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Application of Traditional Islamically Integrated Psychotherapy (TIIP) and Its Clinical Outcome on Psychological Distress Among American Muslims in Outpatient Therapy

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Although individuals frequently turn to religion and spirituality in times of crises and other mental health concerns (Vieten & Lukoff, 2022; Yamada et al., 2020), limited research explores its utility when purposefully integrated into mental health treatment, especially in Muslim populations. While there is evidence for the clinical efficacy of Islamic adaptations of cognitive and rational therapies for Muslim patients, there are very few clinical outcome studies on inherently Islamic models of psychotherapy (Hook et al., 2010; Smith et al., 2007; Worthington & Sandage, 2001). The present study explored the clinical efficacy of an Islamic model of psychotherapy, known as Traditional Islamically Integrated Psychotherapy (TIIP; Keshavarzi et al., 2020) through a practice-based evidence approach. Five clinicians, trained in the TIIP model, offered services to 107 patients for 420 sessions at an outpatient mental health center tailored to address Muslim mental health concerns. The therapist session checklist indicated that TIIP practitioners not only utilized Islamic spiritual interventions but also integrated cognitive and emotion-focused interventions into the TIIP model of care. The outcomes of the study demonstrated a reduction in clinical distress as measured by Clinically Adaptive Multidimensional Outcome Survey and a reduction in functional distress through clinical outcomes in routine evaluation over time, indicating preliminary evidence for the efficacy of TIIP in application to Muslim patients. Process variables such as session intentions, counseling topics, as well as specific interventions from the TIIP model are presented.

Keywords: Islam, Muslims, traditional islamically integrated psychotherapy, psychotherapy, spirituality

With a population size of 4.45 million Muslims in the United States (U.S. Religion Census, 2020), representation in literature for Islamically integrated approaches to therapy and their efficacies is significantly disproportionate (Haque et al., 2016). Research has shown that some individuals turn to religion and spirituality when suffering from mental health issues and crises (Vieten & Lukoff, 2022; Yamada et al., 2020). Additionally, research on Muslim populations demonstrates a preference for mental health treatment that is Islamically oriented (Koç & Kafa, 2019; Mitha, 2020). In fact, many religiously committed people, including Muslims, hesitate to seek psychotherapy from mental health professionals out of fear that it might undermine their religious faith and values (Pilkington et al., 2012; Richards & Bergin, 2000; Sheikh & Furnham, 2000; Worthington, 1988).

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Research on religion and spirituality in therapy is emerging. In clients suffering from serious mental illnesses, most expressed an interest and desire to discuss spirituality with their providers (Harris et al., 2015). Hook et al. (2010) reviewed existing literature on spiritually oriented psychotherapy (SOP) and identified that they were generally efficacious; however, the database for SOPs was small. Efficacious SOPs for Muslim populations included Islamic forms of cognitive behavioral therapy (e.g., discussing religious issues from cognitive behavioral therapy [CBT] framework) for depression and anxiety. Smith et al. (2007) found that the overall effect of SOPs showed moderately strong empirical support (random-effects weighted average effect size of $d = 0.56$), where Muslim and Chrisitan forms of cognitive and rational-emotive psychotherapy demonstrated the strongest evidence.

Despite the limited data on SOP, there is plentiful evidence that suggests specific spiritual interventions such as instilling hope, instilling a sense of divine support and love, gratitude, and acceptance were found to be useful in developing a relationship with God, increasing psychological well-being, and reducing distress (Moreira-Almeida et al., 2014; Yamada et al., 2020; Pargament, 1997; Rye & Pargament, 2002). In fact, positive psychologists have identified associations between expressing gratitude and positive outcomes, such as increased happiness and decreased depression (Seligman et al., 2005). Although literature on SOP is growing, there are few inherently Islamic models of psychotherapy and none that have demonstrated clinical efficacy. Thus, this process outcome study was conducted in order to explore the clinical efficacy of traditional Islamically integrated psychotherapy (TIIP) utilizing the practice-based evidence (PBE) approach.

