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Quantitative evidence supporting the efficacy of Islamic counselling, towards the case for a rethink in mental health provision for UK Muslims.

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Abstract

The following paper presents evidence of the efficacy of Islamic counselling, a faith-based therapeutic approach for working with mental health practised in Muslim communities in the UK. This evidence is based on data from clients analysed three years prior and three years post initial intervention. Noting both the spiritual and psychological reality of the model and the Muslim communities which it serves the paper also discusses concerns regarding the progression route of such a therapeutic model through proof of efficacy and effectiveness to the possibility of mainstreaming.

This paper builds on the chapter on Islamic counselling, in British Muslims,Ethnicity and Health Inequalities published in 2022, which provided evidence of the efficacy of Islamic counselling as demonstrated through a one-year prior one-year post intervention evaluation of the impact of this therapeutic intervention.

Over recent years, there has been a significant rise in publications regarding Muslim mental health, Islamic counselling, Islamic psychotherapy, and Islamic psychology. In this emergent field, there are several theoretical branches. This article presents further evidence supporting the model of Islamic counselling developed by Dharamsi and Maynard in 1996[1]. This is one of the earliest models of Islamic counselling and psychotherapy, a model supported by over 20 years of practice and training of practitioners to a professional level.As well as since 2010 in practice The Lateef Project.A specific Islamic counselling service currently working with Muslim communities in London and Birmingham.

Following on from the one-year prior one-year post evaluation of Islamic counselling cited above, this paperpresents further analysis of the initial cohort of Islamic counselling clients of the Lateef Project through a three-year prior three-year post assessment period (due

[1] Islamic counselling is a faith-based therapeutic model based on core teachings in Islam. The model stems from the Islamic science of Tessawuf as opposed to other models based on Tibb medicine. As an Islamic therapeutic model concerning other therapeutic approaches, it sits between psychodynamic Humanistic and cognitive or behavioural approaches to counselling and psychotherapy. However, being Islamic, it is not an integration of these approaches but a spiritual psycho-emotional psycho-social therapeutic model routed in the teachings of Islam and addressing the variety of the lived Muslim experience. The first published work on Islamic counselling was in 1998 in a BACP (formally the British Association for Counselling) Journal.

to the timing of the analysis, not all the participants had completed a full 3 years since their first contact with Islamic counselling).
This work is also supported by qualitative data from an additional study of clients of The Lateef Project during the 2020/ 2021 covid pandemic (as of yet this is unpublished). Having presented evidence supporting Islamic Counselling,the paperalsoraises questions and concerns relating to the provision of appropriate mental healthcare to the Muslim community within the UK and raises the argument for change within the understanding of Muslim mental health.

Islamic counselling has been practised in the United Kingdom since 1996, originating from the work of Aliya Haeri and Shaykh FadhlallaHaeri.The model of Islamic counselling was further developed by SabnumDharamsi and Abdullah Maynard between 1994 and 1996 leading to the first accredited qualifications in Islamic counselling in 1998, the completion of the first level 4 diploma or professional qualification in Islamic counselling in 2001 and the current provision of training in Islamic psychotherapy.

Since then there has been a selection of authors writing regarding Islamic counselling or psychotherapy and Islamic Psychology including (Maynard 1998) (Haque 2004) (Skinner 2010) (Keshavarzi and Haque 2013) (Abdallah Rothman & Adrian Coyle 2018) what follows relates to the application of the Islamic counselling model of Dharamsi& Maynard.

In support of this model, The Lateef Project was developed initially in 2010 as the primary counselling agency practising Islamic counselling. Through The Lateef Project's provision of Islamic counselling, both the qualitative and quantitative studies of the impact of Islamic counselling referred to have been completed.

Quantitative long-term analysis of Islamic counselling, the methodology

The initial quantitative evaluation of the model was carried out in 2012 with clients referred to the service from The Pearl Medical Centre.A GP surgery in Birmingham with 10,000 patients (7000 of which were Muslim), wherein the Lateef Project had provided an embedded face-to-face counselling service in several community languages from 2011. Patients were referred to The Lateef Project for counselling after experiencing a variety of common mental health problems most often:

- Anxiety with depression
- Anxiety
- Depression
- PTSD

These patients were referred to The Lateef Project over 12 months, presenting with common mental health problems and long-term physical health conditions or MUS (medically unexplained symptoms). Data was initially collected by an independent researcher regarding these NHS patients one year prior / one year post their counselling in intervention regarding their use of secondary health care.

