COUNSELING MUSLIMS

HANDBOOK OF MENTAL HEALTH ISSUES AND INTERVENTIONS

EDITED BY

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CHAPTER 4
Mental Health Interview and Cultural Formulation

FARAH TASLEEMA RAHIEM and HAMADA HAMID

This chapter is intended to provide general guidelines for the mental health interview and case formulation of Muslim clients. It is not intended to replace the essential process of formal and supervised training. Mental health professionals, as well as pastoral care counselors, imams, and Islamic chaplains, will find this chapter to be a pragmatic reference when caring for a Muslim client. It is important to note that there is no monolithic Muslim culture and there is no formulaic approach to “the Muslim client.” Muslim individuals differ in socioeconomic background, level of religiosity, acculturation, and cultural identity. There is no single personality structure, coping style, or defense mechanism that Muslims share as a group. However, there are some cultural norms and forces that inform the client’s experience. Many Muslims, across different ethnicities, share common existential beliefs about the role of God (or Allah), morality, and emotional health that are distinct from other religious traditions. Many Muslims also share social stressors that are closely tied to their religious identity.

Throughout the chapter the authors will draw from the principles laid out in the Diagnostic and Statistical Manual of Mental Disorder IV–Text Revision Cultural Formulation (DSM-IV TR) as a model. To review, the mental health interview is the means by which information about a client is gathered. The formulation process entails concisely organizing that interview data in order to create a hypothesis as to “causes, precipitants, and maintaining influences” of the client’s psychological distress (Eells, 2007, p. 4). This formulation, in turn, will help with diagnosis and can
be used to tailor treatment options. The cultural formulation highlights the cultural influences upon the client’s symptomatology (Table 4.1). This chapter takes its readers through important components of the interview and cultural formulation of a Muslim client. Readers may also find reviewing published cultural formulations of Muslim cases to be helpful (e.g., Hasan & Kuluva, 2006; Varma, 2008).

The Culturally Informed Mental Health Interview

The first step in the initial interview is explaining the interview process and assessing the client’s language preference. In cases where the clinician and client do not share the same language, the use of a translator will be necessary. Although the subtleties of language often preclude a word-for-word translation, it is important to instruct the translator not to paraphrase the client’s report as important information may be missed. Once the literal meaning of the client’s report is translated, the language interpreter may also function as a cultural informant, providing guidance with idioms, appropriateness of content, and, in some cases, general practices of the client’s culture. Utilization of the translator as a cultural informant should ideally be reserved for a meeting with the interpreter after the interview. After the assessment of linguistic needs, the clinician should discuss issues of confidentiality with the client. The clinician should ensure the client that all mental health records will be kept in the strictest confidence and this information will only be “released with the authorization of the [client] or under proper legal compulsion” (Sadock & Sadock, 2008, p. 710). A discussion about privacy is particularly important for Muslim immigrants, who may not be familiar with the legal ramifications of the clinician–client privilege. Any client concerns about privacy should be thoroughly discussed at this time, as establishing an environment of trust and comfort is essential in setting the ambience for the interview.

Cultural Identity of the Individual

The cultural identity can be ascertained in the context of gathering demographic information. The interviewer should not impose any assumptions
about the client’s cultural identity based on appearance. During the course of the initial interview and later encounters, the multiple levels of the client’s identity may emerge.

Common terminology used to define one’s identity includes race, ethnicity, and culture. For clarification, these terms will be defined, with the understanding that they may hold an entirely different meaning when used in other contexts. Race will be described as the phenotypical similarities of a group that affect interpersonal and institutional interactions and that could lead to a hierarchical status designation within society (Pinderhughes, 1989). Ethnicity will be defined as an individual’s sense of belonging to a group with whom he or she may share a common ancestry, history, kinship, or language (Lim, 2006). Culture will be used as a more general term that may include the client’s race and ethnicity, as well as religious affiliation, gender, profession, nationality, political affinity, sexual orientation, and family role (Lu, Lim, & Mezzich, 1995).