Traditional Islamically Integrated Psychotherapy

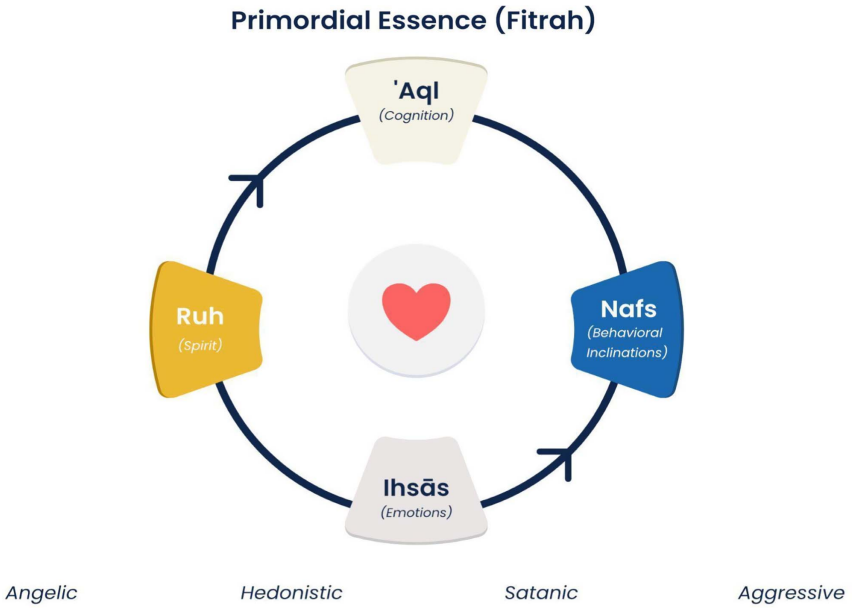
The TIIP model was initially outlined by Keshavarzi and Haque (2013) by drawing from classical Muslim scholarly contributions to psychology and providing an integrative framework for psychological practice. Over the years, this model has been developed further and was given the qualification of "traditional" in reference to its grounding in the Sunni Islamic teachings (Keshavarzi & Khan, 2018) and in order to specify and differentiate it from the general term of Islamically integrated psychotherapy that encompasses a diversity of Islamic approaches (York Al-Karam, 2018). Overall, the TIIP model derives its foundational assumptions by relying on the generally agreed upon positions of the Sunni discursive theologians and derives its ontological framework specifically from the conceptualization of the psyche or soul of Abū Ḥāmid al-Ghazālī (d. 1111 CE), Shihāb al-Dīn Abū Hafs al-Suhrawardī (d. 1234 CE) and Shah Walī Allah Dehlawī (d. 1762 CE) with adaptation and modifications made for psychological application (Keshavarzi et al., 2020). The model has been refined through the contributions of Fahad Khan, Bilal Ali, and others working in the research department at the Khalil Center, the outpatient research and mental health center where this study was conducted (Keshavarzi et al., 2020). The TIIP model also integrates other Islamic traditions through a thematic review of the psychologically relevant literature found within scholastic theology (*kalām*), law (*fiqh*), philosophy (*falsafah*), medicine (*tibb/hikmah*), and spirituality (*taṣawwuf*). These include but are not limited to the writings of classical scholars like Abū Bakr al-Rāzī (d. 925 CE), Abū Zayd al-Balkhī (d. 934 CE), ʻAḍud al-Dīn al-Ījī (d. 1355 CE), Ibn ʻAlī b. Miskawayh (d. 1030 CE), Abū ʻAlī b. Sīnā (d. 1037 CE), Imam al-Birgivī (d. 1573 CE), Mulla ʻAlī al-Qārī (d. 1605), Aḥmad Sirhindī (d. 1624 CE; Keshavarzi et al., 2020). By following this process, the TIIP model's epistemological framework aims to not only be grounded in scripture and spirituality but equally valuing empirical research and reason. TIIP is an integrative approach where the underlying assumptions, epistemology, and human ontology stem from the Islamic tradition; however, mainstream clinical approaches and interventions have been adapted and integrated from other theoretical orientations that align with TIIP's theoretical foundations and applied in the therapeutic setting.

The TIIP model identifies the elements of the human psyche (Figure 1) as being composed of (a) *ʻaql* (cognition), (b) *nafs* (behavioral inclinations), (c) *rūḥ* (spirit), (d) iḥsās (emotion), and (e) *qalb* (metaphysical heart). Changes in any one component lead to corresponding positive or negative effects on the others and ultimately the heart, the center of the human psyche (Keshavarzi & Haque, 2013).

ʻAql is the cognitive aspect of the human being, when fully developed, is capable of sound

Figure 1

Human Ontology According to the Traditional Islamically Integrated Psychotherapy Model



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reasoning and attaining knowledge, beliefs, and sound thoughts (Al-Taftazani, 2000). Muslim philosophers have identified that a fully developed *'aql* can act rationally, attain knowledge, comprehend consequences, distinguish right from wrong, and even regulate emotions (Al-Bajuri, 2002; Al-Ghazali, 1990).

Nafs is translated as behavioral inclinations in TIIP due to it being pulled to act automatically by the two primary drives of appetite (*shahwah*) and aggression-survival (*ghadab*). Or in other words, the *nafs* seeks comfort and avoidance of danger, through safety seeking behaviors. The *nafs'* inclinations to act will be consistent with the stage in which it resides. The untrained or primitive overindulgence of these pleasure seeking appetitive drives are known as the *nafs* that is in the state of *ammarah bi as-su'* (the self that commands to evil; Qur'ān, 12:53). However, through disciplining, reprimanding, regulating, and denying *the nafs* its carnal desires, the *nafs* can grow and be elevated. This developmental stage of being disciplined is referred to as the *nafs lawwāmah* (Qur'ān, 75:2) or the reprimanding self. During this stage, there is an inclination to act hedonistically while being restrained and forced to comply with one's higher spiritual and intellectual demands. Once it is successfully habituated to good and its drives have been balanced and moderated, then *the nafs* has desires that which is good and spiritually healthy, then it enters into a stage of calm and serenity known as *nafs mutma'innah*, (Qur'ān, 89:27; Al-Ghazali, 1990). The process of struggle within the self is known as *jihād an-nafs* or struggle of the soul or the purification of the soul (*tazkiyah an-nafs*; Al-Ghazali, 1990).