Two years later this data was again collected over the same time scale as the initial independent study and evaluated by the NHS CENTRAL MIDLANDS Commissioning Support Unit in 2014.Here, the acute activity before and after the date of the first Islamic counselling session was evaluated for up to 3 years for each NHS number by codification, speciality, and diagnostic code. The results of this analysis are presented in this paper.

The analysis considered the level of activity in secondary care (inpatient outpatient and A&E) as well as the cost differential regarding secondary care budgets for the 87 clients who had presented to The Lateef Project with common mental health problem(s) and long-term physical health condition or MUS. Activities selected were IP/OP/AE events that took place both before and after 1st counselling contact, between 1011-1314.

Due to the complexity of these presentations, the interventions provided by the Lateef Project with this client group were generally 18 sessions, though with some presentations the interventions were longer,particularlyin some cases where The Lateef Project worked in conjunction with Secondary Mental Health Care. For the analysis, the period of three years was taken both prior to and post the first counselling session.The data presented here shows the overall outcomes of the evaluation.

Quantitative long-term evidence of the efficacy of Islamic counselling, results

The following three tables present the overall results of the 3 years prior three years post analysis.

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Activity Before Intervention		
Dataset	Sum of Activity	Sum of Cost
Accident & Emergency	139	£13,134
Inpatient	161	£216,326
Outpatient	722	£81,133
Grand Total	**1022**	**£310,593**

Figure 1 All patient activity and related costs before initial contact with Islamic counselling.

Activity After Intervention		
Dataset	Sum of Activity	Sum of Cost
Accident & Emergency	87	£8,398
Inpatient	67	£79,457
Outpatient	427	£49,482
Grand Total	**581**	**£137,336**

Figure 2 All patient activity and related costs 3 years after initial Islamic counselling intervention.

Difference		
Dataset	% Diff Activity	% Diff Cost
Accident &Emergency	37%	36%
Inpatient	58%	63%
Outpatient	41%	39%
Grand Total	**43%**	**56%**

Figure 3 Difference in activity and difference in relative cost before initial Islamic counselling intervention and 3 years after the initial intervention.

The results of this evaluation show a significant reduction in patient activity in secondary care across all three conditions following up to 3 years of the initial encounter with Islamic counselling, with p scores being less than .05.

Inpatient p score	0.0271224
Outpatient p score	0.0083508
A&E p score	0.0236737

As can also be seen from the above tables, with the reductions in patient activity there are also key reductions in secondary care patient costs over the corresponding times. The above data comes from a small client sample, and it is essential to note that there was not a control group for this research. Large-scale randomised testing concerning Islamic counselling is not possible without further investment in both Islamic counselling itself and its evaluation. The lack of a control group is a design concern.However, this is compensated for by the long-term prior and post analysis to identify the enduring impact of Islamic counselling. What's not clear are the long-term outcomes for patients of the surgery with similar presentations that were not referred to The Lateef Project. Gaining this data was made difficult by the removal of alternative primary care mental health provisions at the time due to patient preference for the Islamic counselling service.

It is of note that in general attempts to identify the efficacy of a therapeutic process are carried out in less complex conditions, (the intervention is generally tested in a sample group sharing one other variable say for example depression with an outcome being measured against the impact of that intervention, in that specific context). However, there are indicators that mental health presentations within the Muslim community are often complex (for example anxiety with depression) accompanied by physical health concerns (with disproportionally high rates of heart and circulatory disease as well as diabetes in many of the larger ethnicity Muslim communities).As well as the correlation between mental ill health and MUS within sections of the Muslim community which lack a linguistic history of discussing mental health. A caveatwith these results is that patients could have been diverted to other services within a community setting - this is something that this report does not capture. What's not clear are the long-term outcomes of patients from the same GP surgery with similar presentations that were not referred to The Lateef Project.