For instance, a Muslim who was born and raised in the United States, but whose parents are of Guyanese-Indian origin, may see him or herself as racially Indian and ethnically Guyanese—but culturally as a Muslim American of Guyanese Indian descent who is a second-generation immigrant. Gathering such information during the initial interview and future sessions may be useful in elucidating the dynamic and multifaceted nature of the client’s cultural identity.

Religiosity Assessment

As suggested previously, religious affiliation can be a defining feature of a client’s cultural identity. In addition to having differing sectarian affiliations, such as Sunni or Shi’a, Muslim clients may also have varying degrees of identification with Islam. Questions pertaining to the level of socialization with other Muslims and the client’s religious practices should be asked, but in a nonjudgmental fashion. One valuable point to consider is that the religious commitment of some Muslims could be the result of external (societal or familial) pressure, internal commitment, or some combination of the two. Other topics that could be explored include the client’s perceived religious discrimination, the level of religious exploration prior to “owning” Islam as the client’s religion of choice, the extent to which religious beliefs may promote or interfere with help-seeking behaviors, changes in religious perspectives over time, the parents’ religious background(s), and any stress resulting from differences between the religious preference of the client and that of parents, spouse, siblings, and friends (Caraballo et al., 2006; Puchalski, 2006; Sadock & Sadock, 2008). Delving into these aspects of the patient’s life may give the clinician insight into religiously oriented psychological stressors or coping mechanisms.
Sample questions clinicians may consider using include

- Do you consider yourself a religious person? How so? If asked what religion you practice, what would you say? Is this the religion of your parents? How did you come to incorporate religion into your life?
- How do your religious beliefs affect your day-to-day life? Do you find comfort in prayer and/or fasting?
- Do you have friends who practice your religion? Do you feel comfortable around them?
- Are you involved in any religious groups in your community? Do you find this to be a source of support or distress?
- Do you find that your connection with religion is distressing to you? How so?
- Do you find that your religious connection is helpful to you in dealing with stress? How so?
- Are there any aspects of your religious beliefs that have helped you come in to see me today? Are there any aspects of your religious beliefs that may have prevented you from coming to see me or from getting treatment?

There may be a developmental component to the client’s perception of religion. During childhood and adolescence, the individual typically internalizes the values—critiques or praises—of the caregivers (McWilliams, 1994). The experiences with the caregivers and their levels of religiosity may shape the client’s perception of religion as a whole. For example, if the client was raised by a religious and critical father but a less religious and more accepting mother, the client may grow to associate religion with criticism. Clinicians could inquire about the level of religiosity of caregivers and the caregivers’ influence on the client by asking questions such as

- Which parent did you identify with more?
- Do you believe that has affected your perception of Islam or your level of religiosity?

Immigration History

Another essential element of the client’s background is his or her immigration history. Of note, mistakenly assuming that a native-born client is from another land, with opening questions such as, “So what country are you from?” may be insulting and create barriers between the client and clinician. Many European and American Muslims are second-/third-generation immigrants or converts to Islam who are well settled and view themselves as natives. A less presumptive line of questioning would be,
“Where were you born? Where did you grow up?” If the client is an immigrant, important questions to ask include (Caraballo et al., 2006)

- Was there a reason you immigrated? (Typical reasons include the pursuit of economic or educational opportunities and escape from war and persecution.)
- Who came with you?
- What did you leave behind? (This includes relatives, belongings such as a home, profession, and social circle.)
- When did you immigrate? Was time spent in a displaced location such as a refugee camp? What was that experience like?
- Any future plan of returning to your country of origin?
- Are there any difficulties revolving around your immigration status?

Immigration status is a sensitive subject that should be approached with caution, as the client may be illegally living in the country and thus apprehensive about providing such information (Caraballo et al., 2006).

