical Psychology from Bahria University, Islamabad Campus. I am carrying out a research based in intervention on Depressive Symptoms Among Youth. It is assured that any information obtained from you shall be utilized solely for the research purpose. No identifying information shall be disclosed and confidentiality will be maintained by changing the demographic information. You have been briefed about the research and the intervention. You have asked questions and have been responded to with satisfaction. You give your consent to participate in this research with your voluntary will. You take personal responsibility for your decision to join which is done with your freedom of choice. If you volunteer, you may withdraw at any time without consequences of any kind or loss of benefits to which you are otherwise entitled. If you voluntarily agree to participate in this study, kindly sign this form. Thank you for your participation. In case you wish you learn about the findings of this study; you can reach us at: mthumanitarian@gmail.com

Signature _____ Date _____

ANNEXURES-B

Scale

Brief Symptom Inventory

Below is a list of problems people sometimes have. Please read each one carefully and circle the number that best describes HOW MUCH THAT PROBLEM HAS DISTRESSED OR BOTHERED YOU DURING THE LAST 14 DAYS INCLUDING TODAY. Circle only one number for each problem and please do not skip any items.

HOW MUCH WERE YOU DISTRESSED BY:	Not at All	A little Bit	Moderately	Quite a Bit	Extremely
1. Nervousness or shakiness inside	0	1	2	3	4
2. Faintness or dizziness	0	1	2	3	4
3. The idea that someone else can control your thoughts	0	1	2	3	4
4. Feeling others are to blame for most of your troubles	0	1	2	3	4
5. Trouble remembering things	0	1	2	3	4
6. Feeling easily annoyed or irritated	0	1	2	3	4
7. Pains in heart or chest	0	1	2	3	4
8. Feeling afraid in open spaces or on the streets	0	1	2	3	4
9. Thoughts of ending your life	0	1	2	3	4
10. Feeling that most people cannot be trusted	0	1	2	3	4
11. Poor appetite	0	1	2	3	4
12. Suddenly scared for no reason	0	1	2	3	4
13. Temper outbursts that you could not control	0	1	2	3	4
14. Feeling lonely even when you are with people	0	1	2	3	4
15. Feeling blocked in getting things done	0	1	2	3	4
16. Feeling lonely	0	1	2	3	4
17. Feeling blue	0	1	2	3	4
18. Feeling no interest in things	0	1	2	3	4
19. Feeling fearful	0	1	2	3	4
20. Your feelings being easily hurt	0	1	2	3	4
21. Feeling that people are unfriendly or dislike you	0	1	2	3	4
22. Feeling inferior to others	0	1	2	3	4
23. Nausea or upset stomach	0	1	2	3	4
24. Feeling that you are watched or talked about by others	0	1	2	3	4
25. Trouble falling asleep	0	1	2	3	4
26. Having to check and double check what you do	0	1	2	3	4
27. Difficulty making decisions	0	1	2	3	4
28. Feeling afraid to travel on buses, subways, or trains	0	1	2	3	4
29. Trouble getting your breath	0	1	2	3	4
30. Hot or cold spells	0	1	2	3	4
31. Having to avoid certain things, places or activities because they frighten you	0	1	2	3	4
32. Your mind going blank	0	1	2	3	4
33. Numbness or tingling in parts of your body	0	1	2	3	4

HOW MUCH WERE YOU DISTRESSED BY:	Not at All	A little Bit	Moderately	Quite a Bit	Extremely
34. The idea that you should be punished for your sins	0	1	2	3	4
35. Feeling hopeless about the future	0	1	2	3	4
36. Trouble concentrating	0	1	2	3	4
37. Feeling weak in parts of your body	0	1	2	3	4
38. Feeling tense or keyed up	0	1	2	3	4
39. Thoughts of death or dying	0	1	2	3	4
40. Having urges to beat, injure, or harm someone	0	1	2	3	4
41. Having urges to break or smash things	0	1	2	3	4
42. Feeling very self-conscious with others	0	1	2	3	4
43. Feeling uneasy in crowds, such as shopping or at a movie	0	1	2	3	4
44. Never feeling close to another person	0	1	2	3	4
45. Spells of terror or panic	0	1	2	3	4
46. Getting into frequent arguments	0	1	2	3	4
47. Feeling nervous when you are left alone	0	1	2	3	4
48. Others not giving you proper credit for your achievements	0	1	2	3	4
49. Feeling so restless that you couldn't sit still	0	1	2	3	4
50. Feelings of worthlessness	0	1	2	3	4
51. Feeling that people will take advantage of you if you let them	0	1	2	3	4
52. Feelings of guilt	0	1	2	3	4
53. The idea that something is wrong with your mind	0	1	2	3	4

ANNEXURES-C

DEMOGRAPHIC DATA SHEET

R1	**Research Participant**
Age	22
Gender	Female
Birth Order	4th; youngest
Education	BS (4th semester)
Marital Status	Single (multiple breakups)
Residence	Rawalpindi (lots of migrations)
Occupation	Student
Ethnicity	Pashtun
Language	Pashto

Presenting Complaints

Lack of concentration, fighting with friends, problems at home, relationship issues, annoyance about regular screening (cancer), allergy (pollen), abandonment fear, sadness, anger, difficulty managing stress and frustration, lack of goals and directions, guilt, four break ups, low self-esteem, self-harm in the past.

Summary

R1 is a 22 years old female. She has symptoms of anxiety and depression. Her

parents fight frequently. She was not given due care, love and nurturance in childhood due to her elder sister who has epilepsy and her sister was given more attention. She has a genetic predisposition towards short temper as both her parents are also short tempered. That causes trouble for her in her interpersonal relationships. One of her elder sisters who got married a couple of years ago also has trouble with her spouse due to her anger issues. According to the R1, she gets into relationships for love and care that she has missed and still misses. Her parents are unpredictable – sometimes they are kind and caring and at other times quite neglectful and authoritarian. She has trust issues which have likely something to do with her relationship, schemas and experience with parents. R1 is also prone to being sad and frustrated. Her insight is intact, she knows her own issues, flaws and problems and wants to fix them.

R2	**Research Participant**
Age	23
Gender	Male
Birth Order	1st; eldest of 8 siblings
Education	BS (1st semester)
Marital Status	Single
Residence	Islamabad (Rural; hometown)
Occupation	Student
Ethnicity	Pashtun
Language	Pashto

Presenting Complaints

Low self-esteem, increased heartbeat, muscle tension, problems in social interaction and rumination, anger outbursts, sadness, interpersonal trouble with father, lack of goals and direction, body image issues, bullying by peers, anxious, low mood, strict and

restrictive father

Summary

R2 is a 23 years old male and is one of the 8 siblings. He has symptoms of anxiety and depression. R2 has a history of bullying from his peers and in two instances changed academic institutions. Right now, he experiences negative comments about his face and height and struggles to be comfortable among the majority of the classmates. R2 has a poor relationship with his father who is highly strict and highly religious. R2 admitted to lying many times to his father to avoid conflict and to please him. R2 was bothered that he would go for namaz and still his father would ask him and not show trust. The mother of R2 is depressed. R2 has memories of his father beating his mother. He reports his mother as kind and loving. R2's school experience was poor with regards to peers. When he moved to college away from the native town and known people, he describes his experience as excellent as new people did not know his past and he was not imprisoned by it. As the eldest among siblings, he also feels a burden of responsibility. R2 trembles while giving presentations in the class despite good preparation.

R3	**Research Participant**
Age	20
Gender	Female
Birth Order	2nd; one of the three sisters
Education	BS (4th semester)
Marital Status	Single (Break ups)
Residence	Islamabad (Migrations history)
Occupation	Student
Ethnicity	Punjabi
Language	Urdu

Presenting Complaints

Abandonment fear, commitment issues, anger issues, excessive sleeping, guilt and shame, smoking, fighting with friends, three breaks, body image issues and low self-esteem, mood swings, not able to let go of a close friend since matric, procrastination.

Summary

R3 is a 20 years old female. Her parents have a healthy relationship and she complains about her parents as being overprotective. R3 reports anger issues and a habit of smoking by her father and she exhibits the same two behaviors. She has had distrubed sleep since matriculation - the same time since she has been in relationships. She has guilt and shame related to the intimacy she got herself involved into. R3 reported that she used to block people on social media but that behavior has been stopped for a year now ever since she got to know psychology. R3 fears the opposite gender ever since there was an attempted kidnapping on her 3-4 years ago. R3 lacks routine, goals, and discipline and completes things in the eleventh hour.

R4	**Research Participant**
Age	19
Gender	Male
Birth Order	2nd; a male and female sibling
Education	BS (2nd semester)
Marital Status	Single
Residence	Islamabad
Occupation	Student

Ethnicity	Punjabi
Language	Punjabi, Urdu

Presenting Complaints

Sadness and uncertainty, on and off depressed, fear and paranoia, attention and concentration issue, loneliness, negative thinking, low self-esteem

Summary

R4 reported the first episode of depression in high school. Mother and sister have GAD. The elder brother of R4 has OCD. Father has had anger issues. R4 described that he was strongly attached to his father who suddenly passed away in 2018 and has not completely gotten over it. Anxiety symptoms were induced by an event - he joked with his female friend to sit on the bottle - who did not mind it on face but spread it to the class due to which he faced awkward situations and lost old friends. R4 has insight that he did not pay heed to the boundaries and made an inappropriate joke. He also has a tendency to daydream a lot.