For comparison, this evaluation of the Islamic counselling therapeutic intervention may be considered relative to the outcomes of CBT within current IAPT provision, accepting that these are not like-for-like studies due to the reasons mentioned above.A meta-analysis of the long-term outcomes of CBT with none-specific client groups (van Dis et al 2019) found:

"1 to 6 months and at 6 to 12 months of follow-up for a generalized anxiety disorder (Hedges *g*, 0.07-0.40), panic disorder with or without agoraphobia (Hedges *g*, 0.22-

0.35), social anxiety disorder (Hedges *g*, 0.34-0.60), specific phobia (Hedges *g*, 0.49-0.72), PTSD (Hedges *g*, 0.59-0.72), and OCD (Hedges *g*, 0.70-0.85). After 12-month follow-up, these associations were still significant for generalized anxiety disorder (Hedges *g*, 0.22; number of studies [*k*] = 10), social anxiety disorder (Hedges *g*, 0.42; *k* = 3), and PTSD (Hedges *g*, 0.84; *k* = 5), but not for panic disorder with or without agoraphobia (*k* = 5) and could not be calculated for specific phobia (*k* = 1) and OCD (*k* = 0). Relapse rates after 3 to 12 months were 0% to 14% but were reported in only 6 randomized clinical trials (predominantly for panic disorder with or without agoraphobia)."

Discussion and conclusion

A limitation of the quantitative evaluation of Islamic counselling in comparison to the van Dis data is the inability in the above Islamic counselling study to provide more granular information regarding the specific forms of anxiety that were present in a similar way. It is also noted that these comparative studies use different timeframes and analytical tools. The above research indicates that regarding Islamic counselling more specific research on the efficacy/ effectiveness of the model is advisable.

There is unfortunately a lack of like-for-like comparative data concerning Muslim presentations of common mental health problems and the impact of treatment. Currently, most of the material in print regarding Muslim mental health still documents the nature of Muslim mental health presentation or its frequency (Altalib et al 2019)(Ciftci 2012).Significantly the Altalib et al meta-analysis indicates how the papers written globally in English on Muslim mental health, not only disproportionately few (a comparison is made between the global output on Muslim mental health and the number of papers one western university would have published on mental health generically in the same timeframe); but more concerning is their identification of the skewing of the material covered by the majority of publications towards more extreme presentations with the implications this has. With most publications in English on Muslim mental health concerning severe mental health, it is difficult to identify baseline levels or even core understandings of how common mental health conditions present in the Muslim community.

This is significant if only regarding the high correlation between common mental health problems and MUS in the Muslim community.

With Muslims accounting for almost 5% of the UK population in the last census and the lack of baseline knowledge regarding Muslim mental health, where does the responsibility lie to facilitate appropriate research on the presentation of Muslim mental ill health and in that context-appropriate treatment? Who will and how will that be championed?

Concerns regarding the difficulty of maintaining mental wellbeing for Muslims considering factors such as Islamophobia, racism, and class in the UK, in the context of existing mental health provision have been documented (Maynard 2022, Maynard 2022). Yet the workabove presents quantitative indications of an alternative effective approach to psychological wellbeing within Muslim communities. However, within the current statutory mental health framework, it raises questions relating to how this work would be repeated for further analysis, revised regarding more common research frameworks, upscaled or mainstreamed. While the poor recovery rates of Muslims concerning mental health is a known fact within the NHS, there appears to be no strategic response to this at present (NHS 2020), this raises key concerns regarding a health inequality which should be addressed under equalities legislation.

At the time of writing, the above work is one of two evidence-based approaches to Muslim mental health in the UK known to the author. The other model (Mir 2019) is a culturally adapted form of CBT. Islamic counselling would appear to be the only faith-based therapeutic intervention originating from Islamic teachings which address mental wellbeing within the context of Islamic spirituality. However,the above study indicates the efficacy of this model concerning the Muslim experience of common mental health problems. Muslim's lives encompass the spiritual as well as the psychological and social reality. In the psychological worlds of Muslim clients, the lived experience, that holds their mental wellbeing is a rich environment. More research is required regarding the relationships between Islamic spirituality and mental wellbeing, as well as the subtle relationships between Islamic counselling and the psycho-spirituality of Muslim mental health.

