AN EXPLORATORY STUDY OF THERAPISTS' PRACTICES WITH MUSLIM CLIENTS: BUILDING RAPPORT AND DISCUSSING RELIGION IN THERAPY

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ABSTRACT

This exploratory study intended to determine what approaches were useful for engaging and treating Muslim clients from the perspective of experienced therapists. Despite the growing population of Muslims in the United States, there remains a dearth of research on how to work therapeutically with these clients. To increase participation in treatment and decrease premature termination, the current literature suggested the importance of building rapport with Muslim clients and the value of discussing religion in therapy. This study aimed to investigate these factors in addition to discovering other critical recommendations for treating Muslim clients. Fifteen interviews were conducted with mental health providers, including psychologists, a social worker, and a psychiatrist. Additionally, they completed a survey to examine their opinions on the relevance, effectiveness, and likelihood of using 40 recommendations acquired from the literature along with their knowledge and use of common Islamic beliefs and practices. The interviews were analyzed by the Grounded Theory Methodology (Corbin & Strauss, 2008). Respondents first provided information about the common and distinctive problems faced by Muslim clients, their unique presentation styles, the stigma of seeking help, and the possible misconceptions of therapy. Results from the interviews indicated several major themes: the Importance of Knowledge, the Avoidance of Assumptions, the Significance of Rapport Building, the Incorporation of Religion, the Inclusion of the Family, and the Consideration of the Community. In regard to building rapport, the following ways were identified to connect with Muslim clients: provide psychoeducation about therapy, respect religion, normalize their experience, demonstrate empathy, convey openness to learning, and be less formal and more disclosing. Additionally, the three

most recommended methods for including religion found in the study were to understand the impact of religion in the client's life, suggest religious practices as a way to cope, and use Islamic knowledge to counter maladaptive beliefs and behaviors. Results from the survey revealed that therapists endorsed many but not all of the recommendations found in the literature. Implications for mental health providers working with Muslim clients and future research are suggested. Notably, it is especially critical for therapists to consider the wide diversity within the Muslim community.

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Chapter I

Introduction

This dissertation investigated what practices are utilized with Muslim clients to engage and treat them from the perspective of experienced therapists. Though there is a growing literature on psychological issues with Muslim clients, there are still few research studies examining therapeutic factors with these clients (Abu-Raiya & Pargament, 2010, 2011; Ahmed & Amer, 2012; Amer, 2009; Sheridan & North, 2004). This dissertation aimed to gather evidence about what the important considerations are when working with Muslim clients in therapy. In addition, this study examined the current state of practice of therapists who work with these clients by surveying what recommendations in the literature are used. Furthermore, it included an inquiry of whether discussing religious beliefs and practices may be beneficial in treatment.

This area of study is important for several reasons. First, there is an increasing likelihood that therapists may encounter Muslim clients. Muslims are a growing population that require special consideration as a group (Abu-Raiya & Pargament, 2011; Ali, Liu, & Humedian, 2004; CAIR, 2006, Pew Research Center, 2007). In particular, the importance of the role of religion in their lives unites them as a unique population (Abu-Raiya & Pargament, 2010, 2011; Ahmed & Amer, 2012; Carolan, Bagherinia, Juhari, Hemelright, & Mount-Sanders, 2000; Daneshpour, 1998; Keshavarzi & Haque, 2013; Kobeisy, 2004; Hamdan, 2007; Padela, Killawi, Forman, DeMonner, & Heisler, 2012; Pew Research Center, 2007; Springer, Abbott, & Reisbig, 2009), which can be distinguished from focusing on specific ethnic groups, such as South Asians and Arabs. Though the literature on Muslim mental health has increased in the last few years, there

continues to be a need to explore issues concerning treatment with Muslim clients (Abu-Raiya & Pargament, 2010, 2011; Amer, 2009). The literature has noted that Muslims face an array of psychological difficulties like other populations (Ahmed & Reddy, 2007; Ali et al., 2004; Carolan et al., 2000; Hamdan, 2007; Hedayat-Diba, 2000; Daneshpour, 1998; Kobeisy, 2004) but under-utilize mental health services (Al-Krenawi and Graham, 2000; Khan, 2006; Kobeisy, 2004; Inayat, 2007). There are several reasons hypothesized for this trend, particularly their apprehension to seek therapy due to shame, embarrassment, and fear (Ahmed & Amer, 2012; Ali et al., 2004; Carolan et al., 2000; Daneshpour, 1998; Keshavarzi & Haque, 2013; Kobeisy, 2004). The literature in this area seems to place great significance on two considerations when working Muslim clients. One is the emphasis on building rapport with Muslim clients early on in treatment to engage them and reduce premature termination (Ali et al., 2004; Carolan et al., 2000; Daneshpour, 1998; Kobeisy, 2004; Springer et al., 2009). The other critical area is the role religion may play in clients' perceptions of their problems and accordingly, their perceptions of the solutions to their concerns (Abu-Raiya & Pargament, 2011; Ahmed & Amer, 2012; Ahmed & Reddy, 2007; Al-Krenawi & Graham, 2000; Ali et al., 2004; Azhar et al., 1994, 1995a, 1995b; Carolan et al., 2000; Daneshpour, 1998; Graham et al., 2008; Hamdan, 2007, 2008; Hodge & Nadir, 2008; Johansen, 2005; Keshavarzi & Haque, 2013; Kobeisy, 2004; Rezali et al., 1998, 2002; Springer et al., 2009; Williams, 2005). However, there has been little research to examine the specific conditions for building and maintaining rapport with these clients and incorporating religious beliefs and practices into treatment (Abu-Raiya & Pargament, 2010, 2011; Hamdan, 2008). Moreover, there is a dearth of information concerning what therapists as a group are

currently doing in this field (Abu-Raiya & Pargament, 2010, 2011; Sheridan & North, 2004). Though there has been an increase of recommendations for therapists working with Muslim clients in the literature, it is not known if clinicians are utilizing these recommendations. Therefore, this study investigated the dissemination of the current literature on Muslim clients. Finally, considering the low utilization of services along with the feelings of mistrust and shame (Ahmed & Amer, 2012; Ali et al., 2004; Khan, 2006; Kobeisy, 2004), it appears that it is difficult to have Muslim clients participate in research studies, as evidenced by the lack of studies with such participants (Abu-Raiya & Pargament, 2011; Sheridan & North, 2006). To bypass this barrier, experienced therapists were used to provide information on how they engage Muslim client, similar to a study conducted with social workers by Graham, Bradshaw, and Trew (2008, 2009). In summary, the following research questions will be investigated through this dissertation:

1. What do experienced therapists believe is important for working with Muslim clients?

2. What do experienced therapists find helpful for building rapport and maintaining treatment engagement with Muslim clients?

3. Is understanding and discussing religion in therapy useful for treating Muslim clients?

4. Are the recommendations found in the current psychology literature for working with Muslim clients relevant to therapists' treatment approach?

5. Do therapists perceive these recommendations as effective?

6. Would therapists use these recommendations in their treatment with Muslim clients?

7. Are the common Muslim religious beliefs and practices known to therapists?

8. Would therapists use or recommend these religious beliefs and practices in treatment with their Muslim clients?

Chapter II

Review of Relevant Literature

Muslims as a Unique Population of Study

Despite an increase in the psychology literature about Muslims, there is relatively little known about Muslim clients. This is particularly true when considering Muslims as a group. Currently, there has been growing knowledge on specific ethnic groups, such as South Asians and Arabs (i.e. Dwairy, 2006; Randhawa & Stein, 2007). However, there are several reasons for examining Muslims as a separate population. First, there is an increasing likelihood that psychologists will encounter Muslim clients in their settings. Currently in America, there are approximately 6 to 8 million Muslims (Ali et al., 2004, p.635). The Council of American-Islamic Relations (CAIR) noted that the top three ethnic groups within Muslims in North America include South Asians (32%), Arabs (26%), and African Americans (20%; CAIR, 2006, p.2). Ali, Liu, and Humedian (2004) reported that over one third of American Muslims reside in urban centers in the Northeast and East Coast (including New York, New Jersey, Massachusetts, Rhode Island, and Washington, DC) and in California and Chicago (p.636). Additionally, Islam is the fastest growing religion in the world and the United States (Ali et al., 2004). This is due to high rates of immigration, births, and conversions (Amer & Bagasra, 2013; Keshavarzi & Haque, 2013). Therefore, there is a growing need for resources for therapists working with Muslim clients.

Despite coming from many different cultural backgrounds, practicing Muslims are nevertheless united through their common religion by the Islamic concept of *Ummah.* This refers to Muslims being united as one community, regardless of country of origin or

ethnicity (Ahmed & Amer, 2012; Carolan et al., 2000; Daneshpour, 1998; Kobeisy, 2004; Springer et al., 2009). For example, the Prophet Muhammad (S), whom Muslims rely on for guidance, said in his final speech:

> All mankind is from Adam and Eve. An Arab has no superiority over a non-Arab nor a non-Arab has any superiority over an Arab; also a White has no superiority over Black nor a Black has any superiority over White except by piety and good action. Learn that every Muslim is a brother to every Muslim and that the Muslims constitute one brotherhood. (Prophet Muhammad (S), 632 A.D.)

This quote symbolizes the common set of beliefs shared among Muslims across different cultures. It also highlights the important role religion may play in their lives, particularly for religiously devout Muslim clients (Keshavarzi & Haque, 2013). As Hamdan (2007) stated, "Islam is a religion that covers every aspect of life: spiritual, social, economic, political, and the family [and]...is considered a way of life that does not separate religion from all other spheres" (p.95). Additionally, Islam provides a "variety of functions, such as the provision of comfort, meaning, identity, spirituality, and community" (Abu-Raiya & Pargament, 2010, p.183). The Pew Research Center (2007) conducted a large scale study of American Muslims and found that 72 percent indicated that religion played a "very important" role in their lives while 18 percent said that it was "somewhat important" (p.24). Additionally, though Islam is similar to other religions, there are unique factors to understand and consider with Muslims (Abu-Raiya & Pargament, 2011). Thus, it will be critical to understand the impact of religion on treatment and how it affects the process.

Need for Information on Muslim Clients

There is a growing need for specialized information on how to reach Muslim clients and engage them in treatment. Notably, despite the growing population of Muslims in America, Muslims are less likely to seek psychological services (Kobeisy,

2004; Patel et al., 2000, as cited in Inayat, 2007). Moreover, Muslims may under-utilize or prematurely terminate services (Al-Krenawi & Graham, 2000). Inayat (2007) noted several reasons for the underutilization, including mistrust of service providers, fear of treatment, fear of racism and discrimination, language barriers, differences in communication, and issues of culture/religion. Khan (2006) conducted a survey with 459 Muslims in the Ohio region on attitudes toward therapy. It was found that only 11.1 percent indicated use of professional counseling in the past two years (Khan, 2006, p.26). This reluctance to utilize treatment is not due to the lack of psychological difficulties. In fact, Khan found that 15.7 percent of participants indicated need for services (p.26). Several authors (Ahmed & Reddy, 2007; Ali et al., 2004; Carolan et al., 2000; Daneshpour, 1998; Hamdan, 2007; Hedayat-Diba, 2000; Keshavarzi & Haque, 2013; Kobeisy, 2004) have identified struggles currently facing American Muslims, including anxiety, depression, psychosomatic difficulties, PTSD, alcoholism, family problems, adjustment disorders, and difficulties with prejudice and discrimination. For this reason, Muslims are in need of clinical services as much as other populations. It is vital to understand the similar and unique concerns of the Muslim community.

Furthermore, the current literature focusing on Muslim clients is relatively limited. Sheridan and North (2004) examined the psychology literature by analyzing PsycINFO, a major database containing psychology literature in several forms from 1887 to present (p. 151). They searched the database for literature containing the words "Islam," "Muslim," or "Moslem" and found only 1354 abstracts (North & Sheridan, 2004, p.152). These abstracts were then analyzed on several dimensions. The most common type of literature found were articles (82.7%) with dissertations (6.5%), book

chapters (6.4%), and books (4.4%) being the other main categories (Sheridan & North, 2004, p.153). The authors found that 62.5 percent were empirically based articles, 19.9 percent were comments, advice, or non-scientific observations, 7.1 percent were literature reviews, 5.7 percent were case studies, and 4.8 percent were theoretical papers (Sheridan & North, 2004, p.152). In other words, 37.5 percent of the literature found were not scientifically based and thus, highlighted an increased need for more data driven research in the area on Muslim clients. The major countries where abstracts were published are the United States (53.8%) , India (16.5%), the United Kingdom (11%), France (4.1%), Pakistan (2%) and other countries that have less than two percent each (Sheridan & North, 2004, p.154). The main topic found was on the health and education issues (22.1%), which mainly described recommendations to clinicians about working with Muslim clients (Sheridan & North, 2004, p.153). The next two largest topic areas (total of 30.3%) did not directly concern Muslims as an area of study but were mostly correlation or empirical studies that had Muslims in the sample population (Sheridan & North, 2004, p.153). Therefore, there is a need for studies that not only have Muslims in the sample but where Muslims are the focus of study. Finally, Sheridan and North found that though the majority of studies had a balanced view of Muslims (79.8%) or positive perspective (12.9%), there were still a number of articles with a negative tone (7.2 %; p. 153). The following table from Sheridan and North summarizes the increase in abstracts over the years:

Table 1

Percentage of Articles with Positive, Negative, or Balanced Tone by Period

Period	% Positive	% Negative	% Balanced	Total No. of Abstracts
1998 – 2002	11.0	15.7	73.2	299

Table 1 cont.

1993 – 1997	10.9	11.3	77.8	293
1988 – 1992	5.1	10.2	84.7	236
1983 – 1987	3.5	9.0	87.6	201
1978 – 1982	2.7	13.3	84.1	113
1973 – 1977	5.6	16.9	77.5	71
1968 – 1972	7.0	18.6	74.4	43
1963 – 1967	8.0	8.0	84.0	25
1958 – 1962	--------	4.0	96.0	25
1953 – 1957	4.0	32.0	64.0	25
1948 – 1952	--------	--------	100.0	5
1925 – 1947	11.1	33.3	55.6	18

Note. From "Representations of Islam and Muslims in Psychological Publications," by L.P. Sheridan & A.C. North, 2004, *The International Journal for the Psychology of Religion*, 13, p.157. Copyright 2004 by Lawrence Erlbaum Associates, Inc.

More recently, Abu-Raiya and Pargament (2011) reviewed 101 articles in the literature relevant to Muslims, Islam, Religiosity, Psychology and Mental Health. The four main categories of articles found included:

> (a) the birds-eye perspective – studies that utilised a single-item index of religiousness among Muslims; (b) the derivative perspective – studies that used measures validated in Christian samples or were comparative in nature (i.e. used samples from different faiths and did not focus exclusively on Muslims); (c) the Islamic-based perspective – studies that reported the development of measures of Islamic religiousness or the findings of studies conducted based on these measures; and (d) the clinical perspective – studies that tested the efficacy of religious forms of psychotherapy with Muslim clients. (Abu-Raiya & Pargament, 2011, p.94)

The authors noted that many of these articles have limitations and that overall, "empirical studies of Muslims are scarce; the field of the psychology of Islam is still in its infancy" (Abu-Raiya & Pargament, 2011, p.107). In particular, they noted that there are few studies which are derived from the Muslim experience. The authors stated that, "using qualitative research methods might be an important first step in this direction" as it would

give voice to Muslim participants (Abu-Raiya & Pargament, 2011, p.106). However, there may be reluctance of Muslims to participate in psychology research (Abu-Raiya & Pargament, 2011; Amer & Bagasra, 2013). They noted "the antipathy, mistrust, and suspicion that characterise the attitudes of many Muslims towards the field of psychology (Abu-Raiya & Pargament, 2011, p.107). Additionally, they stated that many studies rely on "small, convenient sample" of Muslims, which may misrepresent the variation and complexity of Muslims (Abu-Raiya & Pargament, 2011, p.108). Their overall conclusion is that more research is needed in this area.

Currently, there has been a notable increase in articles, books, and research studies discussing various issues about Muslims. For example, the *Journal of Muslim Mental Health* was established in 2005 to provide a space and direction for emerging research in this field of study. To update the 2004 Sheridan and North study, Amer and Bagasra (2013) reviewed 559 articles relevant to Muslims Americans from the PsychINFO database from 1991 – 2011. They reported that between 2000 and 2010, there has been a 983 percent increase in the annual number of publications related to Muslim Americans (Amer & Bagasra, 2013). It was found that 53.3 percent of articles were not empirically based (Amer & Bagasra, 2013). Quantitative research (such as questionnaires, experiments, etc.) accounted for 24.3 percent while 21.1 percent were qualitative studies (such as interviews, focus groups, case studies, etc.; Amer & Bagasra, 2013). Approximately 22.5 percent of publications were related to counseling and clinical psychologists with only 6.6% based on empirical research (Amer & Bagasra, 2013). There were 35 publications that discussed the role of religion (Amer & Bagasra, 2013).

However, there continues to be a great need for further research in many different areas. As Amer (2009) stated in her Editor's Introduction, "when researchers select any topic related to Muslim mental health, they find that the body of literature is often thin, superficial, with many gaping holes" (p. 1). Thus, there is substantial work to be done in the field. Additionally, it has been noted that "historically, the psychology of Islam has relied almost exclusively on clinical observations, theological speculation and anthropological methods of inquiry (Abu Raiya, Pargament, Stein, & Mahoney, 2007 as cited in Abu-Raiya & Pargament, 2010, p.181). The implication for current clinicians is that there is not an established literature to refer to when working with Muslim clients. Amer (2009) stated that "clinicians often give up looking for published research that could inform their service provision...[and] end up instead turning to mainstream media or local colleagues for advice, sources that are usually flawed with misinformation and biases" (p. 1-2). This then may imply that therapists are not using the best practices for Muslim clients. Abu-Raiya and Pargament (2010) noted that "there is a need for empirical studies that examine the effectiveness of some promising techniques suggested by psychotherapists working with Muslim populations" (p.187). This highlights the important gap in studying the effectiveness of recommendations in the literature. As Amer and Bagasra (2013) summarized,

> Greater research efforts by psychologists can reduce the existing disparities in studies focusing on Muslim minorities. An expanded body of knowledge can better ensure the well-being of Muslims in North America and inform effective services for this group—a group that is highly visible in the mainstream media and yet marginalized in the scholarship. (p.142)

Therefore, there is a great need to provide therapists with empirically based information for treating Muslim clients to provide the best possible treatment.