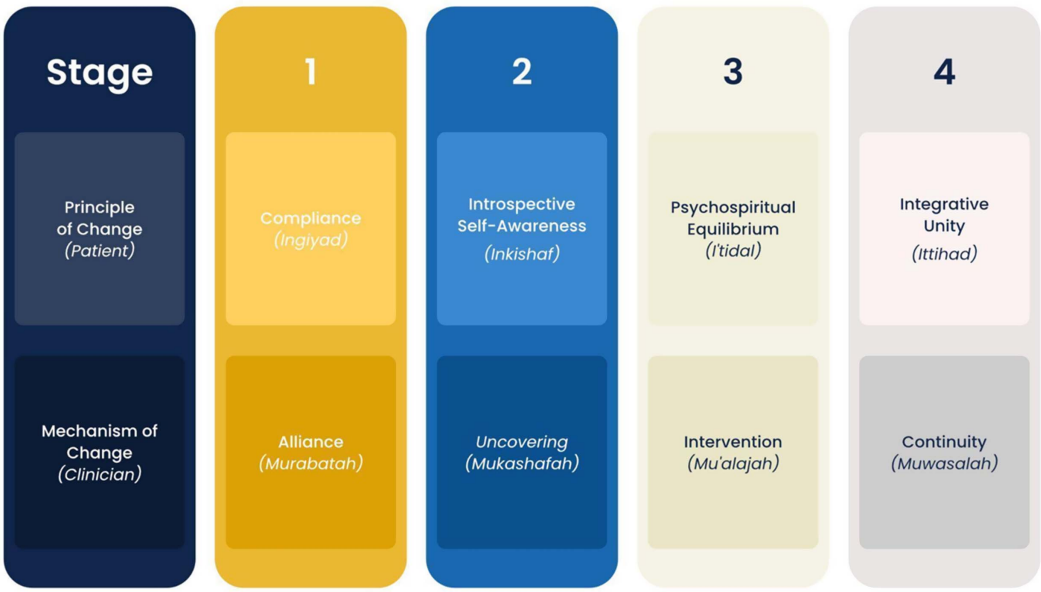
Emotions (*Ihsās*), from an Islamic perspective, encompass biosocial processes while also containing spiritually inherent motivations. Simply put, they serve as alarm signals directing an individual to look inward and to find and identify their ultimate needs. This is done through bottom-up emotional processing to uncover the underlying associated needs. Rumi (d. 1273 CE), a Sufi Muslim poet, for instance, has considered positive and negative emotions as "guests" from the divine (Helminski, 2005). However, underlying needs may need modification based upon the source of the emotions. This is because *iḥsās*, in the TIIP model, is conceived as being a byproduct of the interaction between the other aspects of the psyche. For instance, emotions may develop due to covert

beliefs (*aql*) or anger due to being denied one's the primitive drives of the underdeveloped *nafs* or spiritual experiences such as serenity or calm despite stressful conditions. Emotions are evaluated on a spectrum where any extreme is considered to be unhealthy and moderation is desired just like in all the other components (Keshavarzi et al., 2020).

The *Rūḥ*, or the spirit, consists of two subdivisions: (a) the *rūḥ 'ulwī samāwī* possessing an inherent inclination toward the connection with Allah and divine engagement and (b) simply the life force (*rūḥ ḥayawānī*) giving life to the body (Keshavarzi & Ali, 2020). Once, the *'aql* has been developed through beneficial knowledge, beliefs, and correct thinking and the *nafs* has been trained to be at rest, the full potential of the spirit can be unlocked. Spiritual actions such as prayer, *dhikr* or divine remembrance, charity, and contemplation develop the spiritual connection and nourish the soul. The *Qalb*, or metaphysical heart, is the center of the psyche that bears health and dysfunction. Balance or imbalance in any of the other three components ultimately leads to the manifestation of health or pathology contained within the heart. The heart in Arabic has a linguistic connotation of something that turns or can be flipped. Islamic scholars have described this as either being turned toward good indicating health or evil indicating pathology (Al-Suhrawardī, 1993). The Qur'an states, "Nay, their hearts have rusted on account of what they have earned" (The Qur'an, 2004, 83:14). A prophetic tradition states, "In the body, there is a piece of flesh, when it is sound, all else is healthy, when it is corrupt, then all else is sick, behold it is the heart" (Bukhari, Hadith 52). The fully balanced heart is known as the *qalb salīm*.

Figure 2 outlines the process of change in the TIIP model. This process consists of four stages. In the first stage, the clinician works on creating a therapeutic alliance (*Murabatah*) with the patient resulting in compliance and increased motivation to go through the arduous therapeutic process (*Inqiyad*). After this, the goal of the therapy process is to increase introspective self-awareness in the patient (*Inkishaf*). This is done through utilizing mostly empathic following and deepening techniques to facilitate a process of unveiling and uncovering (*Mukashafah*) the patient's inner intrapsychic world. Al-Ghazali (d. 1111), Abu Zayd al-Balkhi (d. 322), and Abu Bakr al-Razi (d. 313) posited that *inkishāf* requires a psychospiritual relationship with an authoritative teacher, wise one or mentor since it can be difficult for an individual to fully uncover one's own deficiencies