R5	**Research Participant**
Age	18
Gender	Female (identifies as non-binary)
Birth Order	2nd; a male and female sibling
Education	BS (3rd semester)
Marital Status	Single
Residence	Islamabad (rural; hometown)

Occupation	Student
Ethnicity	Pushtun
Language	Pashto

Presenting Complaints

Strict and restrictive step mother, problem at home, sadness and uncertainty, perfectionist, lack of direction, anger, existential crisis, attention issue, low self-esteem, loneliness, anxious, mood swings, negative thinking, self-harm in the past

Summary

R5 is a 18 years old female. R5's father had an extramarital affair when R4 was in grade 2 and her father asked the first wife - R5's mother to let him do the second marriage, which was not agreed upon which led to divorce. Shortly afterwards, her mother passed away. R5's father married the lady with whom he had an affair and is the current step mother of R5 for the last thirteen years. At the hands of her step mother, R5 experiences verbal bullying, hitting, anger, excessive restrictions and limitations on her freedom of choice. R5 complains she may have a good day at the university and otherwise, but she becomes sad and anxious at home especially when she is alone at home with the step mother. R5 sometimes feels connected to religion and spirituality out of her own volition and at other times, she does not. R5 reported that when she became overwhelmed with emotional pain, she cut herself with the knife in the kitchen.

R6	**Research Participant**
Age	20
Gender	Female (identifies as gender non-conforming)

Birth Order	2nd; total 4 siblings
Education	BS (3rd semester)
Marital Status	Single
Residence	Islamabad (Middle East since childhood)
Occupation	Student
Ethnicity	Urdu speaking
Language	Urdu

Presenting Complaints

Father's anger outbursts, existential crisis, sadness, anxious, religious family and personal irreligiosity, concentration issue, interpersonal issue with parents, cultural shock (moved from KSA – lived there for 9 years; UAE – lived there for some years to Islamabad alone), body images issues and low self-esteem, gender dysphoria

Summary

R6 is a 20 years old female. Her parents' relationship on the surface with each other is fine. She considers her father as the big cause of her mental health issues due to his anger issues and authoritarian attitude. R6 describes that due to physical distance, her relationship with the mother has improved. She finds her siblings to be accepting and supporting with regards to her religious beliefs while she does not share her religious beliefs with the parents. R6 reports gender, sexual orientation confusion coupled with doubts over religion. R6 also reported being diagnosed with seasonal affective disorder in KSA upon which her father commented we keep you like a princess, why are you depressed to which she responded that it is due to chemical imbalance as a polite response while in fact she thinks her father is the chief cause of her depression.

R7	**Research Participant**
Age	24
Gender	Female
Birth Order	1st; total 5 siblings
Education	MS (4th semester)
Marital Status	Single
Residence	Islamabad (Rural; hometown)
Occupation	Student
Ethnicity	Pashtun
Language	Pashto

Presenting Complaints

Lack of fear and guilt for spiritual shortcomings; lack of motivation; emotional dysregulation; anxiousness about the future; laziness with regards to exercise which is necessary for her, otherwise, she experiences back pain.

Summary

R7 is 24 years old, and is the eldest of five siblings. Her family has no psychiatric history except the recent diagnosis of OCD, that of her maternal granny. Her family setting is nuclear while currently she lives in a girl's hostel near the university. Her father has a pharmacy shop and mother runs a boutique at home. The family has a history of arthritis, BP and back pain. Her relationship with parents and siblings is good, moreover, her parents' marital life is also good and peaceful. She was a position holder academically until grade Eight. In grade ten, eleven and twelve, she wasted time and her grades plummeted as her company of friends was fun loving and not into studies. Her friends were caring personally. R7 is also prone to social comparison and that disturbs her. Her family and relatives also do

the comparison which disturbs her further. Due to stress and poor time and academic pressure management, the R7 observes, she has started to neglect her spiritual side for which she feels guilt and shame at times but she is perturbed by the fact that mostly that guilt and shame and sense of shortcoming is missing. The respondent also mentioned that she can get angry quickly and then cry quickly; according to her, she feels she has emotional regulation problems. Her family has financial constraints hence she is confused whether she should sit for the civil service exam which will take 6 months or should she immediately opt for a job to assist her parents for whom she is very grateful for all the support, care and love they have given to her.

In conclusion, R7 wants to be decisive about her career plans; reconnect with her spirituality; have better stress and time management; and be emotionally in control of herself.

ANNEXURES-D

TREATMENT RELATED MATERIAL

Table 5.1 Assessment and treatment planning for *'aql*

Domain	*Quantitative Assessment*		*Qualitative Questions*	*Treatment Planning* (Mu'ālajah)
***'Aql* Cognitive**	Presence of negative thoughts towards self/ others/future?	☐ Yes ☐ No	- In what areas of life does the individual present with these negative thoughts? - Are they universal or specific? - Are they negatively attributed to the self?	- Increase awareness (*inkishāf*) of thoughts (both negative and positive) through thought processing during sessions and thought records as homework. - Teach the patient the ability to identify negative thought patterns and distortions. - Challenge the negative thoughts, reverse the distortions during sessions and coach the patient to continue in-between sessions. - Process with the patient how these negative thoughts create an imbalance and negatively affect the patient's overall internal psychological state (i.e. the *qalb*).
	Cognitive Distortions?	☐ Selective abstraction ☐ Disqualifying the positive ☐ Personalization ☐ Arbitrary inference ☐ Magnification or minimization ☐ Overgeneralization ☐ Polarized/all-or-nothing thoughts ☐ Jumping to conclusions/mind reading ☐ Emotional reasoning ☐ "Should's" ☐ Labeling/ ☐ mislabeling ☐ Other	- How did these cognitive distortions develop? - How do these distortions negatively affect the individual's relationships? Functioning? Spirituality? - Is the individual aware of these problematic thought processes? - How do the thoughts and schemas disrupt the *i'tidāl* and affect the *qalb*?	
	Do thoughts manifest in dreams?	☐ Yes ☐ No	- Do the dream patterns represent the negative thoughts experienced by the individual?	- Have the patient keep a journal to write down dreams as well as negative thoughts.
	Presence of obsessive thoughts?	☐ Yes, identify obsessions. ☐ No	- What thoughts are obsessive (intrusive, repetitive, unwelcomed, and painful)?	- Utilize exposure and response prevention to treat obsessive thoughts.

Table 5.2 Assessment and treatment planning for *iḥsās*

Domain	*Quantitative Assessment*		*Qualitative Questions*	*Treatment Planning* (Mu'ālajah)
***Iḥsās* Emotion**	Presence of positive emotions? ☐ Love ☐ Respect ☐ Understanding ☐ Happiness Presence of negative emotions? ☐ Sadness ☐ Fear ☐ Rejection ☐ Jealousy	↑ + Extreme + Quite + Very + Little ----------0---------- - Little - Very - Quite ↓ - Extreme	- Have the emotions caused adaptive actions: * Anger leading to assertiveness or defensiveness * Sadness leading to withdrawal * Shame/disgust leading to avoidance * Fear leading to fight, flight, or freeze * Joy leading to connection or engagement?	- Increase emotional awareness (*inkishāf*). - Identify unmet needs from childhood and beyond. - Track repetitive problem cycles. - Enhance emotional regulation through spiritual struggle (*mujāhadah*). - Empathically listen and reflect emotions. - Interrupt and redirect as needed. - Balance (*i'tidāl*) and transform emotions.
	Presence of primary emotions?	☐ Sadness ☐ Hurt ☐ Fear ☐ Shame ☐ Loneliness	- What are the root causes of primary emotions? - How and why have the primary emotions turned into secondary emotions?	- Access unacknowledged emotions behind actions and decisions. - Identify the adaptive/healthy primary emotions below the secondary emotions.
	Presence of secondary emotions?	☐ Anger ☐ Jealousy ☐ Resentment ☐ Frustration	- How do the primary emotions increase the quality of relationships? - How do the secondary emotions push others away?	- Utilize two-chair enactment as needed (e.g. unfinished business, self-critic)

Table 5.3 Assessment and treatment planning for *nafs*

Domain	*Quantitative Assessment*		*Qualitative Questions*	*Treatment Planning* (Mu'ālajah)
***Nafs* Behavioral Inclinations**	Is the individual behaviorally inclined towards gratification or self-destruction?	☐ Yes, identify behavioral inclinations ☐ No	- What is the driving force behind day-to-day decisions and actions? - How much of the behavior is driven by appetites and desires as compared to needs and necessities? - Which specific areas of the behavioral inclinations are most prominent in the individual? - Has the individual previously attempted to discipline the *nafs*? - If yes, what was effective, what was not?	- Increase awareness through identification of daily actions and how these acts satisfy the *nafs*. - Set goals and challenge the patient in opposing (*mujāhada*) these inclinations. - Utilize the opposite behaviors in decreasing negative behavioral inclinations (e.g. fasting when having a binge eating problem).
	How much of the behavior is driven by *nafsānī* inclinations?	☐ Throughout most of the day ☐ A few times a week ☐ Rare to none		
	Which category of behavioral inclinations are catered to (al-Ghazālī 1993)?	☐ Cattle-like: (بهيمية) (eating, drinking, comfort, entertainment, sex) ☐ Predatory: (سبعية) (attacking, killing, stealing, controlling) ☐ Satanic (شيطانية): (plotting, lying, deceiving, cheating) ☐ Angelic (ربانية): (kindness, fairness, justice)		