Muslim Clients' Attitudes toward Therapy

There are several hypotheses as to why Muslim clients under-utilize therapeutic services and may end treatment prematurely. On one hand, there is some evidence that professional help may be viewed favorably. Khan (2006) found in her large study that 63 percent of the 459 participants had pro-counseling attitudes as measured using the "Attitudes toward Seeking Professional Psychological Help" scale (p.26). On the other hand, only 15.7 percent indicated a need for services while only 11.1 percent used services in the past two years (Khan, 2006, p.26). Specifically, 49 out of the 72 respondents who said they needed services did not use professional counseling (Khan, 2006, p.35). This discrepancy may indicate a difference between a general view of therapy and a personal view to therapy.

One important reason suggested is that therapy is not the natural route Muslims take when facing psychological difficulties. Forty-two percent of participants indicated that they "always" sought comfort from their families (Khan, 2006, p.32). Graham, Bradshaw, and Trew (2008) interviewed 50 social workers who worked with Muslim clients and found that Muslim clients "resolve their problems within their family or community rather than seeking outside help" (p.131). In addition, Carolan, Basherinia, Juhari, Himelright, and Mouton-Sanders (2000) interviewed 40 American Muslims on several important issues in their study, including their process of seeking help. It was found that they would initially choose to work on their problems with "someone who knew them, either a trusted family member or a trusted family friend" (Carolan et al., 2000, p.76). This may be due to a "deep sense of shame" in discussing personal problems outside of the family (Daneshpour, 1998, p.364). Additionally, Muslim clients may be

reluctant to share the secrets of the family to an outside counselor (Amer & Jalal in Ahmed & Amer, 2012). For example, Carolan et al. (2000) found that most in the study often turned to the family of their spouse for assistance with relationship trouble because they knew them best and the spouse would be more receptive to their advice and guidance. Springer, Abbott, and Reisbig (2009) also noted that family help is sought first over professional help for couples. It appeared then that seeking outside professional help is considered a last resort after all other traditional supports are exhausted. However, Daneshpour (1998) suspected that because Muslim families living in America may not have such support (such as extended family), they may be forced to seek outside help when in distress or in crisis.

Before seeking professional help, Muslims may be more likely to seek help from a religious leader (Kobeisy, 2004; Springer et al., 2009). Springer et al. (2009) noted that Muslims believe that to solve personal and family problems, they need to turn to Islam (p. 232). Padela et al. (2012) study of 13 focus groups of Muslims revealed that the majority of respondents reported utilizing Imams as substitutes for mental health professionals. The authors stated,

> Respondents described the imam as 'a counselor for moral support,' and as someone 'in whom everybody confides,' because 'sometimes people [do not] want to go the psychiatrist,' and they 'go to a person that is . . . religious and knowledgeable [and] . . . find consolement.' (Padela et al., 2012, p.851)

Therefore, they may look within their religion and its leaders for help with their problems. Ali, Milstein, and Marzuk (2005) reported in "the Mosque in America Study, which described the structure and functioning of 416 mosques and the roles of the leaders of these mosques, [they] found that 74 percent of the mosques provided marital and family counseling services directly to their congregants" (pp.202-203). Thus, it may be

expected in the community that one turn to religious leaders for help. Ali et al. (2005) also surveyed 62 religious leaders (*Imams)* to understand how they met the mental health needs of their communities. It was found that "fifty percent of Imams...reported spending one to five hours each week in counseling activities, and 30 percent...reported spending six to ten hours each week" (Ali et al., 2005, p.203). The two main concerns that are addressed with clients are religious or spiritual issues and relationship or marital concerns (Ali et al., 2005). However, Khan (2006) found in her study that 45.5 percent never seek comfort from a religious leader (p.32). This interesting finding raised the question about whether Muslims are really seeking religious leaders to address their mental health needs.

A common circumstance that does prompt the use of outside counseling is when it is "requested by a significant family member (e.g., a parent or a spouse), a medical health professional, a court judge, a social worker, a school administrator, a teacher, or a counselor" (Kobeisy, 2004, p.113). This may force clients into treatment and cause shame, embarrassment, anger, or guilt (Kobeisy, 2004), which may influence what type of counselor they may request for treatment. In their study of 121 Religious Muslims in Washington, DC And Chicago, Kelly, Aridi, and Bakhtiar (1996) found that a slight majority (52.9%) would prefer a Muslim counselor, whereas 43.8 percent would be okay with either a Muslim or non-Muslim counselor (Procedure section, para.3). They also found that "if they had to go to a non-Muslim Counselor, over 50% of the respondents said it was very important and another 25% somewhat important for the counselor to have religious values similar to theirs" (Kelly, Aridi, & Bakhtiar, 1996, Procedure section, para.3). It was also critical for the counselor to have an understanding of Islam, with 56.2 percent considering it very important and 29.8 percent considering it somewhat

important (Kelly et al., 1996, Procedure section, para.3). Carolan et al. (2000) found similar results in her study, where when looking for outside help, their first preference would be a Muslim counselor. However, a "non-Muslim [therapist] known to the Muslim community as a culturally sensitive and caring professional" (Carolan et al., 2000, p.77) would be the other option when there are no Muslim professionals available. In addition, there may be some clients who may prefer a culturally sensitive non-Muslim therapist because they feel it may be more confidential (Keshavarzi & Haque, 2013; Kobeisy, 2004). Based on these findings, it seems critical to further understand what is important for Muslim clients to seek help from a professional but there are concerns about being able to trust the therapist as well as the need for an understanding of Islam and Muslims by the therapist.

In addition to the shame in going to therapy, there are other beliefs that have been noted to make it difficult. There may be a belief that seeking outside help reflects negatively on the family (Ali et al., 2004; Hedayat-Diba, 2000). Daneshpour (1998) described that Muslim immigrant families usually equate their problems with a sense of failure. There is a belief that families should take control and responsibility for handling personal problems with the help of the extended family (Daneshpour, 1998). Additionally, cultural and religious beliefs make the family responsible for teaching children how to behave in society, and therefore, problems with their children may reflect negatively on the parents (Daneshpour, 1998). Even in marital relations, the family of origin and one's upbringing are reflected onto the success of the relationship and problems may be a reflection of failure of the family (Daneshpour, 1998). This view that psychological problems are to be blamed on the inability of the family to correctly

manage problems can make seeking outside help as difficult and may be important to consider when treating Muslim clients.

Another stigma attached to coming to therapy for Muslim clients is viewing it as an admission of weakness. Seeking help may mean that one has "weakness in faith, in physical ability, and manifestation of a lack of a strong support system" (Kobeisy, 2006, p.59). One client stated in an interview that "they would think I'm not stable enough to handle life and to handle the stress that's why I go to therapy" (Kobeisy, 2004, p.77). Another concern that some Muslim clients may have is that seeking counseling is a sign of one's insanity or craziness (Kobeisy, 2004; 2006). More importantly, they believe others will view them in this way if it is known that they are in counseling (Kobeisy, 2004). These beliefs held by some clients appear important to address early in treatment, particularly for the therapist to ease their fears and concerns.

Another hypothesis for why Muslims may be reluctant to come to therapy is their suspicion of counselors (Inayat, 2007). There may be a belief that the counselor's biases will influence their attitudes toward them (Ali et al., 2004; Altareb, 1996; Daneshpour, 1998; Kobeisy, 2004). Daneshpour (1998) stated that "it is uncomfortable for Muslim immigrant families, even if they desperately need help, to discuss the family's private struggles with a therapist who has limited knowledge or negative views about Islamic ideology and Muslim families" (p.363). In addition, Muslims see themselves very different than what may be portrayed in the media (Daneshpour, 1998). In 2000, Mandani analyzed newspaper headlines from 1956 to 1997 and found that the US media depicted Muslims and Arabs more negatively than Western Europeans and Israelis (as cited in Sheridan & North, 2004, p.151). After the September 11th terrorist attacks, the worry that

people (including therapists) will view them negatively has only increased, particularly due to the rise of acts of discrimination (Ali et al., 2004). Rippy and Newman (2006) found, in their study of 152 Muslims in Oklahoma, that the majority (91.2%) believed that there has been an increase in discrimination since 9/11 (p.12). In addition, they found that 53 percent reported an increase in personal exposure to discrimination since 9/11 while 43.6 percent believed it had remained the same (Rippy & Newman, 2006, p.13). It is also noteworthy that because Muslims are bounded around the world as a faith community (U*mmah*), negative portrayals of foreign Muslims outside of America may affect Muslims, both in terms of distress for problems occurring overseas and concern about how others perceive them (Kobeisy, 2004). This may increase the likelihood that Muslim Americans will withdraw and isolate themselves further (Rippy & Newman, 2006), and thus, may make seeking outside help even harder. This concern of therapists' bias may affect rapport from being built and brings up the question about how therapists can work to address their biases as well as convey this to Muslim clients.

Therapeutic Recommendations

Considering the difficulties Muslim clients may have in seeking treatment, it seems imperative to find ways to engage them in treatment and address their fears and concerns. The current literature provides an array of recommendations for helping Muslim clients throughout the process of therapy (Abu-Raiya & Pargament, 2010; Ahmed & Amer, 2012; Al-Krenawi & Graham, 2000; Ali et al., 2004; Ahmed & Reddy, 2007; Carolan et al., 2004; Daneshpour, 1998; Ghaffari & Çiftçi, 2010; Graham et al., 2008, 2009; Hamdan, 2007; 2008; Hedayat-Diba, 2000; Hodge & Nadir, 2008; Hussain, 2001; Keshavarzi & Haque, 2013; Kobeisy, 2004, 2006; Springer et al., 2009; Williams,

2005). These recommendations are mostly based on experience working clinically with Muslim clients.

Establishing rapport. Because Muslim clients may be reluctant to come to therapy, it appears that building rapport early on is critical (Keshavarzi & Haque, 2013). Generally, if the therapist fails to engage the client or family, there will be decrease a likelihood of continuing therapy (Kobeisy, 2004). Kobeisy (2004) identified the most important factors in continuing therapy, which include "the client's first impression of the counselor, feelings regarding the counselor, and the positive expectation of the counseling relationship" (Kobeisy, 2004, p.86). It seems that establishing a positive relationship with Muslim clients is an important first task in therapy.

Several authors provide important recommendations for creating this positive relationship. Carolan et al. (2000) recommended that therapists "approach the joining process as central to the therapeutic process and pace themselves in accordance with the pace with which their clients are comfortable" (p.78). Springer et al. (2009) noted the importance of not rushing to formal assessments or therapeutic work with Muslim clients because it may take extra time and effort to build the alliance (p. 233). Daneshpour (1998) described the importance of joining as Muslims may "feel vulnerable and powerless when have to present problems to the therapist, who might not understand their cultural background and religious ideology" (p.364). This includes the importance of conveying respect for the family's culture and religion to gain a sense of connectedness without the client feeling judged (Daneshpour, 1998). For example, Hussain (2001) described the importance of bridging the gap and empower clients by simply saying "I don't know much about your culture but I would be interested in learning more" (p.8).

This may help to even out the professional and client power differential and increase communication between cultures (Hussain, 2001). In general, Graham et al. (2008) recommended that service providers "be curious about the client's perspective and his or her values" (p.140). Without trust, clients may be reluctant to share their real feelings, which may hinder treatment progression (Daneshpour, 1998).

The most recommended way mentioned in the literature to convey respect and a nonjudgmental attitude is to have knowledge about Muslims (Abu-Raiya & Pargament, 2010; Ahmed & Amer, 2012; Ali et al., 2004; Daneshpour, 1998; Carolan et al., 2000; Graham et al., 2008, 2009; Hamdan, 2007; Hedayat-Diba, 2000; Hodge & Nadir, 2008; Keshavarzi & Haque, 2013; Kobeisy, 2004; Springer et al., 2009; Williams, 2005). Amer and Jalal (in Ahmed & Amer, 2012) noted that "evidence suggests that mental health professionals are generally very little, if at all, educated in the basic tenets of Islam and the practices of Muslims" (p.87). Carolan et al. (2000) believed that therapists should "first be informed about the specific culture from which the family has emerged and how the culture has had an impact on the practice and application of Muslim beliefs" (p.77). In addition, Ali et al. (2004) suggested that being aware of negative stereotypes about Islam and Muslims and providing a place to discuss their experiences of discrimination may be an important way for building trust. It is also recommended that therapists discuss the attitudes clients may have about therapy, including the stigma attached to entering treatment (Ali et al., 2004). In addition, Ali et al. (2004) reported that "clients may initially hesitate to disclose issues of conflict about their religious beliefs and acculturation until trust is built in the relationship....[and] may appreciate an opportunity to discuss their cultural mistrust and suspiciousness of psychologists and may ask about

the therapists' intentions and motivations" (p.639). In sum, these clinical recommendations focus on creating a nonjudgmental space for the client to open up at their own pace as well as exploring their attitudes and feelings about therapy.

Though having knowledge is necessary, it may not be sufficient. Knowledge may be used as a starting point for working with Muslim clients but as several authors note, there is a considerable diversity within the Muslim community (Abu-Raiya & Pargament, 2011; Ahmed & Amer, 2012; Amer & Bagasra, 2013; Carolan et al., 2000; Daneshpour, 1998; Graham et al., 2009; Hedayat-Diba, 2000; Hodge, 2005; Hodge & Nadir, 2008; Khan, 2006; Keshavarzi & Haque, 2013; Kobeisy, 2006; Williams, 2005). As with all groups of people, it is difficult to make broad generalizations. Springer et al. (2009) stated,

> We give these practical guidelines with a word of caution that they cannot apply to all cases and all situations. In fact, Muslim families vary considerably due to ethnicity, sect of Islam (e.g., Sunni, Shia, Sufi), religious devoutness, extent of integration into American society, if they are recent immigrants or native born Americans, and their unique personal and family values (p.232).

This cautionary note is shared by most authors and may be helpful for therapists to consider when working with Muslim clients. Thus, it is recommended that therapists use active listening to understand the uniqueness of each client (Graham et al., 2008). Therapists are also encouraged to maintain a curious stance with clients and remain open to all the possibilities (Springer et al., 2009).

Other possible factors may be considered in having a positive therapeutic experience. Kobeisy (2004) described in his book, *Counseling American Muslims: Understanding the Faith and Helping the People*, the experiences he has had with American Muslim clients, including their feedback to him. He defines "good counseling"

as methods that are found to be “helpful, encouraging, and productive” (Kobeisy, 2004, p.123). These methods are suggested to help clients continue with the process of therapy once it has begun, build a cooperative relationship, and lead to desirable outcomes to their problems (Kobeisy, 2004). Kobeisy provides further information on what specifically leads to a good counseling experience. He concurred with the above recommendations that building rapport and creating a nonjudgmental, supportive environment for the client are critical (Kobeisy, 2004). He also suggested that the therapists be open to the types of problems Muslim clients come in with and their way of viewing them (Kobeisy, 2004). In addition, it is noted that acknowledging one's limitations may be helpful for maintaining credibility (Keshavarzi & Haque, 2013; Kobeisy, 2004). Examples are presented in which the therapist assumes to understand certain religious or cultural areas that results in the client feeling misunderstood and disregarded. Kobeisy also found that the counselor’s experience based on perception of age and expertise was related to positive therapy experience. Therefore, it is suggested that it may be useful to inform clients about one’s educational background, general knowledge of Muslim cultures, special training related to Muslims and successful cases with Muslim clients (Kobeisy, 2004). These recommendations provided by Kobeisy specify practices that therapist can do to build rapport.

On the other hand, it is also important to note what experiences can negatively impact treatment. Kobeisy (2004) defines “bad counseling” as “the experience that has led a client to terminate...prematurely, discouraged clients from seeking counseling again, or did not help the clients sort out their problems and consequently solve them” (p. 126). One factor identified by Muslim clients was the counselor’s appearance, exhibited by

counselor's formal dress, the cleanliness of his or her office, and the organization of her desk and room (Kobeisy, 2004). These indicated to the client the level of professionalism and authority, which is a delicate balance for Muslim clients (Kobeisy, 2004). A more significant deterrent for Muslim clients was when counselors were judgmental (Kobeisy, 2004). This may occur when clients feel challenged negatively, blamed for their problems, or have conditions put on them to change their customs or beliefs in order to achieve results (Kobeisy, 2004). Finally, counselors who were ignorant of the client's culture discouraged engagement (Kobeisy, 2004). An example of a specific custom that may convey disrespect is when a therapist puts his or her feet on the table facing the client (Kobeisy, 2004).