The work above has clear limitations, yet in the context of prevailing mental health provision and its impact on Muslim wellbeing within the UK, this work indicates a potential way forward which benefits both Muslim clients and NHS provision. In being evidence-based and having been practised for over 20 years this model of Islamic counselling sits apart from much of the more recent Islamic approaches to Muslim mental wellbeing.

Yet still, there are concerns and questions regarding the process necessary to increase the evidence base of this model and with that its provision to the wider Muslim community. Currently, the standard way that NICE assesses therapeutic interventions is through large-scale randomised double-blind trials. Such a procedure is not possible when one voluntary agency working in partnership with the NHS provides most of the evidence to support the therapeutic intervention. Which then begs the question what would the route be for a spiritual psychotherapeutic model such as this to prove its efficacy and effectiveness, to reach a greater proportion of the UK Muslim communities?

References

1. MaynardSA(2022, *in print*).Muslim mental health inequalities – Addressing mental health through Islamic counselling a faith-based therapeutic intervention. In Dogra, S.A. (Ed.), *British Muslims, Ethnicity and Health Inequalities*. Edinburgh: Edinburgh University Press

2. A Maynard A, (1998) Beginning at the Beginning Islamic counselling. British Association for Counselling Race and Education in Counselling Multicultural Journal No 16 22-24

3. HaqueA, (2004). Psychology from Islamic Perspective: Contributions of Early Muslim Scholars and Challenges to Contemporary Muslim Psychologists. Journal of Religion and Health Volume 43(4) 357-377

4. Skinner R, (2010). An Islamic approach to psychology and mental health. Mental Health Religion and Culture Volume 13(6) 547 551

5. HaqueA, & H KeshavarziH, (2013) Outlining a Psychotherapy Model for Enhancing Muslim Health Within an Islamic Context. The International Journal for the Psychology of Religion Volume 23 230-249

6. Rothman A, &CoyleA, (2018). Toward a framework for Islamic psychology and psychotherapy: An Islamic model of the soul. Journal of Religion and Health Volume 57 1731-1744

7. Van Dis EAM, et al (2020). Long term Outcomes of Cognitive Behavioural Therapy for Anxiety Disorders. Published online 2019 Nov 23 JAMA Psychiatry. 2020 Mar 1;77(3):265-273. doi: 10.1001/jamapsychiatry.2019.3986.PMID: 31758858last accessed August 2022

8. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6902232/

9. AltalibHH, et al (2019). Mapping global Muslim mental health research: analysis of trends in the English literature from 2000 to 2015. Cambridge Prisms Global Mental Health

10. https://www.cambridge.org/core/journals/global-mental-health/article/mapping-global-muslim-mental-health-research-analysis-of-trends-in-the-english-literature-from-2000-to-2015/B0B782173C614F6FB8D7935E29C665AA

11. CifciA, et al (2012). Mental Health Stigma in the Muslim Community. Journal of Muslim Mental Health Volume 7 Issue 1 *Stigma*, 2012last accessed August 2022

12. DOI: https://doi.org/10.3998/jmmh.10381607.0007.102

13. Maynard SA, (2022) How do Muslims survive and thrive within secular prejudicial spaces? The British Psychology Society Psychotherapy Section Review Volume 66 17-20

14. NHS September (2020). Advancing mental health equalities strategy. Classification: Official

15. Publications approval reference: 001559 last accessed August 2022

16. https://www.england.nhs.uk/wp-content/uploads/2020/10/00159-advancing-mental-health-equalities-strategy.pdf

17. Mir G, et al (2019.) Delivering a culturally adapted therapy for Muslim clients with depression. The Cognitive Behaviour Therapist Published online by Cambridge University Presslast accessed August 2022

18. https://www.cambridge.org/core/journals/the-cognitive-behaviour-therapist/article/delivering-a-culturally-adapted-therapy-for-muslim-clients-with-depression/B3457DB393BFD4C3B241AF32DBA2EE88