Figure 2
The Process of Change in the Traditional Islamically Integrated Psychotherapy Model



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(Al-Ghazali, 1990). The qualification of the guide is based on their own level of knowledge, experience, and psychospiritual reformation. Hence, why the TIIP model emphasizes competencies such as strong foundational knowledge, robust moral and ethical grounding, seeking supervision and collaboration, and aspiring to model perfection in character (Keshavarzi et al., 2020). This is followed by the third stage where the goal is shifted to creating an overall psychospiritual equilibrium in all areas of the human psyche (*I'tidal*). The central aim of TIIP is to facilitate a balance on all the elements of the human psyche mentioned above. This will require several therapeutic interventions (*Mu'alajah*) that work on changing beliefs, acquiring new perspectives and knowledge on the *'aql*, restricting safety and pleasure seeking behaviors and exposures to feared stimuli on the *nafs*, (*Mukhalafah*), prescription of spiritual acts (*dhikr*), and emotional processing and regulation of the ihsās. After successful completion of the previous three stages, the final stage of continuity (*muwāṣalah*) entails an attempt to bring all the aforementioned parts of the psyche together in serving higher order goals, leading to a removal of the inner fragmentation and dissonance and experience of unity (*ittiḥād*). This leads to an integrative holistic experience where the individual is now freed of psychological illness and can work on more ambitious goals to elevate themselves and increase their resilience.

Process Variables and Practice-Based Evidence

Spirituality and its integration in therapy are difficult to assess and quantify due its innate complexity (Brown et al., 2013). Therefore, when looking at the type of therapy, interventions, and outcomes, it may be more suitable to utilize process variables. A process variable is the current measured value of a particular part of a process which is being monitored or manipulated. Process variables can be helpful in identifying treatment outcomes in psychotherapy (Kolb et al., 1985). These variables allow researchers to measure the therapy process when a manualized approach is not utilized, especially when it may affect the therapeutic alliance between the patient and the clinician (Addis & Jacobson, 2000; Snippe et al., 2019). Kolb et al. (1985) examined the patient and therapy process variables related to change in psychotherapy and found that process variables were better predictors of outcomes.

Process variables can be evaluated through the PBE approach. PBE in psychological practice is the modern equivalent of the traditional observational approach (Evans et al., 2003). This approach allows the clinicians to practice their treatment as usual without the use of a specified manual. The evidence (i.e., data) derived from such a method is perhaps more generalizable to a real session and its outcomes rather than data stemming from simulated lab scenarios (Castonguay et al., 2013).

There are numerous advantages to implementing a PBE approach. PBE offers more flexibility compared to randomized control trials (RCT), which rely heavily on strict adherence to manualization. Adopting a malleable approach that permits spontaneity, flexibility, and therapist discretion offers greater generalizability to real world scenarios. Moreover, a PBE approach allows the usage of existing patients, who often present with comorbid concerns. Under an RCT approach, comorbidities are often excluded. Our study strengthens the existing PBE approach by embedding it into a clear conceptual framework. The TIIP model offers a scaffold for therapists to align themselves on common goals and overarching conceptual formulations. Thus, while we are not manualizing the therapeutic process, we are providing theoretical principles to guide the therapeutic work. This article aims to contribute necessary scholarship on utilizing process variables in a practice-based approach to measure the outcomes of the TIIP model.

Methodology

Purpose

The primary aim of the study was to utilize a practice-based approach to determine the efficacy of the TIIP model. Specifically, therapeutic process–outcome variables and psychological distress were examined with Muslim patients receiving Islamically integrated psychotherapy. The following research aims were explored:

1. Identify the Islamic spiritual approaches and interventions used by mental health professionals that positively affect outcomes.
2. Determine the degree to which therapists utilize process variables (e.g., styles of

therapy, interventions, intentions) when conducting TIIP.
3. Explore the effect of TIIP utilization on psychological distress in Muslim patients.

The overarching hypothesis was that implementation of the TIIP model in psychotherapy would be negatively related to psychological distress in patients over time. Thus, integrating TIIP into psychotherapy with Muslim patients would be associated with improved mental health outcomes. The present study also sought to explore the types of interventions, intentions, and topics that worked best when incorporated into TIIP-based psychotherapy. The findings from this study could advance knowledge regarding integration of Islamic psychology principles into psychotherapy with Muslim patients.

Research Team and Treatment Site

Khalil Center is an outpatient Muslim mental health center providing Islamically integrated psychological services tailored for the Muslim community in the United States and Canada. The mission of Khalil Center is to promote psychological and spiritual community wellness in multifaceted ways. The center provides psychotherapy, engages in research pursuits, and offers psychoeducational community workshops and webinars. Patients who seek services at Khalil Center typically prefer a spiritually integrated approach within an Islamic framework. The team at Khalil Center includes various mental health clinicians such as psychologists, psychotherapists, and physicians, along with members of clergy, researchers, mental health educators, and other health professionals.