According to the literature, a more detrimental therapist practice is when one imposes his or her own values onto the client (Abu-Raiya & Pargament, 2010; Hamdan, 2007; Kobeisy, 2004). There are certain values in Western culture that may not always be held in the same high regard as other values for Muslims (see Jafari, 1993, for an elaboration). For example, Western values like "individualism, self-determination, independence, self-expression, egalitarian gender roles, explicit communication that clearly expresses individual opinion, and identity rooted in work and love" can be contrasted with values Muslims may hold such as "community, consensus, interdependence, self-control, complementary gender roles, implicit communication that safeguards others' opinions, and identity rooted in religion, culture, and family" (Hodge & Nadir, 2008, p.32). This difference in values may affect the therapeutic relationship. Kelly et al. (1996) found in their comparison study using the results from Kelly (1995) that a "generally more conservative, conventional, and traditional approach to life [was

more important] on the part of Muslims, especially highly religious Muslims, than professional counselors in general" (Discussion section, para.4). For example, some therapists may impose their feminist values onto the client's situation with a statement like "No woman needs a man....many women raise children without a husband and without a father" (Kobeisy, 2004, p.131). Though it may be okay for some cultures in America, it may be shameful in the Muslim culture, which may shut down the discussion because of the value judgment made by the therapist. Another damaging scenario is when "secular therapists advising traditionally religious clients to 'give up' some aspect, or even all, of their religious commitment on the grounds that one's beliefs and practices are inhibiting therapeutic progress" (Bergin & Jensen, 1990, p.6). This may be viewed as a threat to their identity or integrity (Bergin & Jensen, 1990). To avoid these missteps, it is suggested that therapists actively re-examine their sources of information on Islam (such as the media, parents, or friends) and how they affect attitudes toward Muslims (Inayat, 2007; Kobeisy, 2004).

Another negative experience for Muslim clients was the counselor's lack of disclosure (Ahmed & Amer, 2012; Kobeisy, 2004). It was recommended that counselors have a moderate balance of disclosure (Kobeisy, 2004). He notes that too little disclosure could be seen as distancing oneself while too much may be compromise one's competence and authority (Kobeisy, 2004). It was also recommended that therapists answer "questions that are relatively innocuous such as, 'Are you married?' (Amer & Jalal in Ahmed & Amer, 2012). To summarize, it appears that there are several ways therapists can attempt to prevent premature termination or negative experiences in therapy.

Therapist role and treatment approach. The role of the therapist may be different with Muslims clients. With Muslim clients, the therapist may play an advisory/teacher role and the client is a learner or a disciple (Ahmed & Amer, 2012; Keshavarzi & Haque, 2013). This is in contrast to the approach with clients from Western cultures, where the choice to do something may be offered by the therapist but the client is not obligated to do it. In addition, Hedayat-Diba (2000) pointed out that although Muslim clients are distrustful of therapists, they will "generally assign a great deal of authority to the therapist and conform to what is advised or prescribed – at least on the surface – because to disagree is equated with confronting, which is considered to be rude" (p.301). This results in a more passive stance in treatment. Hedayat-Diba (2000) also noted that because psychological symptoms are more often expressed physically, "they frequently expect to be cured of symptoms without having to bare their soul, much as one does when visiting a physician" (p.301). This may put a great deal of authority and responsibility onto the therapist. However, Keshavarzi and Haque (2013) stated that "the role of the practitioner is in helping guide the process toward self-actualization and instilling a willingness to be introspective" (p.238). It will be important to understand how therapists can work towards a collaborative approach, which balances the authority given to them with the importance of the client's input.

In addition, treatment engagement may increase if there is a focus on the here-and-now concerns and understanding what the physical symptoms may mean for the client (Ahmed & Amer, 2012; Hedayat-Diba, 2000). It is also suggested that interventions aim to be practical, immediate, and attainable while being congruent with the goals and values of the family and their religious beliefs (Ahmed & Amer, 2012;

Daneshpour, 1998). In contrast, interventions that overemphasize the historical development of the family and individual members or are too philosophical and abstract may be rejected (Daneshpour, 1998). Amer and Jalal (in Ahmed & Amer, 2012) reported that though some aspects of Freudian psychoanalytic treatment mirror Islamic concepts, in general, psychoanalytic theory may not work for many Muslim clients. The authors reported that "cognitive-based therapies are more congruent with the religious beliefs of Muslim clients than, for example, psychoanalysis" (Amer & Jalal in Ahmed & Amer, 2012, p. 96-97).

Orienting clients to treatment. The misconceptions and fears held by Muslim clients may cloud their perceptions about what the process of therapy will be like. Kobeisy (2004) describes that the lack of information about the availability and expectations of counseling as well as misinformation about counseling from others may deter Muslims from seeking professional help. This varies based on the length of stay in America and whether the person or family members have been educated in American academic institutions (Kobeisy, 2004). In general, however, there is limited information about what therapy is. Kobeisy recommended what information would be useful to communicate to clients, including the functions of therapy, the education and training of therapists (including multicultural training), the issues for which therapy can be helpful, and the expected outcome of counseling (p.84). In addition, it may be helpful to inform clients about the practical considerations of therapy, such as the procedures they should expect during sessions and the financial liability (Kobeisy, 2004). Hedayat-Diba (2000) also recommended educating clients on the importance of the time boundaries and "the rules regarding appointment time, lateness, and missed sessions" (p. 302). Furthermore,

experienced social workers in the study conducted by Graham et al. (2008) reported that they can "enhance trust and information sharing by ensuring confidentiality and clarifying the role and intentions of social service agencies" (p.134). Overall, it is suggested that providing this information can be an important step in changing the negative attitudes towards therapy and preparing clients for treatment.

Thorough assessment. Several authors have recommended conducting a thorough assessment of clients (Abu-Raiya & Pargament, 2010; Ahmed & Amer, 2012; Ahmed & Reddy, 2007; Daneshpour, 1998; Hamdan, 2007; Hedayat-Diba, 2000; Springer et al., 2009). This will not only provide valuable information for treatment but also helps to convey a sense of respect and consideration for the client. First, Ahmed and Reddy (2007) recommend for therapists to "educate their clients on the assessment process and goals to increase the clients' comfort and motivation during testing" (p.213). To conduct an extensive assessment of the client, therapists should not only check the client's physical health and psychological well-being but also the spiritual and religious beliefs (Ahmed & Amer, 2012; Ahmed & Reddy, 2007; Hamdan, 2007; Keshavarzi & Haque, 2013). Thus, they suggested that a religious and spiritual assessment is performed. Hedayat-Diba (2000) provides several characteristics that may help therapists judge how religious a client is, including their length of stay in America, their observance of religious required practices, and their feelings about participating in behaviors not allowed by the religion (such as drinking alcohol, eating pork, or dating). In particular, it can help to know the extent to which the client practices the *Five Pillars of Islam*, which include praying five times a day and fasting in the month of *Ramadan* (Hodge & Nadir, 2008; Hodge, 2005). Additionally, it is noted that unless the therapist actively pursues the

religious assessment, they may not know the extent to which it affects their lives (Hedayat-Diba, 2000).

Abu-Raiya and Pargament (2010) found in their research that it is critical to "invite Muslim clients into a 'religious conversation' by explicitly inquiring about the place of religion in their lives" (p.183). They recommend that this is done both at the beginning and throughout the course of therapy (Abu-Raiya & Pargament, 2010). Moreover, there are three questions that can be used to understand the role religion plays in their lives, problems, and solutions:

> 1. Do you consider yourself a religious or spiritual person? If so, in what way?
> 2. Has your problem affected you religiously or spiritually? If so, in what way?
> 3. Has your religion or spirituality been involved in the way you have coped with your problem? If so, in what way? (Abu-Raiya & Pargament, 2010, p. 183)

In addition, it may be important to assess the individual's perspective on their religion. Abu-Raiya and Pargament (2010) recommend asking "what does Islam mean to you?" (p. 184). This open ended inquiry allows one to engage in a discussion about the role of religion in the client's life. Ghaffari and Çiftçi (2010) found gender differences in the use of religion. Muslim men were found to practice more in the public realm and therefore, they may respond better to going to Mosques to pray to get both spiritual and community support (Ghaffari & Çiftçi, 2010). Muslim women, on the other hand, were found to practice more privately and therefore, it may be more helpful to focus on the "internal value and meaning of religion" (Ghaffari & Çiftçi, 2010, p.23). As a result, it is recommended that the assessment includes consideration for what works for the individual client. Finally, it is suggested that therapists "carefully assess the role of perceived discrimination and the distressing effects associated with it" (Ghaffari & Çiftçi, 2010, p.23).

Rahiem and Hamid (in Ahmed & Amer, 2012) discussed the importance of developing a cultural formulation. This formulation is comprised of:

> Cultural identity of the individual, cultural explanations of the individual's illness, cultural factors related to the psychosocial environment, cultural elements of the relationship between the individual and the clinician, cultural elements of disease manifestations, and overall cultural assessment for diagnosis and management options (Rahiem & Hamid in Ahmed & Amer, 2012, p. 52).

These factors should be explored thoroughly to understand the complexity of the client's cultural and religious identity, immigration history, acculturation stress, family factors, and community factors (Rahiem & Hamid in Ahmed & Amer, 2012). Additionally, difficult topics, such as substance abuse, sexual issues, and suicide should be handled sensitively.

Furthermore, it may be helpful to view clients from a holistic and ecological perspective by considering the individual, nuclear, extended families, and others in the cultural context (Daneshpour, 1998). One way to get a broad picture of the client is to create a genogram of at least three generations, which will help to understand the family and their culture (Daneshpour, 1998; Daneshpour in Ahmed & Amer, 2012). It may be useful for eliciting trans-generational patterns, family myths, and illustrating the whole picture of the family system (Daneshpour, 1998). Even if only one or two generations live in the home, emotional ties may be still maintained with the extended family, which are expected to be involved in important issues (Daneshpour, 1998). In addition, Ahmed and Reddy (2007) suggested assessing the acculturation level and how stress related to immigration and acculturation affect the client. Overall, it is recommended that extending one's routine assessment to include religious, cultural and family considerations can increase understanding of the client.

Gender, family, and hierarchy. There are specific recommendations from various authors (Ahmed & Amer, 2012; Carolan et al., 2000; Daneshpour, 1998; Hedayat-Diba, 2000; Springer et al., 2009) that address family concerns with therapy, which is particularly important for Muslims. First, it is suggested that therapists be mindful of a possible gender preference for therapists, especially for women (Ahmed & Amer, 2012; Al-Krenawi & Graham, 2000; Graham et al., 2008; Kobeisy, 2004). It is advised that "where opposite-sex clients occur, reduced eye contact, greater physical distance and culturally appropriate and consciously non-sexual terms such as 'my brother' or 'my sister' may be used" (Al-Krenawi & Graham, 2000, p. 299).

There are suggested considerations for how to work with the family members. For example, treatment engagement may increase if therapists include elder members, who are valued for their experience and knowledge (Daneshpour, 1998; Hedayat-Diba, 2000). For example, clients, and even the therapist, may "benefit from their instrumental resources, their life experiences, their extensive formal and informal ties, and their social status" (Daneshpour, 1998, p.364). In addition, it is suggested that therapists be aware of and respect the hierarchical structure embedded in the family. This may mean, for example, that respect should be paid to the father or an elder's authority (Hedayat-Diba, 2000). In particular, males were found to be more likely to have negative help-seeking attitudes than females (Khan, 2006, p.35). Therefore, it is suggested that engaging fathers or elder males may be essential.

There may also be different communication styles for Muslim clients. The respect for elders and authority figures may make it difficult for members to openly express their views, especially in family sessions (Daneshpour, 1998). The covert

communication style is also valued by Muslim families (Daneshpour, 1998; Daneshpour in Ahmed & Amer, 2012). This style "discourages direct confrontation or criticism of others" (Daneshpour, 1998, p.365). Therefore, family members may be reluctant to discuss negative impressions or concerns openly. Daneshpour (1998; Ahmed & Amer, 2012) recommended using individual sessions with systemic thinking in mind to advance family goals. For example, it can be helpful to have an individual meeting with a reluctant father before engaging in family sessions or to have a discussion on marital concerns with the wife alone first (Daneshpour, 1998).

Whether working with a family or an individual client, it is suggested to widen the scope to include both individual and family goals. When there are conflicts between the interests of the family and the interests of the individual, it may be helpful to utilize interventions that aim to "maintain the unity of the family and emphasize the goals, desires, and interests of the family unit as opposed to those of individual family members" (Daneshpour, 1998, p.365). Then, interventions which support individual goals may be worked on as long as it does not conflict with the goals of the family (Daneshpour, 1998). Additionally, it is recommended that therapists' interventions emphasize the education and advancement of children in family to not only synchronize goals but to help engage the family (Daneshpour, 1998). Finally, it is suggested that the goals of the family may be different than what Western families may identify. For example, enmeshment may not be viewed as the problem but the goal as families may more often complain that they do not feel connected enough (Daneshpour, 1998; Hedayat-Diba, 2000). In sum, Graham et al. (2008) noted in his study with social workers he interviewed that "recognizing the importance of kinship..., respecting the family

structure, and working within the family and community...[are useful] to alleviate concerns and address problems" (p.131).

Working with the community. Considering the reluctance for treatment, it may be helpful to rely on resources within the community to support interventions. Hedayat-Diba (2000) explained that Masjids (mosques) in America have become sources of support and social activity. It is recommended that therapist know what services are provided in the client's area to help direct them to natural support systems (Ahmed & Amer, 2012; Hedayat-Diba, 2000; Keshavarzi & Haque, 2013). Beyond prayer services, "mosques may offer education for children and adults, day care, libraries, and social and sporting activities" (Corbett 1994; Smith, 1999 as cited in Hodge, 2005, p.167). Clients can be encouraged to explore and access resources within their own communities and Masjids, which can help lessen feelings of alienation (Kobeisy, 2004). Additionally, *Imams* (religious leaders) may be a source of information to consult on religious or spiritual components of the problems, including conflicts about Islamic practices (Abu-Raiya & Pargament, 2010; Ahmed & Amer, 2012; Ali et al., 2005; Altareb, 1996; Hodge, 2005; Hodge & Nadir, 2008). Hodge and Nadir (2008) noted that "a local Imam may be able to help...identify concepts that are consistent with Islam as well as language from Islamic teachings that support...interventions" (p.39). Additionally, Keshavarzi and Haque (2013) highlighted that a *Shaykh* (religious scholar) may also be helpful for Muslims to consult when they want to understand the role of religion in their problems.

Another suggestion for utilizing the community is to have an introduction to the therapist made by a Muslim therapist or respected member of the community. Graham et al. (2009) found in their interviews with experienced social workers that having such an

introduction to the client may bridge the cultural gap and help build trust with the client. One respondent in their study said:

> You are really right because I have been noticing that—mistrust. It is apprehension. I was thinking about it and I thought perhaps the best way would be for a social worker from another community, another faith, another group, to perhaps have some Muslim social workers to work with them. For example, if you were going to meet a Muslim family, then if you have a Muslim worker or Muslim acquaintance or friend that is a social worker to start building that—to start bridging that gap because the link that you have with you is very strong. (Graham et al., 2009, p.396)

Exploring how the community can help to make connections between service providers and the Muslim population could increase treatment engagement and trust. Ali and Aboul-Fatouh (in Ahmed & Amer, 2012) noted that Imams may be willing to make referrals to counselors that are sensitive to culture and religion and would support psychotherapy and medications to complement religious coping strategies.

Religion in Therapy

Religion is one of the most important parts of life for Muslim clients (Hamdan, 2007). The small but growing research on Muslim clients has made a case for the incorporation of religious beliefs and practices into psychological treatment (Ahmed & Amer, 2012; Ahmed & Reddy, 2007; Al-Krenawi & Graham, 2000; Ali et al., 2004; Azhar et al., 1994, 1995a, 1995b; Carolan et al., 2000; Daneshpour, 1998; Graham et al., 2008; Hamdan, 2007, 2008; Hodge & Nadir, 2008; Johansen, 2005; Kobeisy, 2004; Rezali et al., 1998, 2002; Springer et al., 2009; Williams, 2005). These authors note that due to low utilization, stigma, and fears, it is recommended that to build rapport, therapists should demonstrate respect for Muslim clients by understanding and including religious beliefs and practices into their treatment.

In addition, there are other reasons in general why religion may be an important consideration in therapy. Similar to Muslims, religion has been found to be an important part of people's lives in general. 93 percent of Americans identified with a religious group (Kosmin & Lachman, 1993 as cited in Shafranske, 1996) and over 80 percent reported that religion is fairly or very important in their lives (Gallup, Jr., 1995 as cited in Shafranske, 1996). It has also been found that 63 percent agreed that religion can answer all or most of today's problems and 57 percent reported that they pray at least once a day (as cited in Shafranske, 1996). Therefore, religion has a great impact on people's lives and is likely to play a role in their views of their problems and ways to improve their conditions.

Beyond the importance in specific populations, the consideration of religion is required by our ethical code. The American Psychological Association's Ethical Code Principles of Psychologists and Code of Conduct (1992) advocate addressing a client's religious beliefs. Principle E: Respect for People's Rights and Dignity specifies that:

> Psychologists are aware of and respect cultural, individual, and role differences, including those based on age, gender, gender identity, race, ethnicity, culture, national origin, *religion* [italics added], sexual orientation, disability, language, and socioeconomic status and consider these factors when working with members of such groups. Psychologists try to eliminate the effect on their work of biases based on those factors, and they do not knowingly participate in or condone activities of others based upon such prejudices. (p. 1063)

In addition, Section 2.01(b), which deals with standards of competence, states that:

> Where scientific or professional knowledge in the discipline of psychology establishes that an understanding of factors associated with age, gender, gender identity, race, ethnicity, culture, national origin, *religion* [italics added], sexual orientation, disability, language, or socioeconomic status is essential for effective implementation of their services or research, psychologists have or obtain the training, experience, consultation, or

> supervision necessary to ensure the competence of their services, or they make appropriate referrals. (p. 1063-1064)

These ethical principles emphasize the importance of being aware and knowledgeable of client's religious beliefs in our psychological work. Moreover, it is required by psychologists to be aware of their biases and prevent it from affecting their work with clients. Considering religion then is not only helpful to treatment but is critical to our work as psychologists.

Difficulty Integrating Religion into Therapy

However, there has been difficulty including religion into therapy. One reason that may be contributing to this problem is the training of psychologists. Over 90 percent of psychologists surveyed indicate that education and training in religious issues rarely or never occurs (Shafranske & Malony, 1990 as cited in Shafranske, 1996). Less than 20 percent reported that they had a working knowledge of the psychology of religion (Shnafranske, 1996). Approximately 10 percent of the subjects had some degree of theological training and 10 percent were current members of APA Division 36, Psychology and Religion (Shafranske, 1996). Therefore, one hypothesis for difficulty incorporating religion into treatment is that psychologists are often not trained in how to do so.