**Acculturative Stress Assessment**

Acculturative stress is closely tied to the cultural experience of immigrants. Acculturation is defined as the dynamic process in which beliefs, values, and social behavior are exchanged between both host culture and that of the client (Mavreas, Bebbington, & Der, 1989). The clinician should explore the client’s identification with the host culture as well as with his or her culture of origin, in an effort to identify potential stress resulting from this possible intrapsychic negotiation. For example, if the client has difficulty with the language of the host culture, this may cause a problem in adjusting to the host culture and should be asked about in a sensitive fashion. Also, if the client was able to obtain employment, but secured a job that is lower paying or of lower social standing than what he or she had in his or her country of origin, this may be a source of distress. Other possible problems include feelings of guilt resulting from a perceived dissociation from the culture of origin when adjusting to the host culture, difficulty adapting to the host culture for fear of losing one’s native cultural values, familial conflicts due to the role reversal of parents and children or husbands and wives, and perceived discrimination (McGoldrick, Giordano, & Garcia-Preto, 2005). Sample questions to ask the client, based on Lim’s (2006) suggestions, include

- Do you have any friends who are from [the client’s culture of origin]? How frequently do you see them? Do you feel comfortable around them? How do you relate to them? Are you involved with any community group associated with [the client’s culture of origin]?

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• Do you have friends who are not from [the client’s culture of origin]? How do you relate to those individuals? Do you feel comfortable around them?
• Which group of friends would you say you relate to better?
• Do you find that adapting to your newer environment has been difficult or easy? How so?
• Have you felt in any way discriminated against in your newer culture? How has this affected you?

Explanatory Model of the Individual’s Illness

The client’s explanatory model of his or her problem is an essential component of any mental health interview. Although a psychiatrist or psychotherapist may draw from the medical, psychodynamic, cognitive-behavioral, and other models in understanding the causes of emotional distress and interpersonal problems, the client may hold a completely different belief system. Although explanatory models of mental health can be classified in varying ways, the authors have chosen to divide them into five broad categories, namely medical, psychological, social, moral, magical, and spiritual/religious. The medical model attributes mental illness to biologically driven processes that shape an individual’s emotional state, perception, cognition, and behavior. It relies on psychotropic medications, surgery, electroconvulsive therapy, and other medical procedures for intervention.

A psychological understanding of distress attempts to address how individuals perceive, process, understand, and react to the world around them. Psychologists, psychiatrists, psychotherapists, and counselors alike employ variations of psychodynamic, cognitive-behavioral, humanistic, and interpersonal techniques to address a client’s psychological needs. According to the social model, the central cause of distress is “everyday” life stress, such as economic strain, loss of employment, loss of housing, physical impairment, limited social supports, and access to services. Moral explanatory models attribute personal defects such as laziness, selfishness, or unethical behavior as the source of personal woes. Formal (such as social workers, occupational therapists, chaplain, religious authority, life coach) and informal (family and friends) resources are important in addressing both social and moral needs. Magical explanatory models are seen in every culture and can present as superstition, witchcraft, and sorcery. In some Muslim cultures, black magic, the “evil eye,” or jinn (a specific type of spirit described in the Islamic tradition) possessions may be blamed for life’s problems (Al-Issa, 2000). Muslims may go to traditional healers, community elders, or imams to address these issues (Aloud & Rathur, 2009). The spiritual and religious explanatory model posits that problems are due to weakness of faith, abandonment of religious rituals, or
misunderstandings of religious teachings—including reasons why Allah (God) has placed one in the world.

Muslims often have multiple explanatory models that act in concert. For instance, among a sample of New York City Muslims, 88% believed in the use of both Qur’anic healing and medication/Western psychotherapy for the treatment of the mentally ill (Abu-Ras, Gheith, & Cournos, 2008). Mental health practitioners should ask Muslim clients about their explanatory models in a nonjudgmental way. Recommendations on how to word such a question are

- What do you believe has caused these symptoms you are experiencing?
- Many Muslims believe in the evil eye, black magic, or jinn; did that play a role in your current situation?

If a Muslim client believes in the role of a magical explanatory model, then it is important to explore the events and circumstance that led to that narrative. If the person visits a traditional healer, imam, or religious authority, offering the client to work with those resources may greatly strengthen the therapeutic alliance.