For the present study, a multidisciplinary team of researchers with relative education and experience, licensed practitioners, mental health educators, and an Islamic scholar (with a formal degree from an accredited seminary and bachelors in the behavioral sciences) supervised the data collection carried out by five licensed psychotherapists at Khalil Center over 1 year. The research team and clinicians for the present study were located in Chicago and the California Bay Area. The multidisciplinary team met monthly to track progress and address any issues related to data collection. Five therapists (two males and three females), trained in the TIIP model, conducted therapy sessions with patients who met the inclusion criteria outlined below. Khalil Center was one of 17 sites that participated in an interdisciplinary project collecting a large data set on spiritually integrated psychotherapies which was organized by the Bridges Consortium.

Procedure

After obtaining approval from the Institutional Review Board at Concordia University Chicago, a convenience sampling method was used to recruit participants for the study. Patients were eligible to participate in the study if they met the following inclusion criteria: (a) were newly recruited patients seeking psychological treatment at Khalil Center with one of the five participating therapists, (b) were Muslims who wanted an Islamically oriented approach applied to their condition, (c) were above the age of 13 years, (d) and presented with subclinical or mild to moderate clinical symptoms. Eligibility based on distress was determined using the Brief Symptom Inventory. A score of 75 or above, indicating severe levels of distress, disqualified patients from participation. The rationale for the exclusion criteria was based on prior research documenting that religious interventions may not be particularly suited for patients experiencing serious neurological or psychiatric concerns (Razali et al., 1998). Patients who met the inclusion criteria were invited to participate in the study. Those who opted to participate signed an informed consent form detailing the potential risks and benefits of the study. Participation was voluntary and patients could withdraw at any time without consequences. No personal identifying information was collected, and no compensation was offered for study completion. A secure online system, provided by the Bridges Consortium, was used to gather and store data.

Participants

The final sample consisted of 107 participants. Patients ranged in age from 17 to 65 years (M = 30.0, SD = 10.57). With regard to gender, 31.7% of the reported sample were females while 67.4% were males. The frequency of sessions ranged from 1 to 24. On average, patients attended 4.40 sessions with their therapist (SD = 4.60). The racial composition of the sample included a majority (49%) identifying as South Asian (e.g., Indian, Pakistani, Bangladeshi) followed by smaller portions of the sample identifying as Arab/Middle Eastern/North African (13.6%) and

European/White American (11.7%). A majority (93.4%) identified as Sunni while 6.6% identified as Shia. This demographic composition was expected given the Muslim demographics of the two treatment site locations utilized for the site.

With regard to diagnoses and presenting concerns, some patients (41.1%) experienced trauma- and stressor-related disorders (e.g., adjustment disorder, posttraumatic stress disorder), while smaller portions reported depressive disorders (20.2%), anxiety disorders (14.5%), obsessive–compulsive disorders (13.8%), and other disorders (10.3%; e.g., borderline personality disorder, behavioral addictions).

Measures

Therapist Session Checklist

The therapist session checklist (TSC) is a process measure that allows therapists to document, in a few minutes, the clinical issues explored, the theoretical orientation(s) that guided the sessions, the therapist's intentions during the sessions, and the interventions used, including spiritual interventions (Lea et al., 2015; Richards et al., 2015; Sanders et al., 2015). The checklist was created for the purposes of the Bridges data collection. In the present study, therapists completed the checklist at the end of each session with the patient. Some interventions were added as they pertain to treating psychospiritual problems from the Islamic literature. When using the checklist, psychotherapy process variables utilized during the application of the TIIP model were identified. Since the approach is not manualized and the methodology was based on the practiced-based evidence approach, the therapists had the option to check multiple orientations whenever their interventions overlapped with those theoretical schools, topics, interventions, and intentions.

The following variables were measured using the practice-based evidence approach: theoretical orientation (e.g., cognitive behavioral therapy, acceptance and commitment, behavior therapy, emotion-focused), counseling topics (e.g., abuse, addictions, relationships, emotions), intentions (e.g., facilitate insight, instill hope, create a supportive environment), and spiritually integrated interventions (e.g., explored religious questions and doubts, discussed forgiveness, affirmed patient's divine worth). The therapists checked off the variables that were used in each session.

Distress

The 25-item Clinically Adaptive Multidimensional Outcome Survey (CAMOS; Sanders et al., 2018) was used to measure a patient's therapy expectations and distress over the past week in five areas: concerns about therapy (CT; four items; e.g., "I felt anxious about beginning therapy"), relationship distress (RD; six items; e.g., "I felt misunderstood by my loved ones and friends"), psychological distress (PD; seven items; e.g., "I felt sad or depressed"), spiritual distress (SD; four items; e.g., "I felt distant in my relationship with God or my Higher Power"), and physical health distress (PHD; four items; e.g., "I experienced physical pain or discomfort"). Items are measured on a 6-point Likert scale ranging from 1 (*never*) to 6 (*always*). Responses are averaged with higher scores indicating greater levels of distress on the respective dimensions.

The instrument development study found satisfactory reliability estimates for the CAMOS in samples of students at a religious university and female patients at an eating disorder clinic (CT: $\alpha = .84$, RD: $\alpha = .83$, PD: $\alpha = .90$, SD: $\alpha = .81$, PHD: $\alpha = .82$; Sanders et al., 2018). Validity was demonstrated with the scale's correlations to measures assessing negative emotions, social alienation, somatic complaints, and theistic spirituality. In the present study, Cronbach's α estimates were satisfactory ($\alpha = .92$).