Beyond the reported lack of direct training, another possible reason it may be difficult to incorporate religion into treatment is psychologists' own religious beliefs. Religion seems to play a minimal role in the lives of most psychologists in the United States. In a 1984 survey of religious preferences of academics, psychologists were found to be among the least religious, with 50 percent responding that they had no current religious preference, compared with only about 10 percent of the general population

("Politics", 1991 as cited in Jones, 1996). Bergin and Jensen (1990) summarized the research indicating that therapists were less inclined to traditional values and religious affiliations than the general population (Jones, 1996). Their survey found clinical psychologists to be the least religious of the major psychotherapy provider groups (Jones, 1996). They also found that only 33 percent of clinical psychologists described religious faith as the most important influence in their lives, as compared with 72 percent of the general population (Jones, 1996). In addition, in a national survey, it was found that only 29 percent of therapists expressed a "belief that religious matters are important for treatment efforts with all or many of their clients" (Bergin & Jensen, 1990, p.6). It is suggested then that psychologists often take a stance of neutrality or silence toward religion, which is described as a respectful position to take towards what one does not personally endorse or understand (Jones, 1996). This may be one hypothesis for why psychologists are reluctant to incorporate religious beliefs into therapy and may send the implicit message to clients that religion does not have a place in treatment. Above all, it may confirm the fear that Muslim clients have about their beliefs and values being ignored in therapy.

The stance taken by psychologists may have developed from the historical dichotomy between religion and science. Jones (1996) presents the argument that they are incompatible based on their respective essential nature, where science rests on facts while religion is based on faith. Throughout its development, psychology has attempted to establish its place in the scientific world by adopting the scientific method as well as its preference for objectivity. Though there is some indication that traditional religious belief and practice can yield certain personal or societal advantages, many psychologists

have argued that science would provide them more consistently and without religion's harmful consequences (Wulff, 1996). Psychologists, such as James Leuba and George Vetter, have consistently tried to challenge religion's place in society. For example, Leuba found in his questionnaire in 1950s that "eminent scientists and historians are much less likely to believe in God and immortality than their less distinguished colleagues and were most knowledgeable about biological and psychological processes" (Wulff, 1996, p.48). This appears to be reflected in the lack of religious beliefs among psychologists currently found.

One prominent figure, B.F. Skinner believed that like all other behaviors, religious behaviors occur because they have been followed by reinforcing stimuli, often provided by priests and other powerful agents of control (Wulff, 1996, p.49). In addition, religious behavior is likely to continue if it is randomly reinforced like pigeons who exhibit "superstitious" behavior (Wulff, 1996, p.49). Thus, his view of religion's worth was demeaned to the simple explanation of reinforcement attainment. Another major figure in psychology, Sigmund Freud, contributed to the negative view of religion (Smither & Korsandi, 2009; Wulff, 1996). He compared elements of religion ("compulsive qualities of rituals, aura of inviolability that surrounds religious ideas, and the individual's proneness to feelings of guilt and to fear of divine retribution") to the obsessive symptoms of neurosis, which he believed was a defense against unacceptable impulses (Wulff, 1996, p.51). This view of religion characterized one's faith as an immature defense equivalent to other pathological defenses and in contrast, psychological maturity was to give up one's reliance on it. Overall, the historical development of psychology may have frowned upon incorporating religion into treatment as religion was

seen as non-scientific and infantile. This history may continue to deter the use of religion in therapy among psychologists, which may exclude an important aspect of Muslim clients' lives.

Historical Efforts to Integrate Religion in Therapy

On the other hand, throughout history, there have been attempts to utilize religion in psychology. Wulff (1996) summarizes some of these major figures. William James viewed religion as a way to human excellence (Wulff, 1996). He believed that when inspiration and intellect combined, we may expect high levels of human excellence that are otherwise unobserved (Wulff, 1996). In addition, those who achieve these levels influence others positively and attempt to make the world a better place (Wulff, 1996). He concluded that religion is "an essential organ of our life performing a function which no other portion of our nature can so successfully fulfill" (Wulff, 1996, p.53). This view of religion highlights that when used intelligently, religion can offer benefits to the person and to society in general.

Another major figure, C. G. Jung, viewed religion as way to wholeness (Wulff, 1996). Influenced by William James, he also believed that religion was seen as an essential function of the human psyche (Wulff, 1996). From his over 30 years of therapeutic work with mostly Protestant patients, Jung concluded:

> Among all my patients in the second half of life (over 35), there has not been one whose problem in the last resort was not that of finding a religious outlook on life. It is safe to say that every one of them fell ill because he lost what the living religions of every age has given to their followers, and none of them has been really healed who did not regain his religious outlook. (Wulff, 1996, p.53)

However, he did not mean following a specific religion or religious organization. Instead of coming from an outside source, Jung believed it lied within our human psyche, which

he called *archetypes* (Wulff, 1996). The goal according to him was to individuate or develop self-realization into a whole being, through participation in religious traditions (Wulff, 1996). Jung believed that in modern times, many people have lost the capacity to participate in the images and rites of religion (Wulff, 1996). Without this process to guide them, they develop forms of psychoneurosis and psychosis while societies project the neglected archetypes onto other groups and nations, transforming them into dangerous enemies (Wulff, 1996). He believed psychologists need to understand and use the full range of human experience, including religious ones, to carry on the process of individuation (Wulff, 1996).

Finally, Wulff (1996) describes Erik Erikson's perspective on religion as seeing its value for hope and wisdom. In respect to his psychosocial stages, Erikson believed religion makes trust universal and provides institutional hope, the strength that emerges from this stage (Wulff, 1996). It also universalizes mistrust through a shared conception of evil (Wulff, 1996). Religious traditions also offer societal support for the attainment of wisdom in the final stage of development where one achieves integrity and its accompanying sense of coherence and wholeness (Wulff, 1996). Therefore, religion aids in important developmental milestones. Erikson believed religious rituals help to modulate impulsivity and excessive control while providing a particular understanding of human existence (Wulff, 1996). Despite its vulnerability to distortions and its long history of misuse, Erikson concluded that religion is vital for the attainment of human maturity (Wulff, 1996). Overall, these major figures in psychology see the potential for religion to have benefits to human existence and should not be disregarded due to the unfortunate mishandling by some. This may help to provide some directions on what role

religion can play in therapy, which may be especially important for religious Muslim clients.

Benefits of Religion and Spirituality

In addition to the usefulness of religion described by major historical psychology theorists, there are also important findings on the benefits of religion and spirituality on mental health. Kobeisy (2006) stated, "Faith can provide a great source of support and help to individuals and societies in prevention of mental illness as well in treatment" (p.61). He pointed out the role religion often plays in crises, like natural disasters or national tragedies (Kobeisy, 2006). In a 2001 review article, Koenig et al. examined 850 articles and found that two-thirds showed a positive effect of religious activity on overall health (Sahraian et al., 2013). The results from Richards and Bergin (2000; 2005) major findings are presented here (p.14)[1].

The first major findings show religion improves well-being and lowers psychological problems. Religiously committed people tend to report greater subjective well-being and life satisfaction (Richards & Bergin, 2000). People who engage in religious coping (e.g. praying, reading sacred writings, meditating, seeking support from religious leaders & community) during stressful times tend to adjust better to crises and problems (Richards & Bergin, 2000). Intrinsic (devout) religious people tend to experience less anxiety, including less death anxiety (Richards & Bergin, 2000). They also tend to be freer of worry and neurotic guilt. Religious commitment is usually associated with less depression (Richards & Bergin, 2000). Among elder people, church attendance is strongly predictive of less depression (Richards & Bergin, 2000).

[1] The next three paragraphs were taken directly from Table 1.3 in Richards & Bergin (2000). I was not sure how to properly present the findings without plagiarizing them. Therefore, I want to give them full credit.

Religiously committed people report fewer suicidal impulses, report more negative attitudes toward suicide, and commit suicide less often than nonreligious people (Richards & Bergin, 2000).

The second major findings, presented from Richards and Bergin (2000), focus on moral behavior. People who attend church are less likely to divorce (Richards & Bergin, 2000). Studies have also consistently shown a positive relationship between religious participation and marital satisfaction and adjustment (Richards & Bergin, 2000). People with high levels of religious involvement are less likely to use or abuse alcohol and drugs (Richards & Bergin, 2000). Religious denominations that have clear, unambiguous prohibitions against premarital sex have lower rates of premarital sex and teenage pregnancy (Richards & Bergin, 2000). Religious commitment as measured by church attendance is associated negatively with delinquency (Richards & Bergin, 2000). Religious commitment is associated positively with moral behavior (Richards & Bergin, 2000). Devoutly religious people generally adhere to more stringent moral standards, curbing personal desire or gain to promote the welfare of others and society (e.g. not gambling, drinking, or engaging in premarital or extramarital sex; Richards & Bergin, 2000). Finally, intrinsic religious commitment is associated positively with empathy and altruism (Richards & Bergin, 2000).

The last major findings point to the benefits of religion on one's health, taken from Richards and Bergin (2000). Religious commitment is associated positively with better physical health (Richards & Bergin, 2000). Religious people have a lower prevalence of a wide range of illnesses, including cancer, cardiovascular disease, and hypertension (Richards & Bergin, 2000). As a group, religiously committed people tend

to live longer and to respond better once they have been diagnosed with an illness (Richards & Bergin, 2000). Individuals' religious beliefs can help them cope better with their illnesses, including a reduced likelihood of severe depression and perceived disability (Richards & Bergin, 2000). Religiously committed surgical patients have shown lower rates of post-operative mortality, less depression, and better ambulation status than patients with lower levels of religious commitment (Richards & Bergin, 2000).

Richards and Bergin (2005) provide several explanations for why these benefits are seen. First, it may be that religious devout people have a more secure sense of identity that leads to more resiliencies. Second, religion may provide a sense of purpose and meaning, which helps to understand difficulties. Third, positive emotions are present during religious practices. Fourth, religious affiliation provides a community of support. Fifth, religious connection with a Higher Power may provide a personal sense of inner peace. Lastly, religious beliefs may lead to healthy practices, such as not smoking or drinking.

This summary of findings is important for several reasons. First, it counters the negative stereotypes about religion portrayed in society and within science. Secondly, these findings use scientific methods to provide evidence of its usefulness, which helps to provide a rationale for the scientific world, including psychology, to consider religion into their practice. Furthermore, for psychology in particular, it is evident that religion can help with some of the major problems clients come for therapy. It provides rationale for therapists to find effective ways to utilize religion for clients who identify it as being important since it can have these positive outcomes. Therefore, there may be benefit to

including religious beliefs and practices into treatment to help Muslim clients.

Discussing Religion in Therapy

There has also been work on discovering ways to integrate religion into treatment. Tan (1996) presents the steps offered in the workshop "Psychotherapy with Religiously Committed Clients" conducted by Shafranske, Tan, and Lovinger at the APA convention annually from 1990 to 1993 (p. 367)[2]. The first step would be to identify religious themes important to the client during the assessment phase (Tan, 1996). Then, therapists can examine the potential influence of religion and culture on the client's perception of his or her psychological difficulties (Tan, 1996). Next, the therapist can unpack the sources of resistance and support of the therapeutic process that have their origin in religion (Tan, 1996). Using the religious worldview of the client to support therapeutic change and use interventions of a religious nature can facilitate the therapy (Tan, 1996). In addition, identifying systems of support within religious traditions is useful (Tan, 1996). Finally, therapists can consult with religious professionals to get a clearer understanding of the client's perspective (Tan, 1996). These steps, provided by Tan (1996), highlight how religion can be considered at every step in the therapeutic process and how the responsibility may fall on the therapist to search for ways religion can be incorporated into the process. Evidently, the extent religion included directly into treatment is dependent on the extent that the client identifies religiously in the assessment phase. This model provides a basis for how to specifically incorporate religious beliefs and practices into treatment for Muslim clients.

However, Hamdan (2008) cautioned therapists with some concerns of integrating religion into therapy. There are ethical and clinical considerations in involving religion

[2] These steps are quoted directly from Tan (1996) to avoid misrepresentation.

into treatment, including fear of imposing values, informed consent and collaboration, and professional competency to do this work (Hamdan, 2008). In addition to a thorough assessment and strong therapeutic alliance, Hamdan summarizes three guiding values:

> (a) respect for client's autonomy and freedom, (b) sensitivity to and empathy for the client's religious and spiritual beliefs, and (c) flexibility and responsiveness to the client's religious and spiritual beliefs (Garzon, 2005; Richards & Bergin, 1997 as cited in Hamdan, 2008, p. 102).

These guidelines help to make space for a client centered approach to the integration of religion into treatment. It also provides an important reminder for the therapist to not impose their values and beliefs onto clients, including the idea that religion should always be the focus in treatment. Understanding further in what manner therapists decide when and how to use religion into treatment with Muslim clients will be an important inquiry.

Discussing Islam in Treatment

There have been researchers who have studied the effects of incorporating religious concepts into treatment. In 1994, Azhar, Varma and Dharap conducted a controlled study in Malaysia with 62 religious identified Muslim patients who were diagnosed with Generalized Anxiety Disorder. Both groups were given standard treatment with weekly supportive therapy and medication (Azhar, Varma, & Dharap, 1994). The experimental group of 31 patients were given additional sessions of "religious psychotherapy in the form of discussions of religious issues specific to patients (such as the reading of verses of the Holy Koran and the encouragement of prayers as a form of relaxation)" (Azhar et al., 1994, p.2). The results found that at 3 month post intervention follow-up, the patients in the experimental group improved significantly more than the control group (Azhar et al., 1994). However, at six month follow-up, both groups were similar in improvement (Azhar et al., 1994). Azhar et al. recommended that therapists

should “use these [religious] beliefs in treating patients rather than challenging or attempting to change the patient's values and beliefs” (p.2). A similar study was conducted in 1995 by Azhar and Varma with depressive patients. All 64 religiously inclined patients were given medication, along with 15 to 20 cognitive behavioral therapy sessions, while 32 patients received additional religious psychotherapy that incorporated religious belief and practices into treatment (Azhar & Varma, 1995a). At the one month and the three month interview, the experimental group improved significantly better than the control group (Azhar & Varma, 1995a). However, similar to the previous study, the improvement between the two groups evened out by six months (Azhar & Varma, 1995a). Finally, Azhar and Varma conducted a similar study with 30 religiously inclined patients who were dealing with depression as a result of bereavement or the loss of a loved one (1995b). In addition to medication and supportive cognitive behavioral therapy, fifteen patients were given extra religious psychotherapy sessions that incorporated religious beliefs and practices like prayer (Azhar & Varma, 1995b). Notably, in this study, significant differences in improvement were found for one month, three month and six month interview for the experimental group (Azhar & Varma, 1995b). Overall, these three studies show that incorporating religious beliefs and practices can be beneficial to treatment and provide more rapid results. This may be due to better compliance with therapy early on, alignment to client's values, family support, and using techniques clients believe in (Azhar & Varma, 1995b).

In 1998, a similar study was conducted in Malaysia by Razali, Hasanah, Aminah and Subramaniam. In this study, they had 103 clients with Generalized Anxiety Disorder or Major Depressive Disorder (Razali, Hasanah, Aminah, & Subramaniam, 1998). This

study randomly assigned religiously identified clients to the experimental group, which included enhanced religious-sociocultural psychotherapy techniques along with the standard therapy and medication given to the control group (Razali et al., 1998). They modified faulty beliefs by incorporating religious and cultural themes. In a case study example, Razali et al. (1998) described how they countered a man's negative impression of himself. This man felt down because he believed his girlfriend left him based on his appearance and low socioeconomic status. The therapist reminded him that, "in Islam the status of human beings is equal, regardless of their appearance and social class" (Razali et al., 1998, p.869). She also encouraged him to turn to God and ask to send him a spouse that was good for him soon (Razali et al., 1998, p.869). These interventions as well as utilizing Islamic practices helped the client to feel better. Overall, Razali et al. (1998) found that clients in the study group improved more rapidly than the control group but were similar at the end of 26 weeks (p.870). The other addition to this study was the respect given to traditional sources of help, including visiting spiritual healers (*bomohs*). Interestingly, they found that there was a lower relapse rate of 35 percent for those who had the religious-sociocultural therapy than the clients who received standard treatment, whose relapse rate was 65 percent (Razali et al., 1998, p. 871). They hypothesize that this resulted from the good therapeutic alliance developed by accepting the clients' view of the illness and incorporating religious and cultural beliefs (Razali et al. 1998).

Razali, Aminah, and Khan (2002) conducted a study in Malaysia that compared a standard treatment of cognitive behavioral treatment (CBT) to an enhanced religious-cultural CBT approach for treating patients with Generalized Anxiety Disorder (GAD), in addition to medication. The religious-cultural psychotherapy (RCP) incorporated Islamic

concepts in modifying and challenging distorted beliefs as well as encourage coping skills based on Islamic practices (Razali, Aminah, & Khan, 2002). There were several guidelines recommended by Razali et al. (2002) for the RCP:

> (1) Encouraging patients to be close to Allah s.w.t. (Almighty and Glorious is He), pray regularly, read the *Holy Koran* and Zikr (commemoration of Allah's name). (2) Advising patients to change their lifestyle to follow the custom of the Prophet (S.A.W. Allah bless him and give him peace). (3) Acceptance of patients' interpretation of symptoms. (4) Discussion of the aetiology of the illness from a cultural perspective (appropriate to social class and educational background). (5) Avoidance of preaching or opposing the patients' view. (pp. 132-133)

In addition to the incorporating religious concepts, there were efforts made to take the client's perspective on the symptoms and begin working from it. There were 165 patients in the study, including 85 religiously identified clients and 80 non-religious clients that were then split between the experimental and control groups (Razali et al., 2002). The religious patients showed "significantly more rapid improvement in anxiety symptoms than those in the control group at the fourth and twelfth weeks....[but] became non-significant at the end of 26 weeks" (Razali et al., 2002, p.133). The clients who were not religious did not show any difference between the two types of intervention, both improving at the end (Razali et al., 2002). Therefore, Razali et al. (2002) found that for religious Muslim clients, incorporating religious concepts would make them improve faster than standard treatment. This may be particularly important in the managed care system where the emphasis is on more efficient approaches to treatment (Hodge & Nadir, 2008). They hypothesized that because of their religious commitment, they utilize the Islamic concepts more readily than standard treatment as well as have implicit belief that using Islamic practices will work (Razali et al., 2002). These studies highlighted the benefits of incorporating religious beliefs into treatment for Muslim clients.