Cultural Components of the Psychosocial Environment

The client’s psychosocial environment is a vast milieu that includes, but is certainly not limited to, family, ethnic community, cultural and religious institutions, occupation, and social network. The specific psychosocial settings of family and religious community are discussed in this section. In Muslim cultures, generally speaking, the family is regarded as the basic unit of society. Qur’anic verses and traditional teachings emphasize the importance of maintaining kinship ties, particularly those with one’s parents. Islamic tradition also places great importance on one’s relationship with the Muslim spiritual community. A Muslim client’s family and the religious community may contribute greatly to the psychosocial environment (Hamid, 2008; Muslim, 2009a).

Family Psychosocial Factors

Probing into family-based psychosocial stressors should include questions about the level of the family’s involvement in the client’s life, the amount of influence family authority figures have over the client’s decisions, which members of the family are seen as the authority figures, the role the client plays in the family power dynamic, and the client’s familial responsibilities. Many Muslim societies have hierarchical family structures that promote authoritarian and collectivist environments (Dwairy, 2006). This is of particular importance to immigrants living in Western countries who
have maintained close relationships with their cultures of origin. In collective systems, priority is given to the goals of the group and interpersonal responsibilities, rather than the goals and freedoms of the individual. As a result, there can be significant psychological, economic, and social interdependence of family members. To the clinician, it may appear that the familial authority figures micromanage the lives of other family members—having influence over their choices of dress, food, friends, and major life decisions such as career path and spouse. This involvement is typically not restricted to the nuclear family, but can also involve cousins, uncles, aunts, and grandparents. The clinician must keep in mind that what may appear to the Western-trained clinician as a family being enmeshed could actually be quite normative and may not be a source of psychological distress. It should also be noted that while such a familial system lends itself to much individual sacrifice and responsibility to the family, the familial network may also provide significant emotional, economic, and other support, especially in times of personal crises. As can be imagined, however, such a closely knit family structure can also be the source of substantial distress. Asking the client about familial interactions in an open-ended manner is thus essential. The family may be a central aspect of the client’s psychosocial well-being and family cohesion may be highly valued. When offering interventions, clinicians should be mindful that compromising that individual–family relationship could lead to the client discontinuing treatment (Dwairy, 2006).

Clinicians should also be aware that a common feature of collective families is an authoritarian child-rearing style. As noted by Dwairy (2006), corporal punishment tends to be commonly accepted as a part of authoritarian parenting (Al-Kittani, 2000; Al-Mahroos, 2001; Al-Shqerat & Al-Masri, 2001; Qasem, Mustafa, Kazem, & Shah, 1998; Saif El-Deen, 2001). Although clinicians must be very careful not to condone or promote physical abuse, they should remain keen to the nuances of authoritarian parenting styles. Some studies of children exposed to either authoritarian parenting or corporal punishment have shown that it may be detrimental to the child’s mental health (Gershoff, 2003; Mulvaney & Mebert, 2007). However, other studies suggest that the cultural and environmental context should be considered. For instance, a study involving 431 Arab adolescents raised in Israel found no significant correlations between authoritarian parenting styles and poor mental health outcomes (Dwairy, 2004). Researcher Marwan Dwairy (2006) argues that authoritarian parenting, when applied to the authoritarian Muslim society, does not have the negative outcomes that are associated with authoritarian approaches in Western populations. In fact, studies show that Arab youth are generally content with authoritarian parenting styles and experience that style as an expression of care and concern on the part of their parents (Hatab

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& Makki, 1978). That being said, the clinician should still remain alert for any accounts of excessive physical punishment.