Table 5.4 Assessment and treatment planning for *rūḥ*

Domain	*Quantitative Assessment*		*Qualitative Questions*	*Treatment Planning* (Mu'ālajah)
***Rūḥ* Spiritual**	Does the individual engage regularly in acts of worship?	☐ Five daily prayers ☐ Fasting ☐ Charity ☐ Reading Qur'ān ☐ Kindness towards others ☐ *Du'ā'*: supplication	- What is the purpose of life? - How do the acts of worship bring the person close to Allah? - What are the intentions of the individual behind the actions? - Does the person live a holistic life with a balanced inner self? - Is the individual able to reorganize the thoughts and seek to worship Allah in all daily acts? - Does the individual attempt to follow the Prophetic tradition in daily life?	- Identify the areas of daily life where the individual lacks spirituality. - Assess and overcome cognitive, emotional, or behavioral issues that impede in spiritual growth. - Find areas of improvement and set goals toward the ideal. - Educate the individual on the Prophet tradition and identify ways to achieve this goal.
	How active is the individual's *rūḥ* (*tab'ī*, *nafsānī*, and *ḥayawānī*)?	☐ *Ṭab'ī*—vegetative ☐ *Ḥayawānī*—animalistic ☐ *Nafsānī*—Psychic		
	Does the individual employ other spiritual practices in daily life?	☐ *Murāqabah*: contemplative meditation ☐ *Tafakkur*: deep thinking ☐ *Dhikr*: remembrance ☐ *Muḥāsabah*: accountability ☐ *Mujāhadah*: struggle to overcome desires ☐ *Mu'ātabah*: repentance		

Table 5.5 Assessment and treatment of *ijtimā'ī* functioning

Domain	*Quantitative Assessment*		*Qualitative Questions*	*Treatment Planning* (Mu'ālajah)
***Ijtimā'ī* Social**	Does the individual cater to the personal factors that affect others?	☐ Appearance ☐ Hygiene ☐ Mannerisms ☐ Responding to others ☐ Reaching out to others	- How does the individual's appropriate appearance and presentation affect his inner as well as social functioning? - What does the patient consider a socially and Islamically acceptable interaction? - When others call on him, how does he respond? - How does the individual reach out to others within familial and social circles? - How often does the individual leave the house to interact with the community/society? - Is the person capable of managing their own health and finances? - Does the individual possess too few or too many belongings?	- Identify the areas in need of improvement. - Increase or decrease social functioning as needed. - Identify the need for increased social connection if the individual isolates and suffers. - Identify the need for solitude as part of spiritual growth if the individual socializes more than appropriate. - Identify the need to socially connect with family members and community members in an attempt to increase overall spirituality.
	Does the individual interact with others in a manner most beneficial and appropriate?	☐ Speech ☐ Choice of words ☐ Going out of the house ☐ Interacting with the community		
	Other socially related factors:	☐ Leisure activities ☐ Personal health ☐ Personal finances ☐ Possessions		

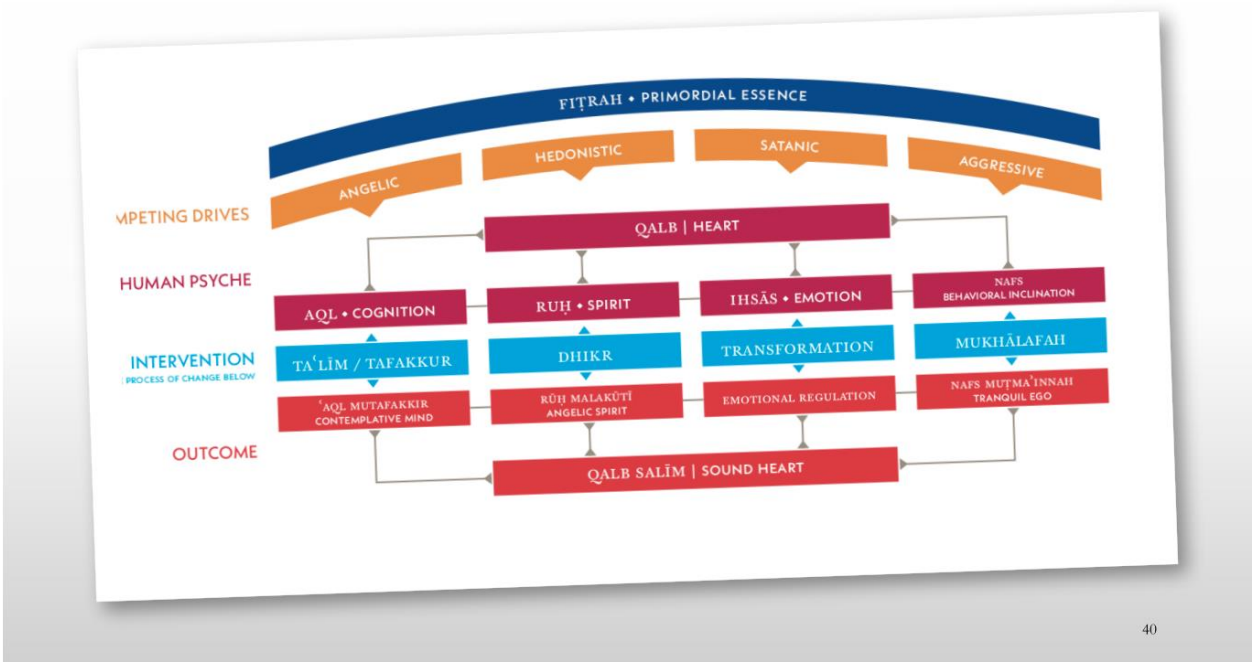
Table 9.3 The six M's—daily log

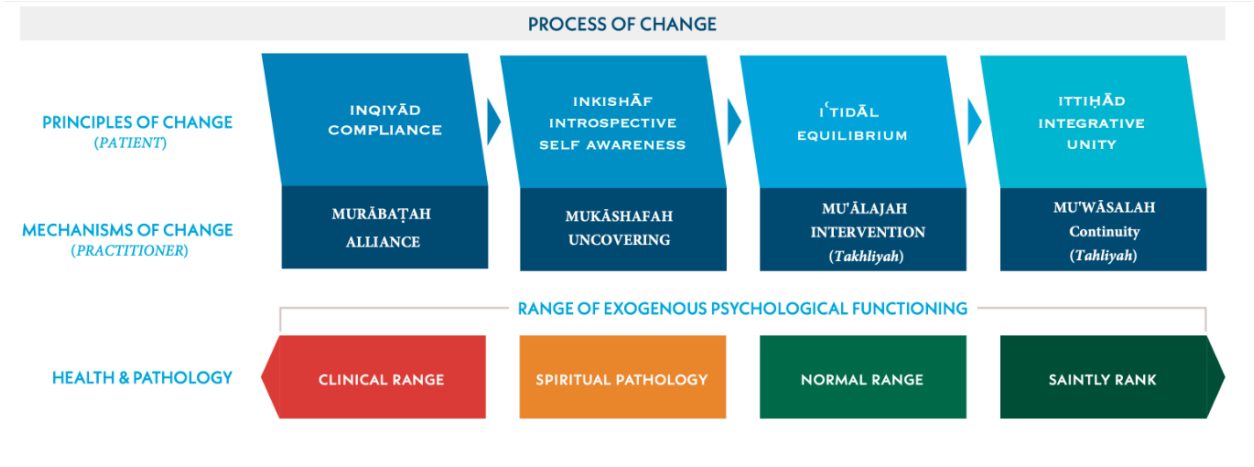
	Beginning of the Day	*End of the Day*	*Score**
Mushāraṭah (goal-setting or stipulation)	What is the action or non-action that is desired?		
Murāqabah (self-monitoring)	List the triggers, cues and thought processes that lead to both success and failure.		
Muḥāsabah (self-evaluation)	How many times during the day will you stop and evaluate yourself?	How would you rate your achieving of the goal you set today?	
Mu'āqabah (consequences)	What consequence will you give yourself for not achieving the goal?	Did you give yourself the consequence for not achieving the goal?	
Mu'ātabah (self-reprimand)	What will you say to yourself when you are not achieving the goal?	Did you use this self-talk/reminder?	
Mujāhadah (exertion)	What do you need to do in order to fulfill your goal throughout the day?		