Keshavarzi and Haque (2013) discussed the importance of considering psychotherapy from an Islamic perspective. They provided a review of Islamic concepts that can inform the process of therapy. Keshavarzi and Haque stated that Ghazali, a famous Muslim scholar, noted four aspects of the soul: the *nafs, aql, ruh, and qalb* (p.238). The *nafs* is described as being "like the ego that gives rise to reactions to the environment…[and] may be animalistic…[and] somewhat similar to Freud's conception of the id" (Keshavarzi & Haque, 2013, p. 238). However, this does not have to be its fixed state but can be trained to be good. The *aql* is described as "the rational faculty of man…[and] is home to logic, reason, and acquired intellectual beliefs" (Keshavarzi & Haque, 2013, p.239). The *ruh* can be thought of as "spirit of the man that, if kept healthy, allows one to live a meaningful and wholesome life" (Keshavarzi & Haque, 2013, p.239). Lastly, the *qalb* is the heart, which is similar to the "self" and "soul" (Keshavarzi & Haque, 2013, p. 239). The heart is where sickness may occur as a result of deficiencies in the other three parts. For example, Keshavarzi and Haque noted that Ghazali discussed how the heart may succumb to jealousy, envy or pride as a result of "the *nafs'* evil inclinations, the *aql* remaining dormant to the *nafs*, or a lack of good reason and malnourishment of the spirit" (p.239). Therefore, to purify the heart, it is recommended that one work on "modifying the inclinations of the *nafs* toward good, restructuring and acquiring positive/moral thoughts in the *aql*, and feeding the spirit through remembrance of God" (Keshavarzi & Haque, 2013, p.239).

To apply this in the clinical setting, Keshavarzi and Haque first recommend assessing the client in terms to ascertain the appropriateness of interventions. For example, a more directed approach in one area of the soul may be warranted if there is a

specific problem or if therapy is time sensitive (Keshavarzi & Haque, 2013). In regards to interventions, the authors discuss how to work at the different levels. They noted that cognitive restructuring techniques aimed at helping clients connect with Islamic useful thoughts is intervening at the level of the *aql* (intellect; see Keshavarzi & Haque, 2013 for full description). The goal of working with the *nafs* is to shift it toward good actions and behaviors, which can easily incorporate behavioral concepts such as shaping and reinforcements (Keshavarzi & Haque, 2013). To affect the *qalb* (heart) and *ruh* (spirit), spiritual interventions that help the person connect to God are recommended. This may include Dhikr (remembrance of God), reading the Qur'an, performing prayers, reciting Du'ahs (supplication), meditating while focusing on God, etc. Keshavarzi and Haque cautioned that if clinicians were unaware of these practices, they should refer to spiritual healers to help Muslim clients.

The recommendation of utilizing Islamic beliefs and practices into treatment is also growing in the Western psychology literature. One way is provided by Hodge and Nadir (2008). They discuss how to construct culturally relevant cognitive interventions, using concepts from Islam. The steps they use to translate these interventions are presented. First, a therapist should develop a good understanding of underlying concepts or goals by removing the Western cultural influence in the development of the interventions (Hodge & Nadir, 2008). Second, the concept should be checked to see if it is congruent with Islamic values (Hodge & Nadir, 2008). An example of Western culture's influence is the "repeated use of 'I' statements... [that] tends to implicitly locate authority in the individual, autonomous self" (Hodge & Nadir, 2008, p.34). This may not fit with a Muslim client's perspective, which may be uncomfortable focusing on the self

and instead view God as having the ultimate control (Hodge & Nadir, 2008). Thus, one can adjust the intervention so that it resonates with Muslim clients. For example, one can include the role God plays in the client's life (Hodge & Nadir, 2008). Below are two more specific examples provided in Hodge and Nadir (2008):

Table 2

How Cognitive Concepts are modified for Muslim Clients

Problem	Cognitive Concept	Islamic Modified Statements
High Frustration Tolerance	Nothing is terrible or awful, only – at worst – highly inconvenient. I can stand serious frustrations and adversity, even though I never have to like them.	Misfortune and blessing are from *Allah*. Misfortunes are not terrible or awful, but rather a test. Although adversities may be unpleasant, we can withstand them. *Allah* tells us that He will not test us beyond what we can bear. By reminding ourselves of *Allah's* goodness, and engaging in regular *Du'ah* (informal prayer), we can cope with life's challenges.
Self-acceptance	If I fail at work, school, or some other setting, it is not a reflection on my whole being. (My whole being includes how I am as a friend, spouse, etc. as well as qualities of helpfulness, kindness, etc.) Furthermore, failure is not a permanent condition.	*Allah* knows us better than we know ourselves. *Allah* knows our weakness. *Allah* knows we make mistakes. Consequently, we can take comfort in *Allah's* mercy and accept ourselves with our strengths and weaknesses.

Note. From Hodge, D. R. & Nadir, A. (2008). Moving toward Culturally Competent Practice with Muslims: Modifying Cognitive Therapy with Islamic Tenets. *Social Work*, 53, 31-41.

Hodge and Nadir (2008) also strongly recommended co-constructing these culturally relevant modifications with your client. This is especially useful because of the impossibility of knowing all the beliefs of every faith and knowing what is important to the client (Hodge & Nadir, 2008). This can be done by asking questions designed to help clients express aspects of their spiritual value system, including their religiosity (Hodge & Nadir, 2008). Then, clinical concepts that are incorporated with their religious beliefs can be suggested as tentative hypotheses that clients can reject or accept (Hodge & Nadir,

2008). Finally, they recommended being familiar with basic tenets of Islam and cultural norms among Muslims as well as consulting with others, especially if from a different background as the client (Hodge & Nadir, 2008).

Hamdan (2007) presented a review of some of the ways religious beliefs can be incorporated into treatment. Like Hodge and Nadir, Hamdan discussed the utility of using Islamic concepts to counter faulty beliefs held by clients. For example, to counter the unproductive belief that "one's sins are too severe to be forgiven," the Islamic idea that "*Allah* accepts the repentance of his servants, regardless of the severity or quantity of sins" (Hamdan, 2007, p.96) can be utilized. She also noted the importance of helping clients with spiritual or religious practices. As she stated, "the client may be reminded to rely upon *Allah* in times of difficulties, to supplicate to *Allah* in times of needs, to turn to *Allah* in repentance when in error, and to focus on the five daily prayers and the reading of Qur'an" (Hamdan, 2007, p.96).

Hamdan (2007) also presented a case study example where religious belief and practices were incorporated in treatment. The client presented with depressive symptoms, including a large amount of guilt for her current life practices and failure to meet her religious duties (Hamdan, 2007, p.97). Hamdan recommended the Islamic practice of *Tawbah* (repentance) to reduce the feelings of guilt and depression. The steps of *Tawbah* are:

> (a) immediate cessation of the sin, (b) seeking forgiveness from Allah, (c) feeling regret for having sinned, (d) making a determination not to return to the sin, and (e) restitution of other people's rights (if appropriate). No intermediary is involved in this process — the person turns to Allah alone for forgiveness. The individual may also perform *salaat al-tawbah* (the prayer of repentance), which involves offering two *rak 'ahs* of prayer followed by seeking Allah's forgiveness for the sin (Al-Munajjid, n.d., p. 14 as cited in Hamdan, 2007, p.98).

This intervention, along with a concrete action plan, helped to motivate the client to initiate again her religious practices helped to relieve her depression (Hamdan, 2007). This case example provided some direction in how to incorporate religious beliefs and practices into a treatment plan.

Similarly, other authors suggested the important inclusion of religious practices in helping Muslim clients. Abu-Raiya and Pargament (2010) noted, "Muslims can draw on multiple Islamic teachings, beliefs and practices to cope with major life stressors" (p.185). Utz (in Ahmed & Amer, 2012) summarized several studies and concluded, "Muslims who are religious/spiritual and practice their faith experience higher levels of happiness, well-being, life satisfaction, and marital satisfaction and have a reduced likelihood of depression, anxiety, death anxiety, antisocial behavior, and suicide" (p.15). Furthermore, Abu-Raiya and Pargament (2011) found in the review of the literature that "self-rated global Islamic religiousness is positively linked to desirable mental health and well-being indicators (e.g. happiness, optimism, satisfaction in life) and negatively tied to undesirable mental health and well-being indicators (e.g. anxiety, depression)" (p. 3).

In a study conducted in Iran, it was found that happiness was correlated with level of religiosity in 271 undergraduate Muslim students (Sahraian et al., 2013). Additionally, Khan (2006) found in her survey of 459 Muslims that 68.2 percent indicated that they always seek comfort from prayer while 44.9 percent indicated that they always seek comfort from the Qur'an (p.32). Both of which were above family and a religious leader (Khan, 2006). Therefore, religion can have a positive effect for Muslims.

Authors described the importance of turning to religious practices (Ahmed & Amer, 2012; Daneshpour, 1998). It was noted that the idea of talking about problems

may not be seen as a solution (Daneshpour, 1998). Instead, "praying is traditionally and religiously considered one of the best ways heal distress" (Daneshpour, 1998, p.365). Therefore, the client may find comfort and ease in their pain through connecting to their religious tradition. Al-Krenawi and Graham (2000) stated that "praying can be viewed as both a preventative and an inexpensive psychological guard against anxiety and depression" (p.297). Naqvi (2013) described the meaning behind the five daily prayers for Muslims, including pausing from everyday life to reflect and appreciate the moment. In addition, "studying the *Qur'an* and performing the five daily prayers can be seen as a medium for meditation, a prophylactic against stress, and a way of promoting psychological and spiritual maturity" (El Azayem & Hedayat-Diba, 1994; El-Islam, 2004 as cited in Smither & Khorsandi, 2009, p.88). Azhar, Varma, and Dharap (1994) noted that prayer is similar to meditation in that "promotes total relaxation and a general sense of well-being" (p.2). Overall, established religious practices may serve to help the client cope with their problems.

Hamdan (2008) provided a summary of Islamic beliefs that can be helpful to incorporate into treatment with religious devout Muslim clients. Because previous studies (Azhar et al., 1994, 1995a, 199b; Razali et al., 1998, 2002) described do not provide extensive details on what Islamic beliefs can be beneficial, Hamdan helped to fill the gap (see Hamdan, 2008 for full review). The first belief discussed, "Understanding the Temporal Reality of this World," refers to the belief that this "life on this earth is only a passing phase through which humans journey on to everlasting life in the Hereafter" (Hamdan, 2008, p.104). This belief may help to put life's struggles in perspective and may help to counter hopelessness and feeling overwhelmed with life (Hamdan, 2008).

Another belief that may be used is to focus on the Hereafter (Hamdan, 2008). Because Muslims believe that after death (which may come at any time), there is an everlasting Hereafter, they may benefit from focusing on preparing to meet God by turning to religious practices (Hamdan, 2008). Because this goal supersedes any worldly goal, this may help "those who have significant worries and stress find it difficult to focus, or tend to procrastinate" (Hamdan, 2008, p.106).

Another belief that can be useful for helping clients with their problems is "recalling the purpose and effects of distress and afflictions" (Hamdan, 2008, p.106). This belief is illustrated with a saying from Prophet Muhammad (S):

> No fatigue, nor disease, nor sorrow, nor sadness, nor hurt, nor distress befalls a Muslim, even if it were the prick he receives from a thorn, but that *Allah* expiates some of his sins for that. (University of Southern California – Muslim Student Association [USC-MSA], n.d., vol. 7, book 70, #545 as cited in Hamdan, 2008, p.106)

This highlights two important points for Muslims. One is that any suffering or pain will expiate sins or increase good deeds, which is critical for the ultimate goal of Paradise (Utz in Ahmed & Amer, 2012; Hamdan, 2008). It also helps to remind Muslims that there is a purpose or plan in their trials and one should remain patient and put their trust in *Allah* (Hamdan, 2008). This may be useful for countering thoughts such as "Why is this happening to me?", "Why not someone else?", "Why did *Allah* choose me for this unbearable trial?" or "*Allah* is punishing me for my disobedience" (Hamdan, 2008, p.106).

One fundamental belief for Muslims is *Tawakkul* or "trusting and relying on *Allah*" (Hamdan, 2008, p.107). This basic premise is an important tenet of Islam, which reminds Muslims that God is in control of all things and therefore, one should have

confidence in His ability to take care of him or her (Hamdan, 2008). This belief is helpful in providing "relief from distress, worries, and regrets because concern about the needs and interests in this world is lifted" (Hamdan, 2008, p.107). Additionally, it is believed that when a Muslim places full trust into God, their "worries and anxiety are reduced or eliminated, hardship is replaced with ease, and fear turns to a feeling of security" (Hamdan, 2008, p.107). Similarly, another belief is the "understanding that after hardship there will be ease" (Hamdan, 2008, p.107). This idea may remind Muslims that *Allah* has promised to make difficulties bearable when the person is patient and accepting (Hamdan, 2008). This is found to be helpful to counter feelings of hopelessness and helplessness (Hamdan, 2008).

Another helpful tool is to direct clients to focus on the blessings of Allah (Hamdan, 2008). By helping Muslims to see the many good things in their life, especially when compared to others, they may be relieved of their worries and distress (Hamdan, 2008). Another way to help relieve stress and anxiety is to remind clients to remember *Allah* and read the *Qur'an* (Holy Book of Muslims; Hamdan, 2008). This can have a "calming effect on the individual's body, mind, and soul" (Hamdan, 2008, p.108). Some forms of remembering *Allah* include the "remembrance of the names of Allah and his attributes, praising Him, and thanking Him" (Hamdan, 2008, p.108). There are sayings of the Prophet Muhammad (S) that remind Muslims that when one remembers God, God remembers him (Hamdan, 2008). Finally, the use of *Du'ah* or supplication is important strategy to help Muslims. This can be used to overcome anxiety, distress, worry, and sadness as well as provide hope and protection for Muslims who turn to God for help through supplication (Hamdan, 2008). Overall, it is recommended that these beliefs may

be used to help clients in difficult moments. It brings up the question of whether therapists know these beliefs and would use them in treatment.

It is also important to recognize circumstances when religion may create problems for Muslim clients. In a review of the literature, Abu-Raiya and Pargament (2011) identified negative religious coping as religious struggles, punishing Allah reappraisals, extrinsic-social religiousness and afterlife motivation. These types of negative experiences were associated with negative outcomes in emotional distress and poor physical health (Abu-Raiya and Pargament, 2011). Specifically, Abu-Raiya and Pargament (2010) described how religious struggles can cause psychological distress, such as withdrawal, loneliness, depression, anger and substance abuse (Abu-Raiya & Pargament, 2010). These struggles may include questioning if God is angry with them or punishing them, doing certain things considered wrong, and questioning rules or beliefs (Abu-Raiya & Pargament, 2010). It is recommended that religious struggles are assessed non-judgmentally and then help to normalize these struggles for the client (Abu-Raiya & Pargament, 2010). For example, Abu-Raiya and Pargament suggested reminding clients of religious figures, such as Abraham and Prophet Muhammad (S), who have had doubts (p.186). If there are further concerns, therapists can consult with religious leaders (Abu-Raiya & Pargament, 2010). The key point is to create a safe, non-judgmental space for these discussions to occur.

In conclusion, there are several suggested techniques for how to discuss Islam in treatment. They provide recommendations for therapists working with Muslim clients. It will first be important to examine if therapists are aware of these techniques and if they would use them in treatment with their clients. The literature has provided an abundance

of ideas for practice. However, it remains unknown if experienced therapists in the field are currently using these suggestions in their work with Muslim clients and if they are not, what interventions are used.

Chapter III

Methodology

Participants

For the purposes of this study, the researcher recruited participants through a network sample using the snowball technique. Initially, the researcher contacted therapists who are known to have worked with Muslim clients. These therapists were then asked if they knew of other therapists that they would recommend participating in this study. An email advertisement (see Appendix B) was sent to the referred therapists to see if they were interested in taking part in the study. Fifteen therapists with substantial experience working with Muslim clients were recruited. Specifically, each service provider worked intensively, for a minimum of five sessions, with at least two adult clients who openly identify as Muslims, from any ethnic, cultural, or racial background. Other than the above criteria, therapists could be from any mental health field, culture, or religion themselves.

In summary, out of the 15 participants, nine (60%) were psychologists, two (13.33%) were school psychologists, two (13.33%) were advanced doctoral psychology students (with Masters Degrees), one (6.67%) was a Licensed Clinical Social Worker and one (6.67%) was a psychiatrist. Thirteen (86.67%) therapists had experience with clients from all backgrounds and religions while two participants had worked mostly with specialized populations (Arabs and South Asian). The range of Muslim clients that participants reported they treated was from five clients to over 200 clients. The majority of therapists reported that their theoretical orientation was Integrative or Eclectic (N=7, 46.67%). Three (20%) reported being Cognitive-Behavioral, two (13.33%) stated

Psychodynamic, two (13.33%) reported Psychodynamic and Systems theory, and one (6.67%) stated Strength-based. Regarding their demographic information, there were 10 female interviewees and five male interviewees. The race of therapists included eight (53.33%) identified as South Asians, three (20%) identified as Arabs, one (6.67%) identified as African American, and one (6.67%) identified as being of mixed races. Regarding participants' religions, there were 11 (73.33%) identified as Muslim, two (13.33%) identified as Catholic, and two (13.33%) identified as other. See Table 3 for details on the participant characteristics of the study.