Community-Based Psychosocial Factors

Islamic traditions and beliefs foster a communal worldview in which Muslims view each other as brothers and sisters who all constitute a larger Muslim community, or ummah (Ramadan, 2007). The Prophet Muhammad metaphorically compared the Muslim community to that of one human body, saying that if there is an illness in one member of the body, then the whole body responds to the illness by becoming sick (Muslim, 2009b). Prophetic traditions also remind Muslims of the strength in unity (Ramadan, 2007). Community-oriented practices such as the breaking of the Ramadan fast together, group prayer, public religious celebrations, and mosque-based activities serve to nurture and reinforce this communal sentiment. Thus, many Muslims are closely tied to their Muslim communities and mosques, and use them as a source of psychological support. A study involving 102 Muslims and 22 Imams in post-9/11 New York City found that 59% of participants sought advice from the imam (religious leader) as a result of the distress of 9/11 (Abu-Ras et al., 2008). Furthermore, the study reported that 94% of participants viewed the imam as a counselor. Other studies have found that the community is frequently the first line of support of some Muslims (Graham, Bradshaw, & Trew, 2008; Al-Issa 1990; Al-Krenawi & Graham 2000; Hodge, 2005). Exploration of these community connections as both sources of support and psychosocial stress is thus critical for Muslim clients.

The Concept of Self in a Collective Culture

Inextricably bound to the understanding of a client’s psychosocial vulnerabilities is a strong grasp of his or her concept of self. Margaret Mahler described a commonly accepted model for childhood development in her four phases of separation-individuation (Mahler, Pine, & Bergman, 1975). The process of individuation is critical for the development of a cohesive sense of self and for developing healthy attachments with others. A break or disruption in this process may result in characterological problems such as borderline and narcissistic disorders and even psychosis. Mahler described the “transition object” as an inanimate object such as a blanket or teddy bear as a tool children use to self-soothe as parents have limited time to spend with their child. Contemporary psychoanalytic theorist Salman Akhtar argues that, although Mahler’s developmental model is very important, it must be historically and culturally placed (Akhtar, 1999). He argues that Mahler’s observations were based on privileged, white New York City babies in the 1960s. The development and notion of self may take on a completely different process in Eastern cultures with large, extended family systems, in which there is little separation of babies from
adult arms. In densely populated urban areas such as Cairo and Karachi, a baby may be passed on from mom to aunt to sister to cousin without ever separating from an adult figure. Interestingly, transition objects are not known to be existent in these cultures. The sense of self and sense of family bond takes on a different meaning in such contexts (Akhtar, 1999).

**Difficult Topics of Discussion: Sex, Drugs, and Suicide**

The three subjects of substance abuse, sexual issues, and suicide may produce some discomfort in both the clinician and the patient during the initial interview. The Qur’an and Prophetic traditions discuss these topics quite bluntly and extensively; however, within many Muslim communities these subjects are sensitive topics of discussion—especially among individuals who have just met.

*Tobacco, Drugs, and Alcohol*

Knowing about the client’s use of tobacco, alcohol, other illicit drugs, and (overuse of) prescribed medications is critical. However, asking questions such as, “Have you ever used any drugs/tobacco in the past?” may not elicit a response that fully reflects a Muslim client’s substance use. Many Muslims may not perceive some substances as harmful or addictive. For instance, *khat* is a psychostimulant used commonly in Yemen and East Africa (Al-Hebshi & Skaug, 2005). Clients may not report using khat, as it may not be viewed as a drug of abuse. Likewise, water-pipe smoking (a tobacco-smoking practice otherwise known as hooka or sheesha) has been gaining noteworthy popularity among teenagers and adolescents. Water-pipe smoking is associated with an increased risk of malignancy, decreased pulmonary function, and the spread of infectious diseases such as tuberculosis (Knishkowy & Amitai, 2005). Asking specifically about the use of these substances during the interview may be useful.

In the Islamic tradition, the use of alcohol and recreational drugs is explicitly forbidden. Many Muslims are likely to hide their substance abuse habits from their family and communities, as a considerable amount of social stigma exists within communities with regard to substance abuse (Arfken, Berry, & Owens, 2009; Tahboob-Schulte, Ali, & Khafaji, 2009). The stigma is generally directed toward substance use itself, as well as abuse (Arfken et al., 2009). The moderate use of some substances, such as alcohol, may be normative for non-Muslim populations. However, for the Muslim client, even in moderate amounts, alcohol use may be looked down upon as a failure to live up to Muslim cultural and religious standards. Inquiry into the client’s perceptions of how substance use has affected his or her relations with family and community members may give the clinician a clearer picture of the client’s experience. Reassurance of clinician–client confidentiality is
key during this component of the interview. Substance use could also be addressed after establishing a stronger clinician–client rapport.