* For each of the M's, one can self-grade themselves using the 3 levels of actions from Qur'ān 35:32 which are:
[0] Fell short (*ẓālimun li nafsihī*)
[1] Practiced it most of the time (*muqtaṣid*)
[2] Went beyond the goal (*sābiqun bi-l-khayrāt*)

Table 9.4 The six M's—weekly log

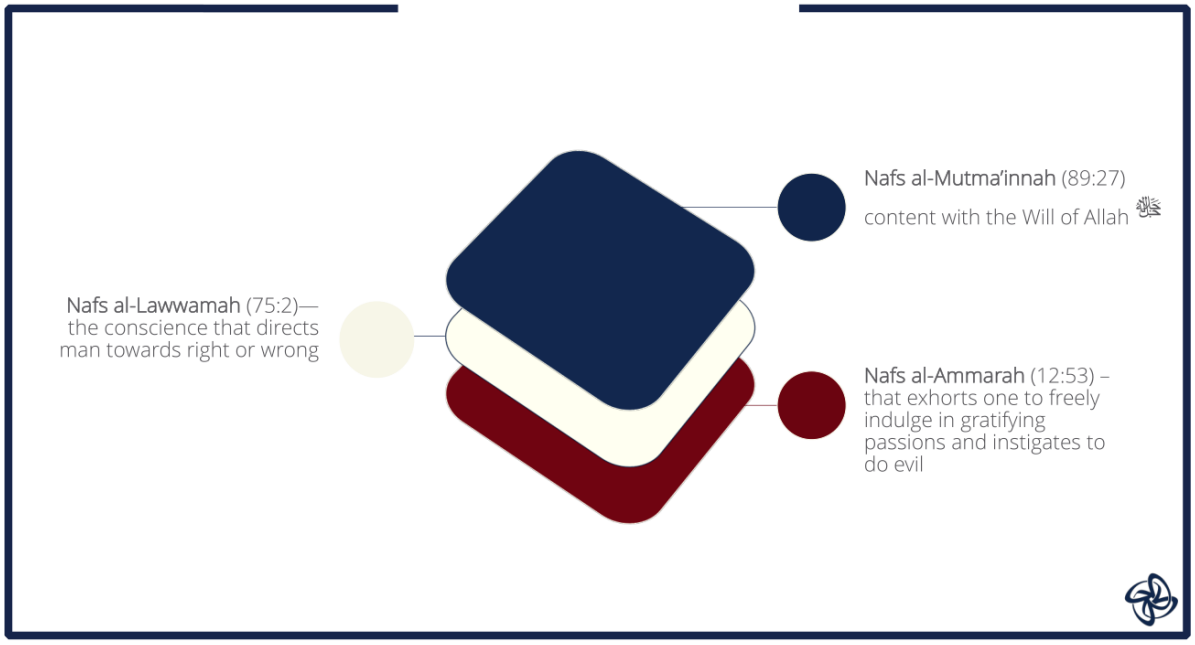
Day	*Mushāraṭah (goal-setting or stipulation)*	*Murāqabah (self-monitoring)*	*Mu'āqabah (consequences)*	*Mu'ātabah (self-reprimand)*	*Mujāhadah (exertion)*	*Muḥāsabah (self-evaluation)*
1						
2						
3						
4						
5						
6						
7						

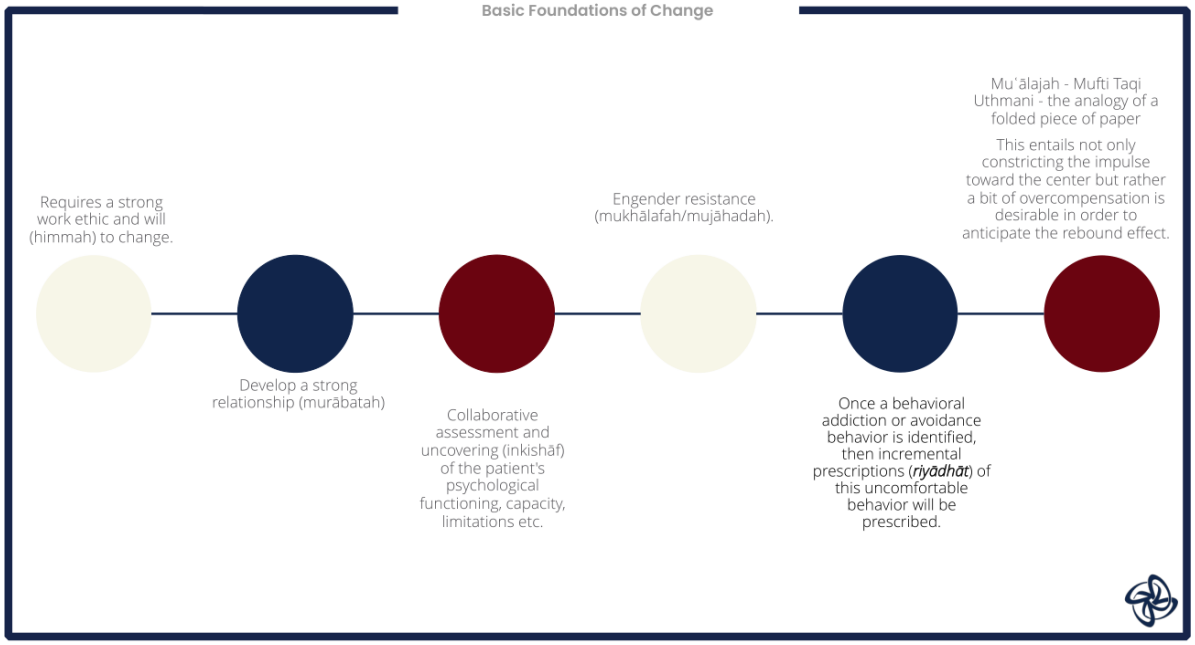




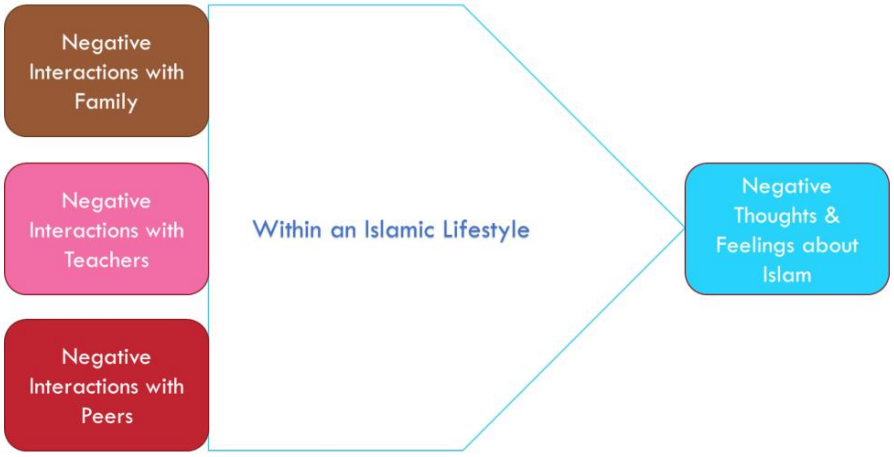
Process of Change

41

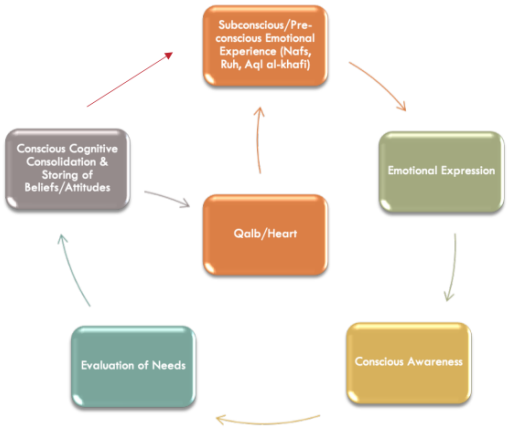

Nafs al-Mutma'innah (89:27)
content with the Will of Allah ﷻ
Nafs al-Lawwamah (75:2)—
the conscience that directs
man towards right or wrong
Nafs al-Ammarah (12:53) –
that exhorts one to freely
indulge in gratifying
passions and instigates to
do evil


Basic Foundations of Change
Mu'ālajah - Mufti Taqi Uthmani - the analogy of a folded piece of paper
This entails not only constricting the impulse toward the center but rather a bit of overcompensation is desirable in order to anticipate the rebound effect.
Requires a strong work ethic and will (himmah) to change.
Develop a strong relationship (murābatah)
Collaborative assessment and uncovering (inkishāf) of the patient's psychological functioning, capacity, limitations etc.
Engender resistance (mukhālafah/mujāhadah).
Once a behavioral addiction or avoidance behavior is identified, then incremental prescriptions (riyādhāt) of this uncomfortable behavior will be prescribed.