Table 3

Participant Characteristics

Characteristics	N (%)
Professional Title	
Psychologist	9 (60)
School Psychologist	2 (13.33)
Doctoral Psychology Student	2 (13.33)
Licensed Clinical Social Worker	1 (6.67)
Psychiatrist	1 (6.67)
Work Settings*	
Outpatient/Community Mental Health	9 (60)
Private Practice	6 (40)
University Counseling Center	3 (20)
Hospital Setting	2 (13.33)
School	1 (6.67)
Total Number of Clients Seen	
≤100	1 (6.67)
>100	3 (20)
>200	2 (13.33)
>300	2 (13.33)
>400	2 (13.33)
>500	2 (13.33)
>1000	3 (20)
Cultures of All Clients Seen	
All Races/Cultures	13 (86.67)
Mostly Arabs	1 (6.67)
Mostly South Asian	1 (6.67)
Religions of All Clients Seen	
All Religions	13 (86.67)

Table 3 cont.

Only Christian and Muslim	1 (6.67)
Only Muslim, Hindu, and Christian	1 (6.67)
Number of Muslim Clients Seen	
5-10	3 (20)
10-20	2 (13.33)
20-30	3 (20)
40-50	1 (6.67)
50-100	3 (20)
>100	1 (6.67)
>200	1 (6.67)
Cultures of Muslim Clients Seen*	
South Asian	13 (86.67)
Arab	11 (73.33)
Persian	7 (46.67)
African American	5 (33.33)
European/Caucasian Converts	5 (33.33)
Caribbean	2 (13.33)
Central Asia	1 (6.67)
How Clients Were Identified as Muslim*	
Self-Disclosure	9 (60)
Initial Assessment	6 (40)
Name of Client	4 (26.67)
Client Requested Muslim Therapist	3 (20)
Religious Dress	3 (20)
Use of Religious Phrases	2 (13.33)
Client Asked About Therapist's Religion	2 (13.33)
Race of Therapist	
South Asian	8 (53.33)
Arab	3 (20)
Caucasian	2 (13.33)
African American	1 (6.67)
Mixed Race	1 (6.67)
Gender of Therapist	
Female	10 (66.67)
Male	5 (33.33)
Therapist's Religion	
Muslim	11 (73.33)
Catholic	2 (13.33)
Other	2 (13.33)
Therapist's Level of Religiosity	
High	4 (26.67)
Moderate	5 (33.33)
Low	2 (13.33)
Spiritual	3 (20)
N/A	1 (6.67)

Table 3 cont.

Does the Therapist Wear Hijab?	
Yes	6 (40)
No	4 (26.67)
N/A	5 (46.67)
Therapists' Theoretical Orientation	
Eclectic/Integrative	7 (46.67)
Cognitive Behavioral	3 (20)
Psychodynamic	2 (13.33)
Psychodynamic and Systems Theory	2 (13.33)
Strength-Based	1 (6.67)

*Note. Multiple responses were accepted and therefore, totals of the category will not add up to 15 respondents or 100 percent.

Measures

Open-ended interview protocol. The interview protocol (Appendix C) was divided into two parts. The first section gathered basic demographic information on the therapists as well as information on their experience and clientele. The second part consisted of open-ended questions, created by the author of this dissertation, regarding the therapist's professional opinions on the different facets of working with Muslim clients. There were a mixed of questions including general questions aimed at eliciting therapists' overarching recommendations and specific questions regarding the focus of this study. In particular, it inquired about how therapists built rapport with Muslim clients in their experience. It also asks them to discuss their views about discussing religious and spiritual issues into treatment with Muslim clients.

Assessment of therapist's practices with Muslim clients. The purpose of this survey was to understand the current state of practice for therapists working with Muslim clients. This self-report survey, which was developed for this study, *Assessment of Therapist's Practices with Muslim Clients* (Appendix D), consists of multiple choice questions in three parts. Part I present questions used to summarize their professional

opinion about their competency in working with Muslim clients and beliefs about incorporating religion into treatment. There is also a section for participants to write additional comments or explanations about their responses. Part II requires participants to evaluate 40 recommendations found in the literature regarding working with Muslim clients. They are asked to rate how relevant the recommendation is to their treatment approach, how effective they perceive it to be, and the likelihood they would use the recommendation with their Muslim clients in treatment. Part III surveys their knowledge of common Muslim beliefs and practices. In addition, participants rate whether they would use these religious beliefs with their clients in treatment or recommend that their client uses religious practices to enhance treatment. At the end of the survey, participants are given an opportunity for open-ended comments.

Procedures

Once potential participants were identified, the researcher scheduled an interview. All interviews were conducted in a private location chosen by the participant or on the telephone. The study was thoroughly explained to each participant. The participant then signed the informed consent (see Appendix A) to agree to be a volunteer for the study. A consent form was given to the participant. The researcher stored the signed informed consents in separate locked filing cabinet to protect the confidentiality of the participants. Participants were then assigned a unique identification code. Their identifying information was not written on any interview materials. In addition, the key for the identification codes was kept in a password protected database on a password locked laptop by the researcher. The researcher will be the only person who will have access to this database.

After the consent process, participants were interviewed using the open-end interview protocol (Appendix C). The interview took on average 60-90 minutes to complete. Interviews were recorded by permission of each participant. The recording was only identified by the participant's unique identification code to assure confidentiality. After the interview, participants were asked to complete the self-report survey (Appendix D). All interviews were transcribed and any identifying information was eliminated. The recordings of the interviews, the transcripts of the interviews, the self-report survey, and other data collected from the participants will be securely and confidentially maintained by the researcher in a locked filing cabinet for seven years after the completion of the study. After seven years, the researcher will destroy all research materials.

Data Analysis

Upon completion of data collection, there were two main ways for analyzing the data based on the different methods used in the study. First, the interview data was analyzed qualitatively utilizing Grounded Theory Methodology (Corbin & Strauss, 2008). This methodology discerned the responses from the interview from all participants noting similarities and differences in their answers to help build themes. There are three tools to complete the analysis of this data. The first step was open coding, whereby the researcher is "breaking data apart and delineating concepts to stand for blocks of raw data....[as well as] qualifying those concepts in terms of their properties and dimensions" (Corbin & Strauss, 2008, p.195). This process of constructing data is done by first breaking the data down into manageable pieces, interpreting those data pieces, and giving conceptual names that represent the ideas within the data (Corbin & Strauss,

2008, p.160). Specifically for this study, the interviews were divided into the main questions and thoroughly examined for main concepts for the question asked.

The concurrent step of data analysis to open coding was axial coding. Axial coding is defined as "crosscutting or relating concepts to each other" (Corbin & Strauss, 2008, p.195). This process is described not only as relating concepts to each other but also as linking the various levels of concepts to build themes (Corbin & Strauss, 2008). This process checks the relationships, based on incoming data, and then either accepts, modifies, or discards them (Corbin & Strauss, 2008). As each question was analyzed, the researcher noted if there were commonalities between the responses from the different participants.

The final step was selective coding. This process focused on the integration of the data. This is defined as, "the process of linking categories around a core category and refining and trimming the resulting theoretical construction" (Corbin & Strauss, 2008, p. 263). The analysis of data will then be used to provide information on the overall summary of the perspectives of therapists working with Muslim clients and provide suggestions for future research. The researcher combined results across questions to develop general themes to represent the concepts with abundant support from many participants.

To ensure that this process was unbiased and valid, the researcher employed an independent person to analyze one question. This person followed the Grounded Theory Methodology to discover discrete concepts and find the interrelationships between interviews for this question. Upon examination, there was a high level of agreement

between the researcher and the independent rater. This helped to verify that the qualitative analysis was valid.

The second procedure was to analyze the objective data. The demographic questions and the self-report survey responses were analyzed quantitatively by calculating the frequencies and percentages of each response. For each recommendation and religious practice, the percentage of therapists who chose each possible response for each question is reported. Based on the information provided by the data analysis, the researcher includes a report on the current practices of a sample of therapists working with Muslim clients in North America. This report includes a summary of recommendations found to be most to least relevant to their treatment approach with Muslim clients, perceived as most to least effective, and utilized the most in treatment. In addition, it includes an analysis of how much knowledge therapists' have about common Islamic beliefs and practices. The most frequently reported religious beliefs and practices that therapists would use in treatment or recommend to their clients to enhance treatment is presented. This provides therapists with information that can be tried with Muslim clients in their settings.

Chapter IV

Results

In this section, the responses of the participants on the subject of working with Muslim clients will be presented. Interviewees were given the opportunity to answer open-ended inquiries about what they believed is important to know when treating Muslim clients and what recommendations they would provide to other therapists working with these clients. They were also asked specific questions about the areas of focus in this study, particularly rapport building and the usefulness of incorporating religious beliefs and practices in therapy. This section begins with the general characteristics of Muslim clients seen by participants and is then organized by the main themes found in the study.

Characteristics of Muslim Clients

Common problems. ***Psychological/Emotional problems.*** Therapists interviewed were asked to list problems that their Muslim clients came to treatment to work on. Out of the 15 participants, 11 participants (73.33%) reported psychological problems common to the general population. Nine participants (60%) stated that Muslim clients presented with Depression (including suicidal ideation and low self-esteem) while eight participants (53.33%) listed an Anxiety disorder (including phobias and Obsessive Compulsive Disorder). Four participants (26.67%) reported that they had Muslim clients who had alcohol or drug abuse problems. Additionally, four participants (26.67%) stated that Muslim clients came to therapy for issues of neglect and abuse (both verbal and physical), with three of those participants (20%) also having clients who experienced sexual abuse or sexual assault.

Moreover, six participants (40%) out of the 15 interviewed provided problems related specifically to children. Four participants (26.67%) identified behavioral issues of a child (such as Attention-Deficit Hyperactivity Disorder and Oppositional Defiant Disorder). Concordantly, three of the participants (20%) listed problems with parenting as reasons for Muslim families to enter treatment. Notably, one interviewee (6.67%) stated that there were Muslim clients and families concerned about gang involvement.

Additionally, six participants (40%) identified academic or learning difficulties as being a major problem requiring therapy. This included clients who were mandated by the school or university they attended. Three participants (20%) reported having clients who were stressed due to work impairment or financial concerns.

Family problems. 12 participants (80%) identified issues in the family to be a significant problem that led Muslim clients to come to treatment. Seven participants (46.67%) reported family conflict. Additionally, six participants (40%) listed marital or couples problems. Three participants (20%) specifically named domestic violence as a reason for therapy.

Distinctive problems. ***Intergenerational conflicts.*** Relatedly, seven participants (46.67%) stated that intergenerational conflicts were a distinctive problem that occurred for both individual Muslim clients as well as Muslim families that sought treatment. Four participants (26.67%) defined this conflict generally as a struggle between one's individual needs and the family/collective needs. One participant summarized this below:

> [A] lot of the issues that came up with the patients that I work with the Muslim background…has to do with this struggle between one's own personal goals, ambition, needs, drives, wishes verses the larger collective, whether it's an actual person, family member, father, mother, or close family circle or the large community as a whole. Or in some cases I had, with the more religious patients I had, I think it was more the issue of one's own individual needs, one, and how it

> conflicts or resonates with their religious beliefs or expectations of how they should be. It varies. And I included also patients of Muslim backgrounds who identify as Atheists. Within those, there wasn't an issue of religion or faith based but is more an issue of a conflict with family expectations and things relating to that. So I looked at them more in terms of the cultural identity.

Other interviewees discussed the effects of the high level of parental control. One stated,

> [T]heir level of control, that the parents…want to exert over the child…[and it] ends up, this young person making really strange decisions. I mean really risky decisions. I am thinking of a young woman who was sexually active...had an abortion, and then arrived in therapy with the statement 'I found myself engaged'…This, of course, is a very interesting statement from a therapy point of view. So, [I asked] 'how did you find yourself engaged?' Because she had just broken up from her boyfriend and had had the abortion in the previous year... And had just sort of in a fit of confusion let herself be pushed along this process and then started wearing Hijab…This is one of the most striking things, she had scarf, long sleeves, elegant tunic down to her knees, beautiful skirt, very elegant, very modest. And bright pink – everything was pink. You could see her a mile away. You sort of have to wonder what relationship she has to this Hijab. It's just so bright yet very traditional. On one level extremely traditional, on another level screaming. But she had no comment about that. She just found herself to be [engaged] and wanting to know how she was going to do this and how she was going to pass herself off as a virgin.

Moreover, three participants (20%) reported that clients often felt pressure from their families to pursue a particular career (such as being a doctor or engineer). Another therapist described a client she once had:

> I am thinking of one student…in an engineering university. And he walks in the door and he's a first year student and he's failing his classes. And I take one look at him…and I say 'okay what are you doing here?' I mean I didn't say that but I was thinking because he had this long flowing hair and this beautiful ponytail and he's beautifully dressed. I think okay, this is not your typical engineering student. The first thing that comes out of his mouth is 'I am not doing well in school.' And I say 'how come?' 'Well, I hate this stuff.'…'Where do you want to be?' He wanted to do fashion design. Ok now here's a kid that is going to have trouble. So, that was what the therapy is about.

Additionally, three participants (20%) identified the unique struggle young Muslim people have in finding a spouse and the pressure to be married, given the cultural expectations and the religious rules regarding dating.

***Difficulties with religious identity*.** Muslim clients appear to face a struggle in defining the role religion plays in their lives. Specifically, this problem was identified by six participants (40%). Three participants (20%) described Muslim clients who grappled with issues of the self-definition and what it meant to be Muslim in America today. One therapist shared how she discussed this topic with her clients:

> [So, with] the first generation Muslim Americans… [I say], 'Not that many people have done it before…This is all new, so you're on the forefront, you're creating this.' Number one [is]…to sort of empathize with the struggle…'you are [not] doing anything wrong…you're trying to create something that's really not been created before.' And to really encourage students that you can be Muslim and be American. [And say], 'If one thing Islam has done is adapted to cultures all over the world. So, there is absolutely no reason that why you cannot be Muslim in America of all places.' And really be a source of hope for them. 'You're going to be able to do this. I don't know what it's going to look like. You don't know what it's going to look like but this is going to happen. You're going to be Muslim and you're going to be American. And that's going to be fine and you're going to do it, you're going to create this. It's kind of painful because no one's done it before. But you can do this.' And that's another thing I feel is really important to sort of carry for the students.

Another three participants (20%) reported that there were Muslim clients that attempted to figure out the role religion would play in their lives. One participant (6.67%) noted that he worked with clients who converted to Islam and how they tried to balance their old life with their new life.

***Special issues*.** There were a few special issues raised by some participants that are worth mentioning for further study. Two participants (13.33%) discussed the unique role immigration played in the problems of Muslim clients, particularly for undocumented clients. For example, one participant worked to help women seek out protections under the Violence against Women Act. She described it below:

> I end up petitioning for their [women] right to stay in this country despite the fact that their spouse, who either is or was abusive, has denied them the right of a green card. I help document their level of trauma or level of distress in response to the abusive behaviors, which usually works for a legal case to get them a hearing

> to help decide on getting their papers without the approval of their spouse, to be either a citizen or resident.

These participants remarked that it was important to be aware and understand the ways in which immigration concerns may enter treatment.

Another participant (6.67%) noted a unique problem that may occur for Muslim women. She reported that there may be an increased risk for suicide for unmarried Muslim women who have a break-up with the man that they lost their virginity to. This risk is due to the religious and cultural ramifications for marriageability. She described it below:

> [D]efinitely for Muslims because this is devastating. These young women who make the decision, who take the risk, of becoming sexually active and these young men dumped them. I have seen various degrees of devastation, going into the suicidal. I think that is something that absolutely must be made known … So this is a very serious event in the life of young Muslim women and who identifies as Muslim and if she has been sexually active and the relationship has gone down the tubes, this absolutely has to be talked about. It cannot pass by.

Last of all, a participant (6.67%) reported that a difficult problem for Muslim men (especially in relationships) is the use of pornography. When treating this problem, she emphasized the importance of considering the religious and cultural interpretation of this behavior, which may contrast with a more liberal viewpoint.

Unique presentation. Interviewees were asked how their Muslim clients presented differently than other clients they treat. There are several important considerations offered by these therapists. First, five participants (33.33%) described how culture, cultural expectations, and acculturation level affect Muslim clients. As one therapist summarized,

> What's a greater issue is the cultural and ethnic overlay and how that affects the manifestation of symptoms, the explanation of symptoms, the perception of symptoms, the very perception of the problem.

Secondly, four participants (26.67%) highlighted that with Muslim clients, the role of religion may be more prominent. One interviewee states that "for how they present, there is definitely a lot more of a desire to understand their experience through the lens of Islam…or to find solutions compatible with Islamic teachings. So there is considerable faith based component in the discussions."

Third, three participants (20%) described how Muslim clients and families were more likely to treat the therapist as family. One participant (6.67%) discussed how being treated like family may also add the burden of responsibility to the therapist:

> [W]hen it goes past the stigma and past the saving face, you're treated like family in that sense. At that point the burden itself is like being shared, with me included. Like I feel the burden on me, even when I know at the end, I feel like I just have this weight now that I am carrying and I realize that it's coming from the sessions…and there is less of the disconnection or disengagement that I might be doing automatically or more willingly with other patients, with non-Muslim ones, that they don't have that expectation of kind of like carrying the burden.