Suicide
Clinicians should also consider religious and cultural factors when assessing suicide risk. In Islam, committing suicide or attempting to do so is considered sinful. The Qur’an states, “. . . and kill not one another nor yourselves. Lo! Allah is ever Merciful unto you” (Qur’an 4:29). Thus, suicide may be regarded by the Muslim client as a weakness of faith and is associated with a significant amount of social stigma. As such, a Muslim client could exhibit some resistance to disclosing such information. A more natural and less direct method of inquiring about suicide is to fit it into the context of assessing for mood and anxiety symptoms.

Sexual Activity
Another sensitive discussion topic for many Muslims is sexual activity. It is common for a Muslim’s first romantic relationship to be with his or her spouse. In Islamic law, having a significant premarital romantic relationship is prohibited. The religious tradition is that an unmarried man and woman should not be secluded together, unless there is a third party (Muslim, 2009c). Such standards usually preclude boyfriend/girlfriend relationships commonly seen in Western cultures. The degree of social stigmatization against premarital romantic relationships varies depending on the views of the client, his or her family, and the Muslim community. Generally, however, premarital sex tends to be a source of considerable shame, especially in the case of females. If it is disclosed that a particular Muslim client has engaged in premarital sex, not only is that individual’s reputation at stake, it may undermine the reputation of the family and also negatively affect the client’s ability to find a spouse within the community.

Remaining chaste until marriage and being loyal to one’s spouse during marriage are considered to be duties incumbent upon a Muslim. Thus a Muslim client may view premarital or extramarital sex as a laxity of his or her Islamic responsibilities. Such beliefs, compounded with community and familial stigma, could result in a significant amount of guilt and conflicted feelings. Therefore, counselors should be very cautious regarding how they address a client’s sexual impulses and practices.

Cultural Elements of the Relationship between the Individual and the Clinician
Cultural elements inevitably affect the relationship between a clinician and a client. Some questions for clinicians to ask themselves when dealing with all clients are
Clinicians should be knowledgeable about the normative practices and values of their clients’ cultures. Acceptable beliefs and behaviors within a client’s culture should not be mislabeled as “signs and symptoms.” A clinician should also be aware of how his or her personal beliefs and worldviews affect how he or she engages the client.

The clinician should be conscious of intercultural and intracultural transference and countertransference. Although it is not possible to enumerate or describe all of the possible ways that ethnicity and religion shape transference and countertransference, several different possible scenarios are provided.

**Intercultural Considerations**

Intercultural considerations consist of both interethnic (when clinician and client are from different ethnicities) and inter-religious (when clinician and client are from different religious traditions) transference and countertransference.

**Transference**  Interethnic transference may result from a perceived power differential between the client and the clinician. For instance, a client from an ethnic minority culture may be overly eager to please a clinician from the dominant ethnicity. In this case, the clinician from the dominant ethnicity may be viewed as an authority figure, or as a member of an institution (e.g., hospital, clinic, government, or the dominant ethnicity in general) that has authority. Interethnic transference may also manifest as distrust toward the therapist. This could be the result of past negative interactions that the client may have had with individuals from the clinician’s ethnicity. Other common interethnic themes listed by Comas-Díaz and Jacobsen (1991) are the client’s denial of the importance of ethnic factors in his or her life and being ambivalent about obtaining treatment.

One inter-religious transference theme is the Muslim client hesitating to share information with the clinician for fear of being stereotyped. A hypothetical scenario is a domestically abused Muslim woman who is uncomfortable telling the non-Muslim clinician about the abuse, for fear of reinforcing stereotypes that Muslim women are oppressed or commonly...
beaten by their husbands. Other inter-religious transference topics are feeling frustrated by the clinician’s lack of understanding of Islamic cultural norms, being distrustful of the non-Muslim clinician who may be perceived as one who dislikes Muslims, and feeling the need to represent Muslims to the non-Muslim therapist and thus hiding information from the non-Muslim clinician in order to give a more positive view of Islam.