Relationships - Enmeshment of Thoughts



Cycle of Emotional Experience



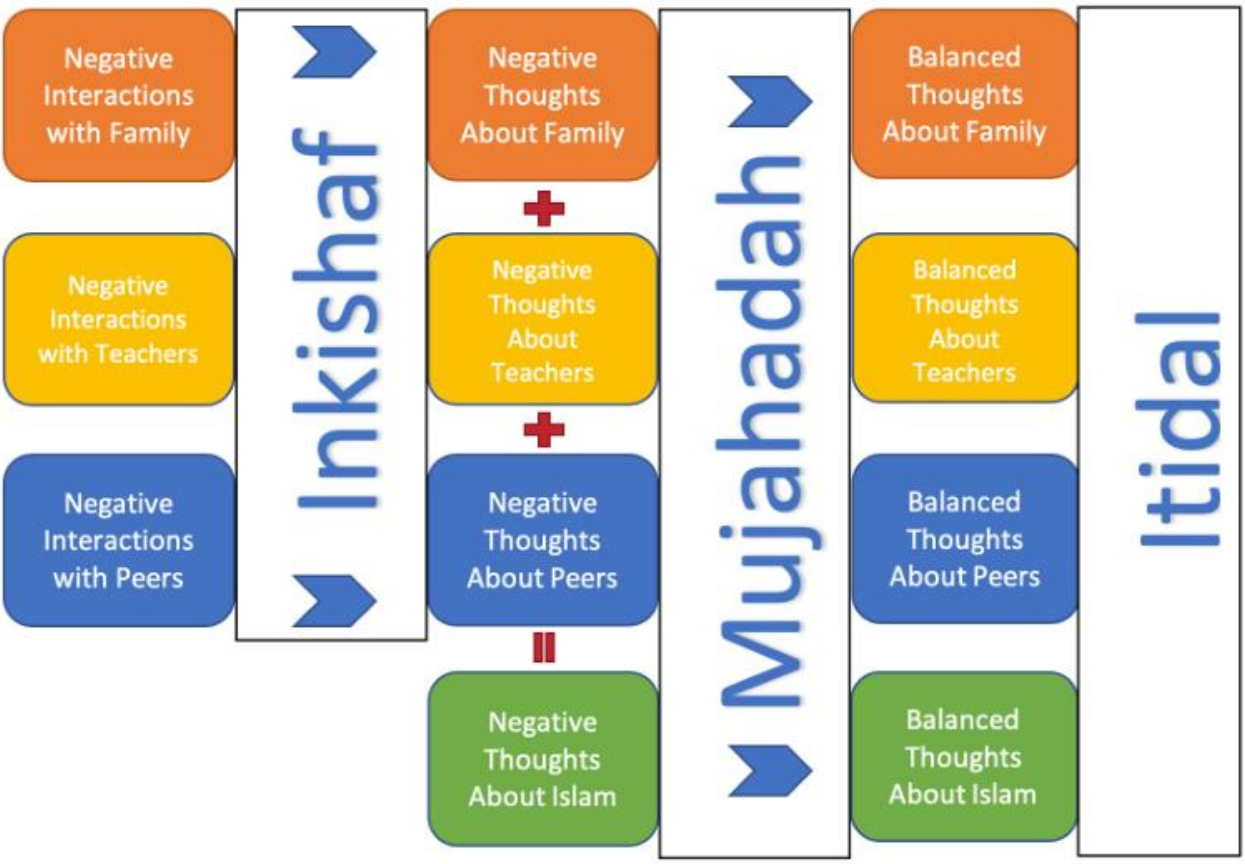
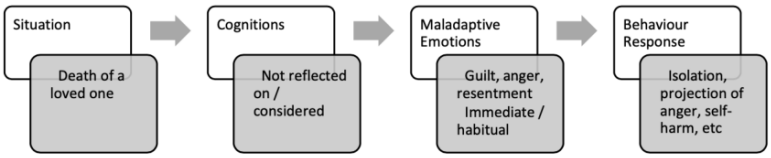
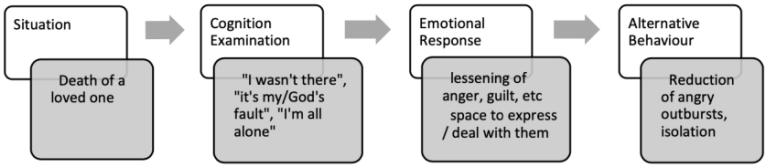


Diagram 6: TIIP stages of therapy in accordance with the *ammara-lawwama-mutma'inna* paradigm

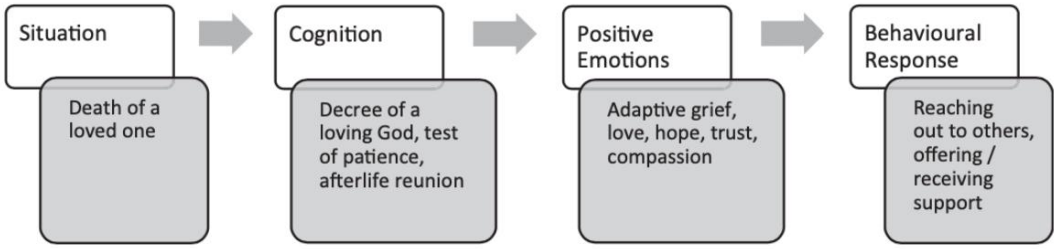
The *Inkishaf / Nafs al-Ammara* stage of cognitive therapy:

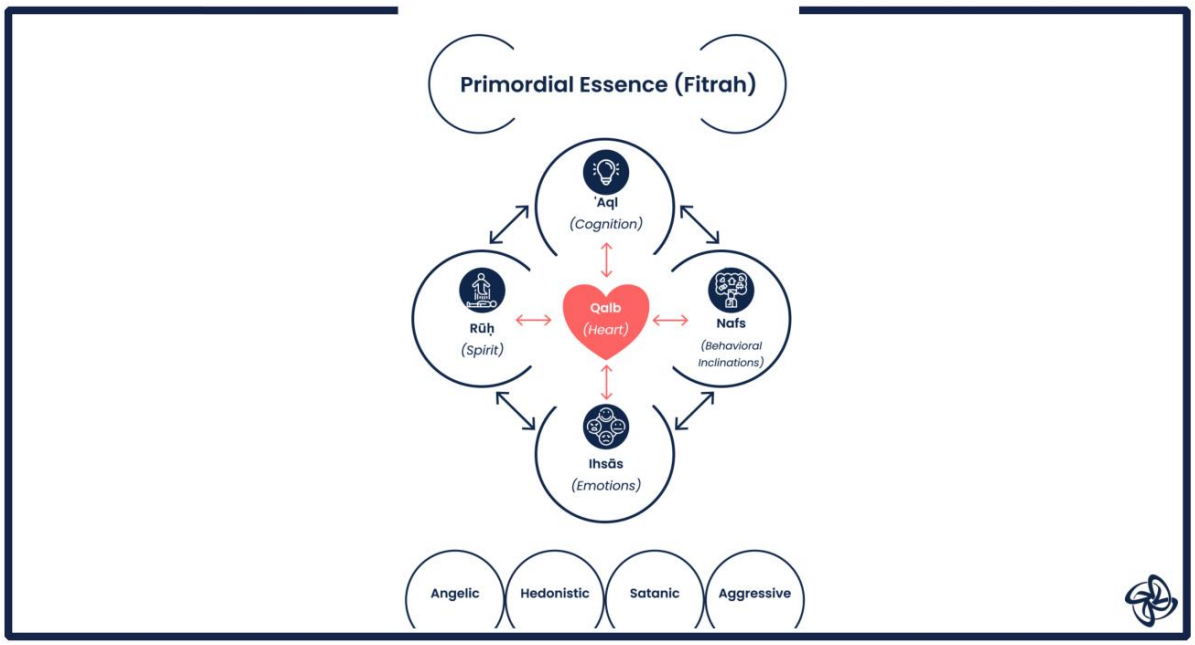


The *Mujahada / Nafs al-Lawwama* stage of cognitive therapy:



The *I'tidāl & Ittiḥād / Nafs Muṭma'innah* stage of cognitive therapy:





CHARACTER STRENGTHS & VIRTUES BY SELIGMAN ET. AL.

Table 9.1 Takhalli (removal) of spiritual diseases

Name of Disease	*Transliteration of Arabic*	*Definition*	*Cause*	*Cure**
Stinginess	*Bukhl*	The prevention of and fear of obligatory spending	Love of worldly things in and of themselves or to achieve desire through them	Reflection on the reality of wealth, considering the state of stingy people in the eyes of others
Blameworthy joy	*Baṭr*	Extreme joy	Love of worldly things, love of position	Hunger, *dhikr*, and verse 28:76
Hate	*Bughḍ*	Hate for other than the sake of Allah	Arrogance, asserting the right of the self (*intiṣār al-nafs*)	Supplication (*du'ā'*) for the one who is hated
Transgression	*Baghy*	Harming another person	Ignorance (*jahl*) of the rights of others, disregard for their rights, rationalization (*ta'wīl*) that the rights can be removed, arrogance (*kibr*)	Learning about the rights and responsibilities of others, reflecting on the stories of the transgressors, humility, doing good for others
Love of position	*Ḥubb al-riyāsah*	The desire to be recognized by others	Lack of seeking the acceptance (*riḍā*) of Allah, covetousness (*ṭama'*)	Reflection on those who gained everything and then lost it or died, realizing that this is a distraction from Allah, doing things that could elicit the critique of people, isolation (*i'tizāl*).
Love of worldly things	*Ḥubb al-dunyā*	Loving worldly things in and of themselves – note that not all love is prohibited as love can fall within five categories (prohibited, disliked, permissible, recommended, obligatory)	This is the root disease of all diseases according to some scholars. Others have considered conceit (*riḍā bi-l-nafs*) as the root cause.	The cure for stinginess can be used here, certainty (*yaqīn*), reflecting on death, increasing rejection of worldly things (*zuhd*), treating conceit as a possible root cause

(*continued*)

Table 9.1 Cont.