Fourthly, two participants (13.33%) described how cultural expectations, often enforced by their families, affect Muslim clients. They reported that these clients may rebel against their parents by engaging in risky behaviors (such as drugs, sex, etc.) due to a lack of development of their own internal self-control or internal motivation. One clinician described the high level of compartmentalization seen in Muslim clients:

> [T]he other thing that was so striking, and this is across the board, the level of compartmentalization that the clients do. One student was gay and Muslim. Just says nothing. Students who are sexually active and another student who…was drinking and partying and smoking dope. And how does he get away with this? Well, his grades were okay. And of course, he was able to get away with it because of course, the parents and children don't talk. So, you know, it's easy to compartmentalize.

Lastly, two participants (13.33%) noted the possibility of more somatic symptoms when they present for treatment. One participant (6.67%) reported that it is helpful to

"recognize the legitimacy in the experience that they have for physical symptoms, not just putting them aside." In general, it is possible that these factors may affect the way Muslim clients present in treatment.

Stigma of therapy. Another important characteristic of Muslim clients found in the study is the stigma attached to coming to therapy. Ten participants (66.67%) described the stigma in seeking psychological help. Four participants (26.67%) reported that they had Muslim clients that are unwilling to tell their family they are in therapy for fear of judgment. One therapist stated that, "the thing I did not mention is that the really high percentage of the Islamic kids that I see here, don't tell their parents that they are coming here to see a counselor, much higher than other groups." Two participants (13.33%) noted that Muslim clients tended to wait until they were in significant distress before they came for therapy, and two participants (13.33%) stated that there are some Muslim clients who only come because they were mandated, forced or tricked into coming to therapy. One participant (6.67%) noted that this may mean that Muslim clients bring in more severe levels of problems or crises. Even when they enter therapy, they may minimize their problems as reported by two participants (13.33%). One therapist described the indirect way a client may ask for help:

> They never come to you and tell you straight-forward...They usually come with a child. It's very interesting. It's like the backdoor. They say, 'You know I have a problem with my children. They are acting up in school and they are acting up at home. And I really want you to help us.' It doesn't take more than one session to figure out that this woman is coming for herself. To remove the stigma from her because if she's been seen by other people, that she's coming to this office, you know then, she will then say that 'I'm coming for my child.'

Two participants (13.33%) mentioned that there is more hesitancy for older Muslim clients to come to therapy, which the participants believed was due to their lack of

acculturation. Interestingly, a participant (6.67%) reported that Muslim clients may also be reluctant to take medication for their emotional problems.

Misconceptions about therapy. Interviewees were asked what assumptions or misconceptions about therapy and therapists that Muslim clients may have had. One therapist summarized common misconceptions she saw:

> Yeah, people come in and think that I'm going to give them something in therapy, or that there is something that they are going to do. They think they will be passive recipients, and that I will give them advice. Parents will come in and think that I am going to have to tell their child this or that, and that I will say it in a way that is different from the way they are saying it. Sometimes people have no clue what this is. They are referred by a doctor, or maybe someone else who benefited from it like a friend or family member, so they come but may not know what it is.

The responses of the participants are summarized by main categories in Table 4.

Table 4

Client Misconceptions about Therapy

Categories *	Respondents (%)
You are an all-knowing doctor	6 (40)
I don't know what therapy is	5 (33.33)
You can help with everything	4 (26.67)
You won't understand me	3 (20)
I have to be a good patient	3 (20)

*Note. Misconceptions were summarized and titled by researcher. They are not direct quotes from participants.

The first category, regarding being perceived as "all-knowing," four participants (26.67%) stated that some Muslim clients viewed them as a doctor who will fix their problems or give them advice. Three participants (20%) added that some Muslim clients expect that therapists will have direct answers for their problems. One participant (6.67%) stated that she has had Muslims clients that believed she could "read their mind." One therapist shared how clients react when she explained her role:

> A lot of them would be like 'well then, why do we come here?' There are people that want specific answers and that's why they go to doctors over therapists. And if you can't give them drugs, then you better at least give them answers and when

> you don't give them answers, then they feel like they have nothing from you. And that's the biggest thing, like when clients are at most risk to drop out and never come back. But my supervisor would always say that if a client comes back for the second session, that's great. The highest dropout rate is after the first session. When they came back, I felt like I was in. I can't tell you how many clients I had that I just saw once.

Concurrently, the second category focuses on Muslims clients not understanding what therapy is. Two participants (13.33%) stated that some Muslim clients were not aware of the length of therapy and often expected it to be shorter. Another participant (6.67%) noted that some Muslim clients may have difficulty with boundaries, including regular appointment times. Other participants noted that clients did not understand the role of therapeutic relationships or not understand the role of the family or environment in their problems.

The third category represents when clients assume that therapy will help with everything in their life, including practical problems (i.e. financial planning, job finding) or theological questions. As noted earlier, some Muslim clients may also expect you to share "the burden" in their problems. The fourth category describes how some Muslim clients may feel that the therapist will not understand them. One therapist stated that,

> I feel like the most critical thing is to get over the initial assumption that they will have of me, that I understand nothing and that I am incapable of understanding anything and so…I will ask people questions about their religiousness that suggests I know a little bit about what they are doing.

Two participants (13.33%) also noted that some Muslim clients will seek others' help, such as an Imam (religious leader), before coming to therapy because they believe the therapist will not truly understand their problems.

The final category highlights some Muslim clients that believe they have to be a "good patient." One therapist described that some Muslim clients believe there is a right and wrong way to therapy while another participant stated that some Muslim clients

believed that disagreement was not allowed. One clinician described the position a Muslim client may take:

> I think at first impression…[there is a] pull for pleasing in some ways, be socially placating in some ways to try and reach out, and it's a formality, even in the attempt in warming the relationship up,…you do it out of a social construct, of the social role… [But] I wouldn't say passive. In our culture, you defer to somebody out of respect, not out of weakness or out of complicity or anything. You give way in terms of honoring yourself and honoring others. You are not arrogant in coming up and putting yourself out there.

In sum, Muslim clients may enter treatment with misconceptions about therapy, which may be important to discuss at the beginning of the relationship.

Recommendations for Working with Muslim Clients

In this section, the major findings on working with Muslim clients are presented as several key themes discovered across questions in the interview. Therapists were asked general questions to elicit their experienced opinions unbiased by the researcher as well as by specific questions related to important areas identified in the literature. The main themes discussed below are the Importance of Knowledge, the Avoidance of Assumptions, the Significance of Rapport Building, the Incorporation of Religious Beliefs and Practices, the Inclusion of the Family, and the Consideration of the Community.

Importance of knowledge. All 15 participants (100 %) noted the importance of knowledge for working with Muslim clients. Specifically, 10 interviewees (66.67%) discussed the criticalness of therapists having familiarity with the religion of Islam and the many cultures of Muslim clients. One therapist described the role knowledge plays in connecting with clients:

> I would just say, just really draw upon everything you know because knowledge is like a really huge thing. Use your religious knowledge like therapeutic tools

> whenever and wherever you can because it's a powerful way for people to connect to you, especially if they're religious and especially if religion is interwoven in their culture as it is in the East. I would just say always keep your eye out when you can use it as a connection because I think that is huge. And I don't know if I've always done that enough. And especially when you're working with an older population, for people who are like over 40. That's a huge way to connect to people older. It's a way to get over an age gap when you're younger. It's a way to get over a socioeconomic gap that might exist between you guys. It kind of transcends age, SES, and all of that. So, I would just say always keep your eye out to see when you can use phrases and words to like let them know that in some way you guys are similar in that way. Or even if you're not Muslim, but just find ways. And if you have the knowledge base, keep your eyes and ears open to be able to throw that in so that they can connect with you and know that you've got the knowledge about it.

She highlights that knowledge of the clients will allow them to feel that you understand them, even if there are differences between therapist and clients. Another therapist added that it is important to demonstrate this familiarity by ensuring the therapy office has culturally sensitive materials, especially for children and assessments. Additionally, seven participants (46.67%) emphasized the significance of knowing the wide diversity of Muslim clients. Moreover, therapists underscored the value of knowing the differences between culture and religion and its impact for clients. This will be discussed further in the next section. Relatedly, therapists reported that it was important to consider level of acculturation with Muslim clients as well as understand their immigration experience, including the losses they may have faced. One interviewee stated, "It's quite complex. It's Islam, it's culture, and it's immigration history. First generation immigrant Muslims present differently than second or third generation. They are oceans apart." Thus, these participants emphasize the value in understanding the unique features of the individual Muslim client.

In addition to those broad areas, therapists identified a few valuable areas to explore to gain a full understanding of Muslim clients. Six interviewees (40%) mentioned

the benefits of knowing specific religious practices that may affect the therapeutic relationship. For religiously identified Muslim clients, this may include avoiding physical contact with the opposite gender, dressing more conservatively, etc. Participants stated that having this basic knowledge may help to make clients feel more comfortable and respected in the therapy. Additionally, four participants (26.67%) stated that it was important to understand the client's worldview as well as the larger ecological perspective. For instance, a therapist said,

> [It's] holistic in a way, because it's like you really have to take all the elements into consideration when you do therapy with anybody…the social, the family, religion, institutions, community, person, time. You don't say one plus one is two. There are so many factors and each factor has different impact on that person and people react differently to that same problem.

Overall, these therapists highlight the importance of having knowledge about the whole picture of a client's life.

Furthermore, four participants (26.67%) noted the usefulness of being aware of the level of discrimination the client may feel in their community and in general, including how it may affect the therapeutic relationship. One therapist discussed this below:

> I do think that because we are living in a time when there is this huge political backlash against Muslims that really being thoughtful about the therapeutic alliance. I think it is a huge issue. I think it cuts across all kinds of ethnicities and religious groups. So, what is the history of the therapist's cultural group, their group's history with the history of the client's group? How directly might you need to talk about the bias and backlash given the time we are in? I think ways of affirming respect for the culture are just vital and even if it is someone who is not as identified, I think you can still be respectful, acknowledging they are not practicing...obviously not going be denigrating this part of their culture.

Last but not least, five interviewees (33.33%) reported the value of therapist knowing their limits, including knowing when to refer a client out to another therapist. Two

participants (13.33%) stated that it was important to not discuss topics if there was a lack of knowledge, such as when discussing religion in therapy. One said,

> When the client is bringing up religion or bringing up the Qur'an [Holy Book] or a Hadith [sayings from the Prophet Muhammad (S)] as his justification for behavior, then I'll play the religious card. Again, I'm pretty familiar with husband and wife relationship and family…[from] a religious perspective so I could play that card. Here again where the therapist expertise, therapist knowledge is critical. The therapist who is not informed, they could do more harm. They could do it because the client knows his religion and you are counteracting this cognitions or his belief system and you are faulty in your counteracting endeavors that can backfire on you as the therapist. Then the client will feel attacked, the client will feel like you don't understand. So if you're not aware, you haven't gotten education and knowledge about these things, better not to use it. And I know my limits, if I need to be educated, I'd ask the client. And I'll do my research for another session.

Another participant recommended that the therapist seek out supervision from colleagues who may understand issues Muslim clients may have. In sum, interviewees agreed that knowledge was one of the most important requirements for working with Muslim clients.

***Culture verses religion*.** As noted above, most participants emphasized the importance of understanding the differences between culture and religion. However, it seemed complicated to distinguish in a clear cut way the role culture plays in a client's life verses the role of religion. There were some participants that believed that culture had more of an influence on the client while others acknowledged the distinctive impact of religion for those who were religiously identified. A therapist discussed the impact of culture and how religion could be wrongly interpreted:

> Culture, the client is socialized within their culture…the cultures are so distinct: their attitudes towards women, their expectations of women, of children, it has a steering influence on their behavior, their expectations. The usual things that we learned in grad school applies here regarding culture as a shaping influence. Our clients tend to mix up culture and religion…It's important to understand that, to differentiate from the two: what's culture, what's religion…I have had a case, working on a domestic violence case…[The wife] is operating, I guess, from a worldview that certain level, a certain amount of domestic violence is tolerated or

> should be tolerated. So what that is kind of doing is fostering a lot of guilt because she is thinking that well, if she could only been a more compliant, a more submissive wife and acquiesce to more of the demands she would not have been such a predicament. That's a cultural thing…It is not a Muslim worldview. It's more of an ethnic/cultural worldview than a religious worldview, which I imagine could confuse our clients into thinking that it is a religious worldview and therapists also and professionals in the field. But I am informed. I am educated in regards to religion so I can parcel out what is ethnic as opposed to what is religion.

In the above example, the therapist was able to help the client see from a religious viewpoint that domestic violence was wrong (further details are discussed later). Knowing this distinction was helpful for the client. On the other hand, religion may be the larger influence in the main problem for one client. A clinician described a case she had:

> Another example I could share… [is a woman] in a pretty religious family, but she was questioning [it]. She was in an inter-faith, inter-racial relationship, and was getting a lot of guilt and pressure from parents and grandmother about breaking up with this guy and marrying someone who is Muslim. She … would talk about how grandmother would sit her down and quote the Qur'an to her. This was really upsetting, because this isn't who she really was. She had to fake it because she was not this perfect Muslim kid that they thought that she was. She was grappling with what to do. She didn't expect him to convert, but that would have to happen at the bear minimum for the parents to approve of them. She was going to visit the church with him, because he was fairly Christian and religious. She was conflicted because she didn't want to let him go, but was very afraid she would lose her family. That was complicated for me…I just did a lot of exploring with her, and validated how upsetting it was for her to hear from her grandmother say that the Qur'an said that Muslim women cannot be with non-Muslims. It might be in the Qur'an, but it was very hard for her to hear. We did some exploring about how she felt about her family, her parents, this guy. You know, was it worth it? Do you want your parents to approve? Not much advice giving. I certainly had thoughts in my head, but that wasn't appropriate to tell her...That was really a tightrope for me to walk. I'm aware of religious rules on some of those things, but I'm also aware that it is not all black and white.

In this example, the therapist understood the reality of the religious prohibition of marrying a person outside of the faith that occurred across cultures. This meant that she had to empathize with the client and help her explore the ramifications of the possible

choices she had. If the situation was only viewed as a cultural expectation, the therapist may have missed the seriousness of the family's point of view and the difficult position the client was in.

Even more complicated is when religion and culture are interwoven (as it often is). As one therapist stated,

> I think, most of the time, what we call religion is influenced by the culture. A Muslim from Jordan versus one from Malaysia versus one from India; sure the basic tenants are the similar, but how we express them and how we seek the connection to God, and how it is played out in society, is all colored by culture. We sometimes practice culture and call it religion.

A clinician described this as it related to career choice:

> They're here in business school, pharmacy school, engineering school and I think this has to do more with culture than religion but because most of Muslims kids are from one of those shame-based cultures. They are in one of the schools because their parents want them to be but there's a tension about it. And so they become lost and they sort of feel like they're supposed to be obedient to their fathers. And there's this whole religious piece around that. The child is supposed to obey their parents and the parent may be crazy or just not really understand the world they live in but have fantasies about this is what they need to do. And their kid is really artistic and likely to do really well in making videos or designing clothes. But their parents want them to be a doctor because that is what they're supposed to be, so they have to be in one of the sciences. And that's not just Muslim kids. The religious piece gets brought into it when they believe a child is supposed to be obedient and that gets turned into the child will be obedient.

In this example, the therapist highlights how both culture and religion impact this intergenerational conflict between parents and their children. Based on these results, it appears that understanding both of these factors is critical to understanding the whole picture of the client's problem. As a therapist noted,

> These are things to explore: What generation are you? How do you identify with your culture? How do you identify with your religion? What is good and bad about it? What role does it play in your life? What role do you want it to play? Just negotiating all that.

Notably, several therapists have emphasized the importance of clarifying clients' misconceptions regarding Islam, particularly when they believe it endorses areas that may not be true, such as domestic violence, divorce, etc. This will be discussed further in other sections.

***African American Muslims*.** Two participants (13.33%) noted the criticalness of acknowledging the unique concerns about African American Muslims. A participant stated that often the African American community is left out of the discussions regarding Muslims. One therapist summarized a few distinctive issues that may arise with African American Muslims:

> You have to realize that within the African-American community, there are many sub-communities that are drawn together by ideological. You have one issue that kind of separates them: Are they a convert or are they the children of converts? In terms of ideologically, you've got the Salafi's, the Sunni's, the Sufi's, the Nationalists, like in terms of black pride, African-centered leadership. So that also plays a role…So the other issue is the interaction with the immigrant community…if you're in a dominated area where most everyone is an African-American Muslim, it's very different than if you're African-American in an Arab community. And so those factors play out in terms of second-generation, where you have the issue of being a double-minority, where you are a minority by the fact that you're Black but then you're also a minority because you're Muslim. And then when you're in the Muslim community, if it's in an immigrant community, then you are also a minority there…and so you never have that feeling of belongingness. But you don't see it as much with converts because they converted to Islam and that was their choice and they had a life beforehand…and they chose to change and become Muslim. Whereas converts kids, they didn't necessarily choose and what you see a lot of times is that many of the young people aren't necessarily as identified to Islam as you would see in [other] second-generation Muslims. They've grown up with a lot more support… [Also] for individuals who are in prison and are incarcerated and they come out, there are a lot of positive things that Islam has done for them in prison but then when they come out of prison, they don't have that same level of support. So, you can't really just say 'African-American community,' it's more complex.

This short introduction into some of the idiosyncratic features of African American Muslims emphasizes the importance of understanding the unique issues that they may

enter with in treatment. It also hints to the need for more information about this population.

Sources of knowledge. Interviewees were asked where their knowledge for working with Muslim clients came from. Results are presented in the table below:

Table 5

The Sources of Knowledge for Working with Muslim Clients.

Source of Knowledge	N (%)*
Academic Journals and Books	9 (64.29)
My Background or Personal Experience	8 (57.14)
Clinical Supervisors or Clinical Training	8 (57.14)
Experience working with Muslim clients	6 (42.86)
Colleagues	6 (42.86)
Islamic Books or Imams	4 (28.57)
Literature/Novels/Movies	2 (14.29)
Other People (i.e. Friends, Neighbors, etc.)	2 (14.29)
Conferences	2 (14.29)
News	1 (7.14)
Websites related to Muslims/Arabs	1 (7.14)

**Note*. Multiple responses were accepted for this question. Also, one participant did not answer this question directly and therefore, percentages are calculated based on 14 participants.