Countertransference One instance of interethnic countertransference is a clinician from the dominant ethnicity feeling guilty about social injustices that a minority client may have to endure. This could result in the clinician being more shy and apprehensive when interviewing the client. Another interethnic countertransference theme is questioning the client about elements of his or her culture based solely on the clinician’s personal interest and not on the clinical situation (Comas-Díaz & Jacobsen, 1991).

Inter-religious countertransference could be due to clinicians harboring negative feelings toward their Muslim clients. If a therapist has Muslim friends or colleagues, those relationships may consciously or unconsciously shape how the therapist thinks and feels about Muslims. A poll of 1,003 American adults found that 41% of people reported being acquainted with a Muslim, 38% had a negative view of Islam, and 35% believed Islam is more likely than other religions to encourage violence (Pew Forum on Religion and Public Life, 2010). Another countertransference theme is the clinician attributing harmful practices—such as domestic violence—to being within the realm of Islamic cultural norms. Other inter-religious countertransference themes parallel the interethnic countertransference themes mentioned previously. For example, the clinician may feel guilty about the social injustices suffered by the Muslim client and be less bold during the interview. The clinician may also feel insecure about his or her knowledge about Islam and ask the Muslim client questions about religious issues that are not relevant to the clinical situation. This scenario may prompt the client to play the role of the “representative Muslim.” Furthermore, clinicians may feel less competent about their abilities to incorporate the clients’ religion into therapy; as such they may avoid delving into religious topics at all (Henning & Tirrell, 1982). Clinicians may also avoid religious topics because of apprehensions about imposing their value systems upon their clients (Henning & Tirrell, 1982).

Intracultural Considerations

Transference Transference can be as potent in intraethnic situations as it is in interethnic encounters. Clients who share the same ethnic background as their clinicians may idealize them. Also, clients who have antagonistic relationships to their own ethnic heritages may have negative thoughts about the therapist. They may even assume that the therapist is less skilled
than a clinician from the dominant ethnicity. Additionally, clients with different levels of acculturation compared to their clinicians may view the clinicians as having “sold out” to the dominant ethnicity (Caraballo et al., 2006; Comas-Díaz & Jacobsen, 1991).

Some Muslim clients who share the same religion as their clinicians may not discuss situations in which the client has acted in a fashion that is contradictory to Islamic norms. For example, a Muslim client who drinks alcohol may not feel comfortable telling this to a Muslim clinician, for fear of being judged. Furthermore, if the Muslim client views mental health problems as stemming from a deficiency of faith, the client may feel insecure about his or her level of religiosity. Thus, the client may emphatically display outward signs of religious commitment when dealing with the clinician.

Countertransference Examples of intraethnic countertransference, as stated by Comas-Díaz and Jacobsen (1991) and later mentioned by Caraballo and colleagues (2006), are defensive distancing by the clinician, becoming angry because of greater demands from the client, feelings of guilt concerning the clinician’s socioeconomic circumstances versus that of the client, and over-identification with the client. Also, clinicians who share the same ethnicity as their clients may feel a sense of “tribal” responsibility to better the condition of the client because he or she is one of “our own.” In such situations, the clinician may find him or herself having difficulty drawing boundaries.

The concept of “tribal” responsibility also extends to the relationship between clients and clinicians who share the same religious background. A Muslim clinician may feel more obligated to assist a Muslim client than a non-Muslim client, and thus may encounter difficulties with maintaining appropriate boundaries. Also, the Muslim clinician may assume that he or she completely understands the way the Muslim client views the world, when actually, despite sharing the same religious traditions, they may have differing ideas about Islam. Additionally, the Muslim clinician may have negative feelings about Islam and could project these on the Muslim client.