Name of Disease	*Transliteration of Arabic*	*Definition*	*Cause*	*Cure**
Love of undue praise	*Ḥubb al-madḥ bi mā lam yaf'al*	Wanting to be praised for something that they did not really do	Religious showing off (*riyā'*), covetousness (*ṭama'*), love of worldly things, love of position	Increasing sincerity (*ikhlāṣ*)
Envy	*Ḥasad*	The desire to have a blessing removed from another person	Enmity, vying for love, arrogance, vying for position, vanity, love of position, and extreme stinginess (*shuḥḥ*)	Actions that are contrary to what one desires to do, reflecting on the harm in harboring these feelings
Blameworthy shyness	*Ḥayā' dhamīm*	Shyness which prevents changing wrongdoing or asking a question that needs to be asked	Coveting things (*tama'*), fear of criticism (*karāhat al-dhamm*)	Increasing courage (*shajā'ah*), increasing certainty (*yaqīn*) in the truth of their beliefs or ideas
Blameworthy thoughts	*Khawḍ fī mā lā ya'nī*	Reflecting on matters prohibited by the Sacred Law	Covetousness (*ṭama'*), transgressing the limits (ḥudūd) of God, ignorance (jahl) of the limits of God, love of worldly things	*Dhikr*, seeking refuge in Allah (*ta'awwudh*)
Fear of poverty	*Khawf al-faqr*	Fearing the loss of what one has and/or not getting what one needs	Having a negative opinion about God in that He cannot provide, excessive hope (*ṭūl al-amal*)	Having a positive opinion about God and His ability to provide, reflecting on the storehouse of God never being diminished
Sycophancy	*Mudāhanah*	Sacrificing one's religion to serve a worldy need	Covetousness (*ṭama'*) and religious showing off (*riya'*)	Treatment the root causes of both covetousness (*ṭama'*) and religious showing off (*riyā'*)
Religious showing off	*Riyā'*	Performing an act of worship other than for the sake of God, for a benefit, to seek praise or to prevent harm	Covetousness (*ṭama'*), love of position, love of worldly things	Reflecting on the true nature of where harm and benefit come from, reflecting on the harm it causes in this life and the next, doing acts of worship in private, *sūrat al-ikhlāṣ*, *sayyid al-istighfār*
Fearing things other than God	*Khawf ghayr Allah*	Fear that prevents one from fulfilling their obligations	Decreased *yaqīn*, fear of poverty (*khawf al-faqr*), decreased dependence (*tawakkul*) on Allah	Increasing *yaqīn* and *tawakkul*
Resentment of Divine ordainment	*Sakhaṭ a-qadr*	Opposing Divine ordainment (*qadr*) by saying things like "I didn't deserve this" or "What did I do to deserve this?"	Not having sufficient certainty (*yaqīn*)	Increasing acceptance (*riḍā*), reflecting on the *Ḥadīth* "The pens have been lifted"
Religious bragging	*Sum'ah*	Telling others about an act of worship after it was completed without any deficiencies like showing off	Some of the same reasons for religious showing off (*riyā'*)	Hiding actions, not speaking about one's good actions, praising the actions of others, reading about the humility of the prophets and the righteous
Covetousness	*Ṭama'*	Constantly wanting and never being satiated by what one attains	Heedlessness (*ghaflah*), doubt about Divine ordainment (*qadr*)	Reflecting on the true nature of the *dunya*
Excessive hope	*Ṭūl al-amal*	Acting as if one will live forever	Heedlessness (*ghaflah*), ignorance of the reality of life	Reflecting on death
Belief in omens	*Tiyarah*	Having a negative belief due to the occurrence of a specific thing	Ignorance of the fact that all things are in the control of God, negative opinions (*sū' al-ẓann*) about God	Having a good opinion (*ḥusn al-ẓann*) about God
Negative opinions	*Sū' al-ẓann*	Having certainty about another person without any evidence	Arrogance, satisfaction with one's own opinion (*i'jāb al-nafs bi-l-ra'y*)	Having a good opinion (*ḥusn al-ẓan*) about the person, praising them publicly, supplicating (*du'ā'*) for the person
Vanity	*'Ujb*	Being overly impressed by a blessing while forgetting that it is from God	Being heedless of the true source of blessings (*nisyān al-ni'mah*)	Reflecting on the fact that God is the Creator and Giver of Blessing, reflecting the fact that one is truly unable to create benefit or harm

(*continued*)

Table 9.1 Cont.

Name of Disease	*Transliteration of Arabic*	*Definition*	*Cause*	*Cure**
Cheating	*Ghish*	Hiding something harmful, whether a religious matter (*deen*) or worldly matter (*dunya*), making what is not the best seem like it is the best	Arrogance, giving victory to the self (*intiṣār al-nafs*), love of worldly things, coveting things (*ṭama'*)	Reflecting on brotherhood (*ukhuwwah*)
Anger	*Ghaḍab*	Unreasonable anger when things do not go their way	Strong belief in the right of the self	Preventative cure: reflecting on the lofty status of the forbearing ones and of humility. Treatment when angry: Reflecting on who is ultimately in control, washing with cold water, silence, sitting or laying down, and seeking refuge in God (*ta'awwudh*)
Heedlessness	*Ghaflah*	Being heedless of the commands and prohibitions of God	Excessive joy (*baṭr*), making light of religion (*tasāhul bi-l-dīn*), ignorance (*jahl*)	Seeking forgiveness (istighfār), visiting the righteous, prayers on the Prophet (*ṣalawāt*), reading the Qur'ān
Deceit	*Ghill*	The heart's resolution to deceive or be treacherous	Anger, hate, arrogance, love of worldly things	Be kind to the person, reflect on the forgiveness given to those who make amends
Boasting	*Fakhr*	Self-praise of one's own characteristics or accomplishments	Arrogance, vanity (*'ujb*), belief that one is complete, believing oneself to be better than others (*ru'yat al-faḍl*)	Humility, hiding one's blessings
Arrogance	*Kibr*	Grandyfying oneself while belittling others	Love of position	Being clear about the true status of God and one's status as a human, working on the station of gratitude and humility
Self-abasement	*Dhull*	Placing oneself in a situation where others belittle them or take their right	Discounting blessings (*nisyān al-ni'mah*)	Increasing healthy pride (*'izzah*)
Disdain of criticism	*Karāhat al-dhamm*	Fear of being criticized by people and seeking out their praise	Love of position, arrogance	Reflecting on where benefit and harm ultimately come from
Fear of death	*Karāht al-mawt*	Fear of death to the point that one is bothered if it is merely mentioned	Love of worldly things, negative opinion about Allah (*sū' al-ẓann*)	Reflecting on death and what is beyond death, increasing hope (*rajā'*) in Allah, good opinion about Allah (*ḥusn al-ẓann*)
Discounting blessings	*Nisyān al-ni'mah*	Being heedless of one's blessings and not showing gratitude for the giver of the blessing	Arrogance, heedlessness (*ghaflah*) specifically of the fact that all blessings from Allah	Counting one's blessings, increasing gratitude (*shukr*), reciting the verses about blessings (specifically 14:7 and 13:11), thinking about those who are less fortunate, the *dhikr* of gratitude (*al-ḥamdu li-llāh*)
Mockery	*Haz'*	Pointing out faults in a manner that causes humour and laughter	Arrogance	Use the treatment for arrogance (*kibr*)

* Note: If a cause is another disease, treatment should also include addressing the root disease(s)