Demographics

Participants also responded to items assessing age, race/ethnicity, gender, religious sect, employment, and presenting concerns along with various items measuring religion/spirituality.

Data Analysis

IBM's Statistical Package for the Social Sciences (SPSS) and the Statsmodels library in the Python programming language were used to conduct data analyses. Before any statistical analysis was done, all variables were examined for any missing data, inaccuracy in data collection, and appropriateness for the proposed statistical analyses. Missing data were replaced using mean imputation within the same variable.

To evaluate the changes over time in psychological distress, hierarchical linear modeling (HLM) was used. Level 1 of the model was the

session number at which the survey was completed. Linear, quadratic, and cubic terms were tested to determine the shape of growth across sessions. Level 2 of the model was grouped by client. For each client in the data set, a variable was created indicating whether the therapist had selected using a specific TIIP intervention on the TSC at any point in treatment. This was used as a Level 2 variable to predict variance around the slope of the Level 1 model.

Results

Along with the aforementioned measures, patients were also asked questions related to religion/spirituality and therapy. Almost all of the sample (99%) reported that religion or spirituality was important in their life. Likewise, a vast majority expressed desire to discuss religious/spiritual issues in counseling (97.6%) and expressed a willingness to consider religious/spiritual suggestions from the therapist (97.1%). One question explored the patients' perceptions on whether religion hurt them or "contributed to [their] challenges?" Approximately one third of participants (30.2%) claimed "yes," which interestingly illustrates that despite instances of some negative perceptions of religion, these patients still sought spiritually integrated services. The data reported and discussed below are from 420 patient responses to the therapist session checklist.

Theoretical Orientation

As stated previously, the TIIP model is an integrated approach that allows clinicians to draw from various interventions from among any of the theoretical schools of psychotherapy. Clinicians may also change approaches from one session to another. Table 1 reports the most frequently used theoretical approaches with CBT-based interventions most commonly used. This can be due to two possible factors. First, CBT is the most commonly taught and utilized approach in psychological practice (Bohman et al., 2017; Cook et al., 2010). CBT is also supported through outcome research for its efficacy on many common depressive and anxiety disorders with Muslim patients (Smith et al., 2007). Second, many concepts from CBT, including third-wave CBT approaches like acceptance commitment therapy (ACT), overlap with religious and spiritual teachings (Yavuz, 2022) and have therefore been integrated into TIIP. For example, the use of acceptance, especially to the divine will, is a common theme in Islamic beliefs which was endorsed as an intention in 23.3% of the sessions. Muslims believe in God's divine plan and are more readily accepting of the events that happen in their life when a cognitive reframing intervention as such is provided. Framing overall distress in the context of spiritual beliefs can assist Muslim patients in accepting their negative situations and positively reframe their condition in light of these beliefs.

Table 1
Frequency of Theoretical Orientations Endorsed in Application of Traditional Islamically Integrated Psychotherapy

Theoretical orientations	Frequency	%
Cognitive behavioral therapy	186	44.3
Acceptance and commitment therapy	155	36.9
Islamically integrated psychotherapy	146	34.8
Emotion-focused	130	31.0
Spiritual-integrated	119	28.3

Intentions

Session intentions are rationales of the therapist for selecting a specific behavior, response, technique, or intervention to use with a patient at any given moment within the session (Hill & O'Grady, 1985). These are what the therapist plans to engender through the process of the session. It is an active, cognitive component that mediates the choice of intervention.

Data from our study (see Table 2) indicated that facilitation of insight was utilized 56.4% of the time during the sessions. This is not only congruent with the goals of most modern therapies but also one of the key stages in the process of change in TIIP (see Figure 2).

Moreover, as seen in Figure 3, facilitation of insight begins from the first session and gradually declines. However, the frequency of other intentions may increase or decrease throughout the process.

Counseling Topics

Table 3 shows the most commonly endorsed counseling topics. Self-esteem/identity-related issues appeared to be most commonly discussed in the therapist–patient dyad (33.3%), followed by religion/spirituality (32.1%). Keeping in mind

Table 2
Frequency of Intentions Endorsed in Application of Traditional Islamically Integrated Psychotherapy

Intentions	Frequency	%
Facilitate insight	237	56.4
Instill hope	138	32.9
Identify problematic thought patterns	115	27.4
Give information/psychoeducation	109	26.0
Explore ways to change	108	25.7
Increase self-control	108	25.7
Explore/deepen emotions	105	25.0
Recognize and/or reinforce positive change	101	24.0

that the therapist was allowed to check multiple counseling topics, religion/spirituality may have been embedded within the sessions where other topics were also being discussed as well. A noteworthy pattern was that family-related issues were discussed very frequently. This shows that American Muslims, who tend to come from collectivistic cultures, may have psychospiritual concerns that stem from family/marital dynamics or indirectly affect their families. Existing literature has found associations between family-related issues and mental health problems (Scully et al., 2020). Emotions, such as grief, depression, anger, and anxiety, also emerged as frequent topics of psychotherapy.