Cultural Elements of Disease Manifestations

Many clinicians trained in Western society are taught about signs and symptoms of diseases, such as depression, as if they were objective findings and universal to all humans around the globe. More recently, cultural influences have gained wider acceptance as substantial modifiers of the symptoms of psychiatric disease (Smart & Smart, 1997). The clinician must keep in mind that the content of complaints and clinical relevance
are culturally influenced. One example of this is the case of a Javanese Muslim woman who was admitted to a mental hospital in Java secondary to “slamming doors and loudly expressing resentment and suspicion.” This kind of behavior was regarded as particularly abnormal in the region of Java where she resided, as the native people pride themselves on having a tranquil affect (Browne, 2001). If this same patient were to be evaluated in a different cultural setting, her symptoms may not have been viewed as pathological, and consequently a mental health practitioner may not have even seen her. The authors are not in any way implying that such a patient does not have underlying psychological problems, but that the manifestations may vary depending on the cultural context. Another example is a Muslim client who claims that he or she knows something to be true because God revealed it in a dream. In the Islamic tradition it is believed that dreams are a means by which Allah (God) may disclose information to an individual (Muslim, 2009d). Therefore, the previously stated claim may not be a delusion. Mental health practitioners should remain aware that a delusion should be distinct from culturally held values (Sadock & Sadock, 2008). The effect of culture on disease manifestation can be quite substantial and clinicians should not hesitate to request a “cultural consultation” from a mental health professional, imam, or community leader who is competent in the client’s cultural needs.

Cultural Formulation, Overall Assessment, and Management Options

Clinicians should list relevant cultural factors that may affect the client’s symptoms and clinical course, making sure to address the following categories:

1. The client’s cultural identity
2. The client’s cultural explanation of the symptoms
3. Cultural components of the psychosocial environment
4. Cultural elements of the relationship between the individual and clinician
5. Cultural elements of disease manifestation

Then, a series of possible hypotheses pertaining to the role of culture on the client’s illness should be generated. Final considerations should include the following:

- How does the cultural formulation affect management (i.e., interventions offered by the clinician)?
- Which type of psychotherapy (if indicated) is most appropriate for the client’s case?
• What are the response rate and side effects of psychotropics in the racial group of the client?
• Should other supports such as family, community, and traditional healers be incorporated into interventions?

Clients from collective cultures may be more interested in family therapy, which could involve the extended family as well. On the other hand, people from individualistic societies may be more amenable to individualized expressive psychodynamic psychotherapy (Caraballo et al., 2006).

The type of treatment recommended for the client should also take into account the client’s explanation for the illness. For instance, clients who are prescribed medications, but do not believe in a biological basis for their symptoms, may not take them. Other issues that could affect adherence to medications in Muslim clients specifically include

1. The use of medications containing alcohol, gelatin (denatured collagen which is frequently derived from pigs), and other pork products
2. The use of medications during Ramadan (the Islamic holy month of fasting)

The religious regulations regarding medication use in these circumstances are quite complex and differ on a case-by-case basis (Ibn Adam al-Kawthari, 2005). Therefore, a cultural consultation from a learned imam—possibly multiple imams—should be sought in such instances. These issues cannot be addressed, however, unless clinicians remember to inquire into what might prevent a client from adhering to a treatment regimen.

**Conclusion**

When interviewing a Muslim client and constructing a cultural formulation, such salient elements as the patient’s cultural identity, explanation for the symptoms, cultural factors related to the psychosocial environment, clinician–client relationship, and treatment options must be considered. An emphasis should be placed on establishing a therapeutic alliance in which the client feels understood. Maintaining an open mind, asking the client to explain aspects of the interview that were not understood, and consulting experts with more knowledge about the client’s culture, such as imams or community leaders, are essential to promoting an environment of empathy and acceptance. Clinicians should keep in mind that parts of the mental health interview can be revisited during later sessions. Components of the cultural formulation and the therapeutic relationship itself will evolve over time, as the client and clinician become more familiar with each other.
References


http://www.routledgementalhealth.com/counseling-muslims-9780415988605