Domains	Clinician (Tabib)	TIIP Therapist	Sufi Shaykh
Religious Authority	No	Authoritative contingent upon formal education	Yes
Credentials (authority)	State Licensure, Formal Academic/Clinical Training	State Licensure, Formal Academic/Clinical Training & Certification in IP (still formative)	Ijazat or Authority/permission granted by their Spiritual Master
Problems Primarily Treated	Clinical Problems	Clinical with appreciation of and understanding of Spiritual Problems, virtue and character development.	Spiritual Problems
Treatment Modality Utilized	Varies (biomedical, humanistic, psychodynamic, etc)	Spiritually-Informed Integrative Approach	Spiritual Reformation
Goals	- Generally: reduce symptoms, increase functioning - Specifically: varies from orientation to orientation	- Reduce symptoms - Increase functioning - Engender Psycho-Spiritual Resilience	- Journey towards the Creator through dhikr (contemplation), suhbat (righteous companionship), rabita (intimate bond with shaykh), and riyadat (contemplative exercises) - Spiritual reformation - Reduction of spiritual symptoms
Style / Approach	Non-Directive	Authoritative & Collaborative	Directive/Authoritarian
Developmental Focus	Increase functioning to normal within the context of worldly existence (i.e. birth to death)	From pre-natal to the post-mortem spiritual existence with a focus on the improvement of present functioning	Direct the focus to the primordial goal of attaining success in this life and in the afterlife
Interventions	Evidence based behavioral science interventions	Adaptation of evidenced based interventions along with interventions drawn from the spiritual tradition with supportive evidence	- Inherently drawn from the Islamic intellectual heritage (i.e Quran and Sunnah) - Based on experiential knowledge
Nature of Contract	Secular and fiduciary	Spiritual agreement upon an integrative treatment approach as well as upholding the requirements of contracts within the area of practice	- Master/Disciple - Formal pledge (bayah) and discipleship
Required Indicators for Pathology	- Biomedical - Psychosocial functioning - Thought disorder - Emotional imbalance	Psychological functioning along with attention to spiritual sicknesses that significantly impacts current functioning	- Covert indicators of spiritual illnesses - Overt concerns related to ritual and non-ritual behaviors
Types of Pathologies Addressed	Medical, psychological disorders within the context of functioning	Psychological disorders along with spiritual diseases of the heart **within the context of mental health and well-being**	Aspirations towards spiritual perfection (Kamaal) Sickness of the heart
Educational Prerequisites	Formal secular degree with licensure	Academic education as well as Islamic education	Islamic education and mentorship of a senior shaykh
Relationship and Boundaries	- In most cases, formal relationship with strict boundaries	- Therapist serves as an authoritative process expert. - Mutual respect and authority	- Formal relationship with strict boundaries - Respect and authority reserved for the shaykh -Handing over self in totality to the Shaykh

practice still tends to be long term and to take place in White middle- to upper-class neighborhoods with white middle- to upper-class clientele. Yet there is no necessary link between such contexts and successful E–H therapy. As E–H practitioners are discovering, the benefits of presence, I–Thou encounter, and responsibility are cross-cultural as well as cross-disciplinary (Vontress & Epp, 2015).

Although E–H therapists realize that they cannot be "all things to all people" and that certain problems (e.g., simple phobias, brain pathology) are best handled by specialists, a definite ecumenism applies to contemporary E–H practice. This ecumenism is correlating with cross-disciplinary openness, adaptations for diverse populations, and sliding fee scales.

Let's consider some examples of brief and long-term strategies (or conditions) in which substantive E–H transformation was facilitated. We will use this opportunity not only to elaborate our strategies but also to animate them in the context of a case.

Short-Term Case: Mimi

The following case is an example of how Orah Krug integrated an E–H approach with cognitive and behavioral techniques to help Mimi, a young mother, rapidly resolve a recent traumatic experience. Although not central to the therapy, Mimi's Persian heritage, culture, and worldview were also factors in how Krug worked with her.

Mimi was an attractive, 29-year-old woman of Persian descent, married, with two small children, and 7 months into her third pregnancy. Mimi had come with her parents and sister to the United States when she was 12. After graduating from nursing school, she worked in a pediatric hospital for several years before her children were born.

Mimi was referred to me by her primary care physician because she was exhibiting posttraumatic stress symptoms resulting from an incident that involved her and her children. Two months previously, she and her children had been sitting in their living room when a small plane making an emergency landing sheared off a corner of their house. In our first session, Mimi described her confusion; at first thinking it was an earthquake, she

grabbed her children and ran to the nearest doorway. Only then did she look around to see the nearby plane and the devastation it caused. As she related the event, I could see how much she was "caught" in the experience; it was as if in the retelling she was reliving the experience. This is a common and unfortunate aspect of posttraumatic stress disorder (PTSD). By emotionally reliving the trauma, she was in effect retraumatizing herself each time she retold the story.

Mimi seemed to be coping with her fear, horror, and sense of helplessness with an overlay of anger toward the person piloting the plane:

I was just innocently sitting in my home, and now because of this person's negligence, my house has been violated, my children were scared, and perhaps my unborn child has been affected. I know I'm not relaxed and happy like I was with my other pregnancies. I'm very irritable, I'm not being the mother I want to be, and we have to live in a cramped apartment until our house is repaired. Mice have gotten into my house and eaten my clothes and shoes. I feel like my things have been defiled.

The injustice of the event was gnawing at her like the mice that ate her clothes. Mimi was unable to stop replaying the event in her mind and the consequent retraumatization. She also was experiencing a general numbing of emotions, as evidenced in her complaint that she didn't feel the joy or pleasure in life she had known before. Moreover, she expressed a desire to move out of her house now that it held such bad memories. She was very jumpy. Loud noises scared her, and she worried that she would never feel calm again. If all that wasn't enough, Mimi had taken on the responsibility of caring for her terminally ill sister who lived with her parents. Mimi's days were spent at her parents' house caring for her own children as well as her sister and her frail parents.

Mimi allowed that she was carrying a heavy load but said she was OK with the situation because it meant that she was fulfilling her role as a dutiful daughter and a caring sister. Mimi explained that in her culture, adult children were expected to care for their elderly parents and siblings when needed. I reflected that on the positive side her tasks seemed to give her life greater purpose and meaning, but on the negative side, they seemed to be not only a physical strain but an added emotional strain to her already

emotionally stressed system. By framing the situation in this way, I hoped to acknowledge the value she placed on her caregiving in light of the norms of her culture but at the same time acknowledge its deleterious impact on her. My approach allowed Mimi to feel supported and not judged. Eventually it enabled her to delegate some of the caregiving tasks to a visiting nurse.

Overall, Mimi appeared to have been a high-functioning woman who, prior to the incident, had felt generally happy and content with her marriage and life but whose sense of security was now badly ruptured. Mimi was drained both physically and emotionally, but she was extremely motivated to feel better and get "her old life back." Given that Mimi was set to give birth in a few months, we had a limited time period in which to work. Consequently, I met with Mimi just eight times over 2 months. Her high functionality, cooperative attitude, and motivation contributed to her rapid progress.

My work with Mimi was an integration of behavioral strategies within an existential context. The aims were to alleviate her PTSD symptoms, to help her be more present to herself, and to constructively incorporate the traumatic experience into her life. I shared my aims with her and explained how I worked in the here and now to help her become more aware of her thoughts and behavior patterns that might be blocking her healing process. I asked her if she felt OK about working with me in this way. She readily agreed, saying that she wanted to do whatever was needed to feel better.

I wanted her to understand that our work would be a collaborative effort, and so I began with Mimi, as I do with all my clients, to build the therapeutic relationship with my self-disclosures. I don't believe in keeping the process of therapy mysterious. I want my clients to understand the way I work and, more importantly, to have an experience of it in the first session. Throughout the work, I made sure to check in about our interpersonal connection by asking questions like "How was it to share that with me?" or "How has the space felt between us today?" or "What was the most difficult part of our session today?" These types of questions brought Mimi's focus to our relationship. By inviting her to express her feelings about me and our relationship, I intentionally cultivated interpersonal presence and a sense of safety and intimacy between us. I also tried to help her feel safe and understood by cultivating intrapersonal presence. I listened to her "music"

as much as her words, mirroring back to her my felt sense of her terror and anger.

After laying this groundwork, I began to focus her on her anger because it was clear that she was stuck in it. She expressed it as a sense of injustice ("it isn't fair; I wasn't prepared"). By tagging these expressions, I helped her become more conscious of how much and in what ways she was expressing this injustice. I held up a mirror to her experience, noting, "Once again, you say how unfair it is" or "Can you hear yourself getting angry again as you tell me what happened?" Fairly quickly, she began to agree with my comment that her repetitive statements were gnawing away at her like the mice gnawing on her clothes. I tried to help her move out of her stuckness by suggesting that she use a "Stop" technique (Penzel, 2000). Whenever she heard herself begin the repetitive litany, she was to say, "Stop; I don't need to go down this road" and imagine a place where she felt safe and cozy. I asked her to practice the Stop technique as many times as she needed to between sessions.

At the next session, she reported that at first she struggled to stop her repetitive thinking, but after using the technique for a while, she was able to stop reminding herself of her plight and started to feel better. Given that Mimi was beginning to let go of her anger, it seemed the right time to help her open to whatever other feelings were associated with her trauma. Consequently, I suggested we explore her feelings of unfairness. I shared with her my sense that the energy with which she said "It isn't fair" implied the existence of some important feelings beyond anger. "First, take some nice deep breaths," I said, "and when you're ready, turn your attention inward and make some space for your feelings of 'It isn't fair.'" As soon as she began to slow down and breathe deeply, tears began to run down her face. "Are there any words?" I asked softly. "There was no place to go, and I thought we were going to die. I didn't know what was happening, and I couldn't protect my children." Mimi was with her experience, not caught in her experience this time. By connecting with her inner self, she was able to be both in the experience and outside of it. This is exactly what she reported at the end of our session. "I felt different," she said. "I felt separate from them [her feelings] for the first time." Now Mimi could begin to heal. By encouraging Mimi to be more present with herself, she moved from

repetitively expressing her anger to experiencing her fear of dying and sense of helplessness in a constructive and healing way.