Spiritually Integrated/Islamically Integrated Interventions

The TSC gave therapists the option to choose the spiritual/Islamic interventions that were utilized in the therapy session. Some of these interventions were already part of the TSC, although others were added as they pertain to treating psychospiritual problems drawing exclusively from Islamic

Figure 3
Frequency of Intentions Utilized in Traditional Islamically Integrated Psychotherapy Over Sessions

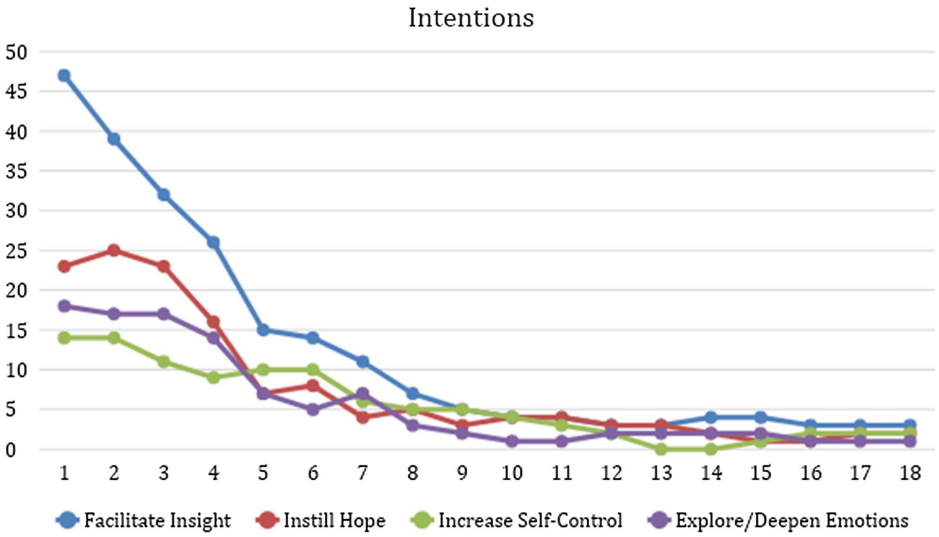

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Table 3
Frequency of Counseling Topics Endorsed in Application of Traditional Islamically Integrated Psychotherapy

Counseling topics	Frequency	%
Self-esteem/identity	140	33.3
Religion/spirituality	135	32.1
Relationships: Marriage/partner/dating	126	30.0
Emotions: Reintegration (grief, depression)	119	28.3
Relationships: Family of origin	103	24.5
Problem management/coping	96	22.9
Adjustment to environmental changes	92	21.9
Employment	68	16.2
Relationships: Other	68	16.2
Emotions: Destruction (rage, anger)	66	15.7
Isolation	66	15.7
Emotions: Protection (panic, anxiety)	63	15.0

literature. The most frequently used interventions are listed in Table 4.

The spiritual practice that was most common was religiously oriented cognitive restructuring, which is a major concept in both TIIP, CBT, and ACT. Another commonly utilized spiritual invention was discussing hope. A good deal of interventions were focused on strengthening the *nafs* (behavioral inclinations). Some of these include *Mujahadah* (goal striving/self-struggle) endorsed during 25% of

Table 4
Frequency of Specific Interventions Utilized in Application of Traditional Islamically Integrated Psychotherapy

Spiritual/Islamic interventions	Frequency	%
Cognitive (*'Aqlani*) restructuring	178	42.4
Positive thinking (*Husn az-Zan*)	164	39
Discussed hope	154	36.7
Listened to spiritual issues	133	31.7
Discussed compassion	120	28.6
Goal striving (*Mujahadah*)	105	25
Discussed self-control	103	24.5
Going against unhealthy behavioral inclinations/impulses	101	24
Acceptance and contentment with Allah's decree	99	23.6
Commitment to behavioral change (*Musharatah*)	93	22.1
Focused on character development	88	21
Positive behaviors to replace negative ones	85	20.2
Embracing and focusing on Allah's mercy	82	19.5
Behavioral self-regulation (*Muraqabah*)	79	18.8
Discussed gratitude	72	17.1
Dishabituation and extinction of unhealthy behaviors	71	16.9
Behavioral retrospection (*Muhasabah*)	67	16
Spiritual dimensions of problems and solutions	66	15.7
Identified pathways to god or the sacred	65	15.5
Prophetic example	59	14
Explored questions about ultimate meaning	52	12.4
Positive character virtues	51	12.1
Explored religious questions and doubts	50	11.9

the sessions, self-control. (24.5%), going against unhealthy behavioral inclinations/impulses (24%), commitment to behavior change or *Musharatah* (22.1%) and character development (21%).

Outcome Measures: Usage of TIIP Effect on Psychological Distress

The HLM model found a cubic model to provide the best fit for the data (see Table 5).

CAMOS Psychological Distress

A single level model with random slopes and intercepts was used (see Table 5). There is a trend of initial decrease of psychological distress, followed by a plateau, and another decrease. Although later trends should be interpreted cautiously as only six patients (10% of the sample) attended more than 10 sessions as noted by increased confidence intervals toward the end in Figure 4. Additionally, Cohen's *d* was calculated for pre- and postmeans. The effect size was $d = 0.62$ suggesting a medium effect size. Overall, this analysis suggests that patients receiving treatment from Khalil Center are benefitting from treatment, especially in early and late phases.