Over the next few sessions, as Mimi allowed herself to be with her death terror and sense of helplessness, her repetitive angry statements gradually disappeared. Now we could help her dissolve her traumatic memories. I used a modified version of eye movement desensitization and reprocessing (EMDR), as developed by Shapiro (1998), by asking her to call up the memory and view it as if she were on a train and the landscape was moving past her. As she recalled the memory, I told her to tell herself, "This is just a memory. It's in the past. I can let it go by and focus on my safe and cozy place." We practiced this exercise after first doing abdominal breathing for 5 minutes. I suggested that she try to do this exercise four times before our next session. I told her that if at any time she felt "caught" in the experience, she should stop, focus on her breathing, and return to her safe place.

Two weeks went by between sessions. Mimi walked in looking more relaxed and alive. She had found the exercise to be extremely helpful, saying that it allowed her to take a step back from the incident and not feel caught up by it. She reported that she was no longer plagued by the memories and was beginning to feel more alive in her life. She reported that she was sleeping more soundly, was less irritable, and no longer jumped at loud noises. Many therapists would be satisfied with these results and would likely have no further aims other than to consolidate the learning. But as an existential therapist, I sensed that one of the difficulties underlying Mimi's symptoms was her inability to accept a crucial aspect of existence, namely that personal safety and security are an illusion—at any moment they can be shattered.

Short-term therapy requires a therapist to balance time restrictions with the ability to help a person open to her or his self and world constructs that are both protective and life limiting. I sensed that Mimi's difficulties in accepting the accident stemmed in part from an aspect of Mimi's self and world construct system. Mimi held, as most of us do, a belief in her specialness that often results in the unconscious belief that life's contingencies happen to everyone else but us.

Yalom (1980) described this process quite well:

> Once the defense is truly undermined [as it was in Mimi's case], once the individual really grasps, "My God, I'm really going to die," and realizes that life will deal with him or her in the same harsh way as it deals with others, he or she feels lost and, in some odd way, betrayed. (p. 118)

This was Mimi's unspoken attitude, and it seemed important to help her explore and hopefully resolve it to some extent within our limited time together.

Consequently, in the next couple of sessions, in addition to practicing the desensitization technique, we devoted a substantial amount of time to working with Mimi's inability to accept the contingencies of existence. As we explored Mimi's feelings about life's uncertainties, she began to realize how she typically coped with uncertainty—by being self-sufficient and by trying to be in control, by being "on top of everything" and "keeping a lid on her feelings." Her phrase "it isn't fair" reemerged, but now Mimi understood it as her unwillingness to face and accept the harsh contingencies of life. "Go slow," I suggested, "and let yourself explore what it means now." She responded, "It isn't fair that there is no plan, no structure, no protection—anything can happen." After a few sessions of being with her recognition that anything can happen to her and to those she loves, Mimi acknowledged, "I don't like it, but I guess that's just how life is." By acknowledging the condition of being unprotected, she paradoxically could now begin to accept the unacceptable. Although she never verbalized her sense of specialness, she implicitly began to accept her vulnerability and finiteness. Because of our limited time together, I decided not to invite a more personal exploration of Mimi's sense of specialness. I felt that given our time constraints, my responsibility was to help her build more effective coping strategies to deal more effectively with an awareness of life's contingencies. Over the next few sessions, Mimi was more able to accept her lost sense of security and to build a more realistic view of what it meant to be safe and secure based on her newly formed awareness.

I met with Mimi 3 weeks later, and she reported that she was doing much better and that she and her family were returning to their repaired home the following week. She said she liked it even better than before, and she felt better about herself and her life than she ever had. She declared her intention to continue practicing the meditative deep breathing every day,

saying it helped her stay calm and energized. I asked her what her experience of our work was together. She said she learned a great deal about who she was and why she did what she did. She reported that she felt more willing and able to face life's challenges even though paradoxically she recognized that bad things can and will happen to her and those she loves.

I followed up with Mimi 4 months later. She and her husband were enjoying their new baby in their rebuilt home. Mimi reported that she felt "like my old self, but better." She told me she wasn't taking on as many tasks and was finding more enjoyment in her children, family, and life in general. She said she rarely experienced bad memories from the accident, and when they did surface, she did her EMDR exercise. She continued to meditate, felt relaxed during the day, and slept as well as could be expected with a new baby.

Appendix A offers a short-term existential–integrative (E–I) case of Hamilton conducted by Kirk Schneider. Let's turn now to techniques used in long-term therapy.

Long-Term Strategies and Techniques

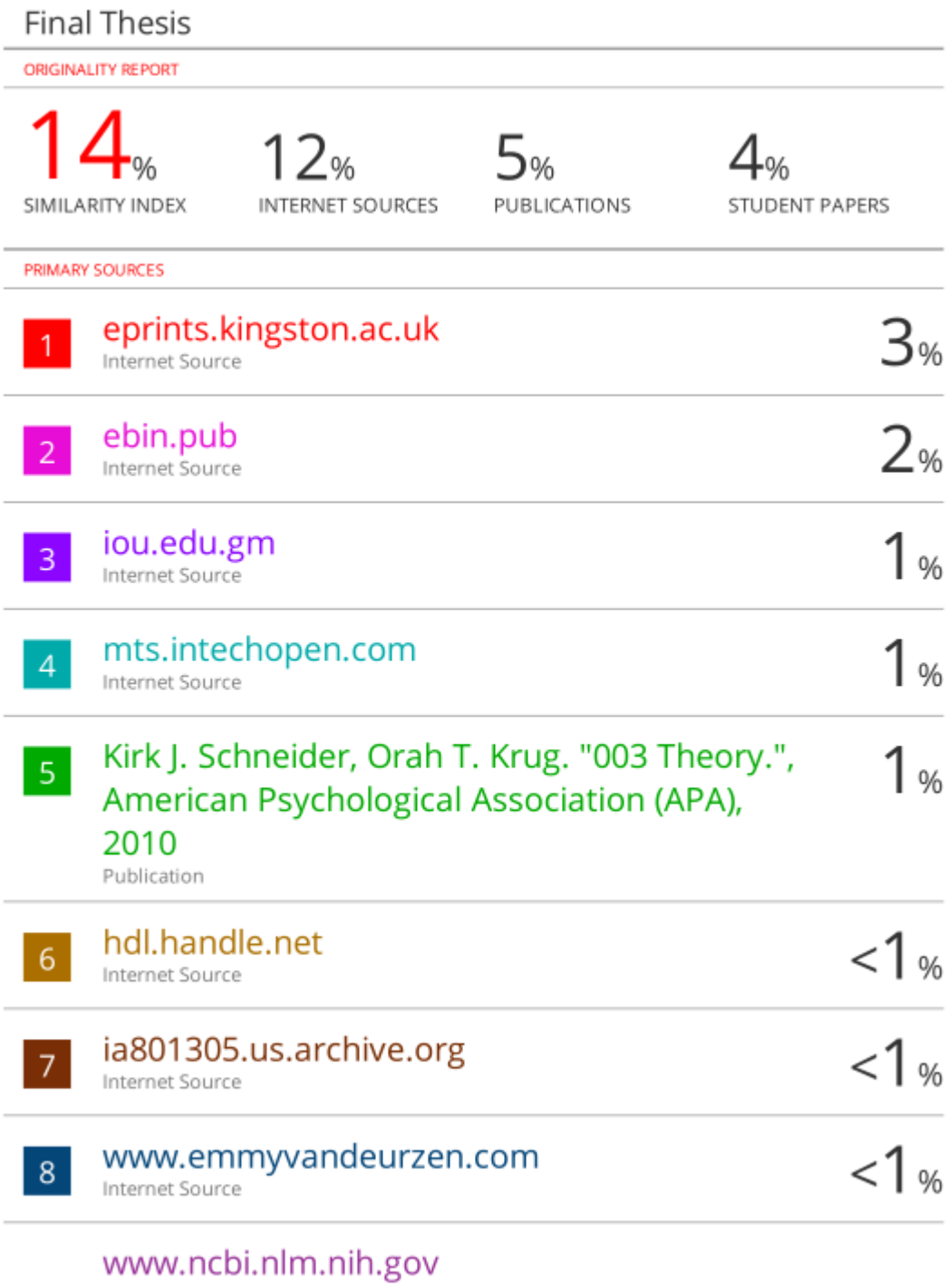
In this section, we present Kirk Schneider's case of Emma, which illustrates his E–I approach to therapy. In addition, in Appendix B we present Orah Krug's conceptualization of the phases of change in a typical long-term therapy, and in Appendix C we present Krug's long-term case of Claudia. Both of these approaches illustrate diverse but related applications of long-term E–H therapy.

Long-Term Case: Emma

In this case, Kirk Schneider elaborated a long-term E–I therapy with a particular emphasis on the experiential level of contact. I use this case to illustrate both the framework within which I understand psychological suffering (polarization) and the means by which core aspects of suffering can be transformed. Although much of this illustration can be understood on the basis of that which has already been described in this volume—particularly regarding constrictive–expansive dynamics, limitation and

ANNEXURES-E

Plagiarism



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