From this model whether Islamically Integrated interventions were used was added to the model as a Level 2 predictor of the linear component of the slope. The result was a nonsignificant interaction ($z = .44$, $p = .90$), suggesting that whether Islamic Interventions were used was not predictive of differential growth curves for patients. Therefore, the Level 1 model with random effects is the best indicator of actual growth curves.

Discussion

The results of this study demonstrate the value of TIIP model, showcasing its significant contribution toward reducing psychological distress. Notably, these findings align with prior data from the Khalil Center on TIIP, further solidifying the model's efficacy (Abdul-Adil et al., 2019; Bakir et al., 2023; Khan, 2019). This study's outcomes are a valuable addition to the SOP literature, endorsing the integration of religion and spirituality in psychotherapy as a beneficial factor in improving psychological functioning.

While specific interventions were not associated with different outcomes, the overarching philosophy of TIIP was practiced by all therapists. This suggests that the positive outcomes are a reflection of the application of TIIP principles. A review of the process variables underscores the integrative nature of TIIP, demonstrating a combination of spiritual topics, intentions, and interventions with mainstream interventions found in traditional psychology theoretical orientations. For instance, positive thinking (*Husn az-Zan*) and discussions on hope, gratitude, compassion, and following the prophetic example, rooted in Islamic tradition, were effectively utilized as therapeutic intentions and interventions, contributing to the reported therapeutic gains.

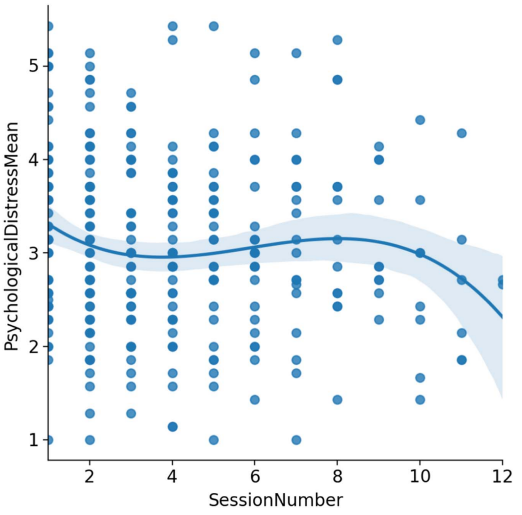
This research adds to the increasing literature on spiritually integrated psychotherapies. Other evidence-based approaches have echoed these results, testifying to the efficacy of spiritually integrated psychotherapies. A Christian-centric approach, for instance, employed spiritual interventions such as "affirming divine worth" and "listening to spiritual issues," which were found to significantly alleviate psychological distress (Currier et al., 2021). Another study on a spiritually

Table 5
Clinically Adaptive Multidimensional Outcome Survey (CAMOS) Psychological Distress Results

Variable	Coefficient	*SE*	*z*	$p > \|z\|$	[0.025	0.975]
Intercept	3.62	0.183	19.819	0	3.262	3.978
Session number	−0.383	0.12	−3.183	.001	−0.619	−0.147
Session number squared	0.006	0.025	2.646	.008	0.017	0.115
Session number cubed	−0.004	0.001	−2.395	.017	0.006	0.001
Client variance	0.649	0.53				
Client × Session Number Covariance	−0.019	0.093				
Session number variance	0.001	0.02				

Note. *SE* = standard error.

Figure 4
CAMOS Psychological Distress Change Trajectory



Note. CAMOS = Clinically Adaptive Multidimensional Outcome Survey. See the online article for the color version of this figure.

integrated approach to trauma used interventions like "prayer logs" and guided meditation, resulting in a significant reduction in posttraumatic stress disorder symptoms (Harris et al., 2015). These findings, among others, underscore the importance of integrating spiritual interventions and spiritually integrated models of psychotherapy, particularly for religious patients.

Despite its contributions, this study does have some limitations. As it was not a randomized controlled trial and lacked a control group, it was not possible to compare interventions and their outcomes. Also, process variables such as specific interventions could not be linked to psychological distress. Future research should aim to focus on the application of TIIP to specific psychological conditions like depression or anxiety, while incorporating a control or comparison group to illustrate its effectiveness compared to mainstream psychological orientations. Process–outcome studies that try to map specific TIIP interventions to symptom reduction would also be beneficial. Furthermore, as this study was conducted in the early stages of TIIP development, a replication of this study could provide more useful insights into the current model, which has since seen more development and tiered training opportunities. Nonetheless, despite these limitations, this research marks the first in literature to showcase the clinical effectiveness of an inherently Islamic and a comprehensive model of psychotherapy, opening up promising prospects for its further development and specification to particular psychological conditions.

In light of recent studies on spiritually integrated approaches, it is important to situate these findings within the broader context. For example, Sanders et al. (2015) found that spiritually oriented psychotherapy was efficacious in improving a variety of psychological and spiritual outcomes for clients with a broad range of diagnoses. Other studies from the Bridges project recently published in the special section of the psychotherapy journal also showed similar efficacy of these therapies. The approaches utilized in these studies, along with TIIP (Khan & Keshavarzi, 2023), were also published in the *Handbook of Spiritually Integrated Psychotherapies* paving the path for furthering the literature in this area.

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