It appears from the responses that academic sources and clinical training are important resources for therapists on working with Muslim clients. Additionally, personal experience and experience with Muslim clients were also critical for knowing how to work these clients. There may be less helpful sources of information. One participant cautioned,

> For non-Muslim, non-Arab therapists, unlearn what you learned about Islam. Try to unlearn, undo everything that the educational system, that the media here, and really if you can't do that, then it is really problematic to work with them. If you look at Muslim patients in the same way they are represented in the media and that is your only source of information, you would do a disservice to the patient because they won't last in therapy and they won't seek therapy after that. Make a referral instead of trying to make it up as you go, unless you are actually willing to learn.

This therapist emphasizes that the source of our information on Muslim clients may negatively influence how we view and treat them, which could be harmful.

Avoidance of assumptions. A related but critical theme that emerged from the study was the detrimental effects of assumptions when working with Muslim clients. Twelve interviewees (80%) identified the importance of not making assumptions in the general open-ended questions. Within this area, several participants highlighted the great diversity within the Muslim population. One participant described this below:

> [D]on't go in with big assumptions just because of the 'typical' presentation. Don't assume anything, and don't think of yourself as extremely tolerant just because you think of yourself as extremely tolerant. You might not be coming across as such. Reading alone is not enough, reading up on Islam is not enough because of the enormous diversity in the Muslim world. That is my recommendation; learn and understand that Islamic cultures have differences within them, even within the same country, people are extremely diverse. Not only in their dress, but in everything they implement. It is not one nation by far, it is not one type of teaching by far, it is not one dialect by far, and it is not one language by far. So many people do not know that Indonesia is not Arabic and that Afghanistan is not Arabic. They don't understand the difference between Shite and Sunni, and they don't' know about all the other religious cliques from Islam. They have no idea about the differences between any of them. They don't know the maps, they don't know the geography, they don't know the languages, they don't know the culture, they don't know the difference between Persian, Urdu, or Arabic, they don't know any of that. A ton of education can still be made to happen. It is remarkable that after all this involvement in those parts of the world, there is still such a lack of basic knowledge on this religion and these people.

This participant emphasized the great importance of knowing and acknowledging the diversity possible within the Muslim population. Similarly, another therapist further describes the criticalness of not making assumptions:

> [I]t would be the realization that Muslims are not a monolithic community…they are not all the same. They are wide variety, so it's a heterogonous group. To not assume anything but also realize that the individual does not want to be the cultural ambassador for their religion and so balancing that. And I've heard horror stories of other people where they've gone to the clinician and the clinician basically starts preaching to them. 'What's wrong with the religion?' which is

> against all ethical guidelines…it should not have happened, but for whatever reason that still happens. Saying stuff like 'your people' or 'your religion' or 'you should do it this way'. So, first of all, there's a lot of hesitancy people will have to seek out treatment but then to encounter something like that is very off-putting and very confusing because you know the person is being vulnerable and sharing intimate details with somebody. So those are two issues, one the issue of realizing that there is a variety. Second, realizing the individual is not a cultural ambassador but just an individual and to treat them as an individual…to be open to learning and understanding the clients perspective what the issues are and how they see it….realizing the issue of social context is really important to address to the client within the clinical setting because the fact as a non-Muslim clinician, the client is always wondering 'how does this person see me? Does he believe or does she believe that I am like all those terrorists' especially when it comes to domestic violence issues or issues with marital problems, that issue often comes up as well…so the status of women in Islam and all that. So for the clinician to be aware of those issues is really important.

The therapist notes how painful it is for a vulnerable client to be judged and for the therapist to assume negative things about their religion or culture. Another therapist describes a case example of the differences in values that may create difficulties. She shared,

> It is having an open mind, and not assuming that everything that comes out of Islam is oppressive. I can highlight that with an example. I was doing therapy in my placements … this girl is referred by [child protective services] for therapy. She is [young teen], and had conflicts with her mother. Though it was not specified that the family was Muslim, the last name was Muslim. I saw the girl was being homeschooled and was rebelling, and she was violating curfew and running away from home...So they walked in,…the girl was wearing a Hijab [*head covering*] at the time, and the mother was wearing Hijab, Jilbab [*long dress*], and Niqab [*face covering*]. I saw that the receptionists both had a reaction, it freaked them out. I did the intake with them, and while her actions were very extreme, they were certainly typical things that people go through. It is a very common Muslim approach to go through the homeschooling approach and everything. So I talked to the [child protective] worker after my intake to get some background and her reaction was that 'Oh my God, this lady is so oppressive. She won't let her daughter get a weave; she won't let her get a tattoo or piercings.' I was like 'Hold on a sec, I get that some of this is cultural, but you do realize she's only thirteen years old, right?' I don't know of very many parents that would approve of that. So it was just because she was Muslim, and was covered in this way, that everything the mother said was assumed to be inappropriate. So that is the number one barrier and fear that Muslims have of going to non-Muslim [therapists].

Even worse is when these assumptions affect treatment. Another therapist provides an example where quick judgments can be harmful. She stated,

> If you have any questions about a religious or spiritual practice, and what it might bring to the issues that you are addressing, try to have that conversation because I think that there are a lot of subdivisions in Muslim families, the roles of Muslim women, and views by the wider community that aren't true to our daily lives. But you shouldn't be afraid to ask questions if they have them. In fact, I have one experience in my first year of graduate school…A young woman in the clinical program was seeing a young Muslim boy in the school clinic. She had him do a drawing of his family. She didn't identify him as a Muslim child, but I was able to identify him as Muslim. The women had scarves, they had over-garments, or something like that. The picture of himself and his dad, they had pantaloons and bell-bottom pants. This lady's interpretation of what she saw was that this boy drew his family as characters from Star Wars. Knowing that the influence was exactly the opposite, they were dressed as Muslims, I said to her, 'He didn't draw them as space characters. They are Muslims. They are covered!' She didn't listen to my opinion, nor did the professor encourage her to listen to what it was that I had said. He went along with the assessment that he had drew his family wearing space costumes and that he was out of touch with reality. All that he had done is draw his mother covered in the way that she was.

It appeared the influence of religion was ignored and instead, misinterpreted to be a symptom. As the therapist emphasized, it may be critical to ask questions rather than make an assumption. Alternatively, participants noted that genuine problems should not be confused for cultural or religious practices. One therapist discussed this below:

> I think if somebody is potentially coming in for a symptom reduction treatment that is you know specific. That is very different that someone coming because of conflict with their family. And I think it matters depending on what the presenting problem is. Even though you get all of the explanations on how these other things contribute and so forth but sometimes it is you know just an understanding what range people see in those types of cases. For example, I refer back that that OCD case, it was related to religion but it was very clear OCD CBT treatment that was time limited, very specific done. Case got ten times better and it wasn't about much else. We didn't discuss other things. It was very clear case, even though he was very religious. Depending on how they work and what they come in for, it might be important to understand that within the context of guidelines just in general how people were.

It appeared that the distress faced by the client was related to his OCD symptoms and it was what he wanted to work on, which was what the therapist helped him with. Another therapist provided additional example:

> On the other extreme, there are times when behaviors are written off as being Muslim.'…After three or so reports of abuse, the [child protective] workers may just write it off saying it's cultural. I've had to say 'Wait a minute, there are three reports. The father may not know the language very well, but he is well aware that this is wrong. He needs to be held accountable.'

This participant highlighted that culture or religion should not rationalized unacceptable behavior. One therapist provided a caution to Muslim therapists' as well:

> If I am recommending to Muslim therapists, I would recommend that as a therapist to try to see the person as well as the culture…Don't assume why he is there and what the problem is until you actually hear them and try to keep unbiased and non-judgmental as much as one can. You might assume there [are] issues of discrimination but there may not. Don't bring it because it's bothering you. It should bother all of us but just like you wouldn't bring it up in the subway with somebody, don't bring it up. You should just have a keen ear for where the patient is and you should just meet them there. Or like a Hijab, for example, if it's not an issue for the patient, you shouldn't bring it up. Or you should work out the issues that make you feel that you need to bring it up. The therapist needs to talk about it because they have unresolved issues. But that's your issue – go to therapy.

This therapist noted the importance on focusing on what is important to the client. In sum, therapists concurred that there are numerous ways assumptions can affect the therapy process when working with Muslim clients.

***Preference of therapists*.** There may be an assumption that Muslim clients will automatically prefer a Muslim therapist. Though not asked directly, five participants (33.33%) volunteered that sometimes Muslim clients prefer non-Muslim therapists. One interviewee stated,

> They may have a lot of issues, ambivalence related to their issues and they may not be comfortable bringing up certain issues and topics with a Muslim as they would with a non-Muslim, [such as] issues with promiscuity, issues with

> substance use, issues that people may not want to talk to somebody because they are someone within the community, they don't want that information out.

Additionally, a clinician stated,

> What I think creates a more difficult time for me is that I think people are most comfortable within their own framework but they are also most judgmental about it. So, we see clients who don't want a Muslim therapist because I am doing all these things that my mom would never approve of but if you're not Muslim then it's okay. And we find the same thing with Hindu clients or South Asian clients or even with Chinese or Korean [clients].

Therefore, it may be helpful to inquire if the client would like the Muslim therapist before assuming that they will automatically prefer one. However, several participants stated that Muslim clients may have a preference for the same gender therapist, which may be important to ask.

***Treatment approach*.** Based on the literature, there may be an assumption that there is a specific treatment approach or theoretical orientation that will work with Muslim clients or alternatively, not work with Muslim clients for some reason. Interviewees were asked if they believed that there was a particular treatment approach that worked best with Muslim clients. Out of 10 participants who answered, five therapists (50%) responded there was not a specific theoretical orientation, but instead they believed the treatment approach was defined by the individual client's needs. One therapist stated,

> No, I mean each time it depends on the individual. Some people work better with different perspectives, so it really depends on the personality, the intellectual abilities, the actual diagnosis, what is going on, their abilities of what they can actually do…so it's very specific to the individual.

This is reflected in the fact that seven of the 15 therapists (46.67%) identified their theoretical orientation as Integrative or Eclectic. The other five therapists (50%) stated that their theoretical approach worked well with their Muslim clients. Specifically, three

participants (30%) believed Cognitive-Behavioral Therapy was useful with their Muslims clients while two participants (20%) stated Psychodynamic Therapy was helpful with their Muslim clients. However, none stated that it was the only way to work with Muslim clients.

Significance of rapport building. Building rapport was found to be important for working with Muslim clients by the two open-ended questions described above. Additionally, there was a specific question asking about how therapists build rapport with their Muslim clients. The results were combined across questions, and results of the main categories are presented in the table below:

Table 6

Ways to Build Rapport

Categories	Respondents (%)
Psychoeducation about Therapy	12 (80)
Assure Confidentiality	9 (60)
Respect of Religion	10 (66.67)
Normalizing the Experience	9 (60)
Empathy and Validation	7 (46.67)
Convey Openness to Learning w/o Judgments	6 (40)
Be Less Formal, More Disclosing	6 (40)

One therapist's response provides a general summary of the important ways to build rapport:

> So I would be a lot less formal with them than I would be with clients here…I would just be very conversational. I would comment on general everyday things first before I even get into anything clinical, so that they know they can connect with me and it's not some weird mumbo jumbo like psychotherapist kind of person. I would just ask them how they feel about being there because I know that they'll have hesitations. And even if they don't have hesitations, I would always ask. I would always ask who in their family knows they're coming here because secrecy is such a huge thing and that also opens access to who I can talk to later if I need to call their family members. You just have to be so much more empathic and like validating with them than I felt…and you have to be okay with the fact that conversation will be muddled everywhere and that they're going to bring in non-clinical and non-therapeutic everyday stressors and ask you to solve

> them…[Y]ou'll probably not have a very concentrated clinical flow of conversation...I just realized I have to be okay with being put on the spot and deflecting direct questions.

This therapist highlights the importance of helping the client feeling comfortable in therapy and mentions several of the important ways to build rapport discussed below.

Psychoeducation about therapy. In addition to the rapport building question, interviewees were asked how they explain therapy to their Muslim clients. The following results include a summary of responses across questions. The first category includes explaining confidentiality, boundaries, and neutrality, which was cited by 12 participants (80%). As noted in Table 6, nine participants (60%) identified assuring clients that therapy was a confidential and private space as critical. One clinician described the importance of this below:

> I think for building rapport, one of the main important things is to discuss the issue of confidentiality at the beginning because it's always at the back of people's minds. Do people discuss these issues outside? Discuss how you're going to deal when you see them in public.

Three participants (20%) added that it is helpful to explain the limits of confidentiality and when it is required for the therapist to share information with others, such as reporting child abuse.

Relatedly, five participants (33.33%) emphasized the importance of explaining the boundaries in therapy as a safety for both the therapist and client. One therapist shared an example:

> We really had to explain a lot about the boundaries. Like she really wanted to bring me a present [because she] thought I was really helping her a lot. I said, 'well, we're not allowed to do that.' I explained the rules. I actually referred her to see a trainee, who was a young man close to her age, and I had to make sure that she understood all the boundaries so went over all the rules, such as therapists don't touch you, they don't this, they don't do that…she was so confused. She grew up in a very, very traditional family.

Another therapist shared the importance of boundaries when the therapist was Muslim or from the same community:

> For the Muslim clinician, boundaries are a huge issue because the community is small. And you inevitably have some connection with everybody. So, making sure that, one, you have clear boundaries and the client understands and you understand and you are able to abide by them because that is where a lot of ethical dilemmas that come up with Muslim clients. And you do change with how you interact within the community…So, taking care of yourself is very important because it's very easy to get negatively impacted by it.

Moreover, five participants (33.33%) emphasized the importance of explaining the benefits of the therapist's neutral and objective stance, particularly related to couple and family issues. One therapist stated that "I tell them that sometimes one needs someone who is impartial to bounce your issues off of and that can be helpful." In sum, an important category to discuss upfront in treatment is confidentiality, boundaries, and neutrality.

The second category found to be critical in the Psychoeducation of Muslim clients is to define what the limits of therapy are and your role as a therapist. Ten interviewees (66.67%) identified this clarification to be important and related to the misconceptions of clients discussed earlier. One interviewee shared what she tells clients:

> [Clients will say], 'Yeah, I am broke and I don't have a job. What do I do?' And I feel I had to be clear…and say that 'this is clinical space and there is things we can do here and there may not be things I can help you with. I'll always hear them but I can't necessarily help you with those things and there are limits to what therapy can do.'

Two participants (13.33%) stated that it was also important to discuss the risks and benefits of therapy with clients. Other participants stated that it was crucial to clarify what a therapist is and what a therapist is not (such as religious leader, case manager, psychiatrist, etc.). One participant (6.67%) believed it was important for the therapist to

disclose their own level of religiosity and how much they planned to use religion in treatment.

Similarly, the third category centered on explaining how the process of therapy works, which was discussed by nine interviewees (60%). One clinician described how he explained it:

> I spend time going over just the structure of it, how a session would work, and…the consent [form]…and then we spend a good portion at the end of that first session talking about what it was like in there and what it is potentially going to be like moving forward. How much I talk? How much they talk? What has worked if they have been in therapy before? What hasn't worked? What are their fantasies, based on movies or books or whatever it is, about what it's supposed to be?

Another participant explained what the therapist does in therapy:

> So I explain therapy as a way to help them, I see it mostly as a way to help people talk about what's going on for themselves. That's sort of in the lay terms…I tell them 'I am here to try to understand what's going on. I cannot promise I always will understand but I can promise you I will always try. Sometimes I won't get it right and then we'll rewind and try again. And we'll start again. I will always be trying to understand.' And my hope is that as they're trying to explain to me what's going on, that it helps them to understand as well, helps them to put words on what's going on for themselves.

Furthermore, five interviewees (33.33%) stated the importance of explaining that therapy takes time. One clinician shared how he explains why:

> I would first start with saying what kind of relationship this is. That this is not a relationship that is different from the ones you may be having with friends, a relationship you may be having with family member, because it's trying to build a relationship with a stranger but at the same time for this to be useful, it's important that you trust and you build an intimate relationship here and that's going to take time until we build that and that is why you look at therapy as taking, not as a quick fix, but as taking time until you feel like something that is safe. So, I would start with that, explained that therapy takes time.

Another therapist added:

> I've had quite a few patients…who kind of want absolution or a quick fix, and just want to know what they should do with their husband or child or whatever. I

> have to explain how often these things might take time and help them see why they might want a quick fix, and just help them reframe what their end goal is.

Overall, it is found that therapists believe it helpful to discuss how therapy works early on with clients.

The fourth category in Psychoeducation about Therapy is the emphasis on collaboration between the therapist and client. There were eight participants (53.33%) who discussed this category. The participants believed that it was important to decrease the authority of the therapist and increase client participation in therapy. A clinician shared this point of view:

> I wanted to say to decrease my own authoritative but their perception of me as the authority figure and to explain the usual limits, their rights of clients in terms of the their rights to terminate therapy in terms of whenever they want to, to engage in mutual treatment planning and so forth.

Another therapist described what she says to the client:

> '[I]t should be a very collaborative approach. I'm not here to tell you what to do, I don't like to give advice, but I can certainly work with you to help explore what might be going on and find some different ways of approaching things. I can notice patterns, if you are okay with that, and point them out to develop better coping skills or stress management skills.'

Also, the importance of explaining that disagreement is allowed in therapy as their opinion is valuable was cited by an interviewee.

The fifth category, identified by seven interviewees (46.67%), is establishing the legitimacy of psychological treatment. Though it is important to define therapy and the therapist's role (as described above), participants note the value in linking psychological treatment to being similar as medical treatment. One therapist shared what she tells clients:

> I guide them a lot at first because some of them have never ever been in the therapist's office, and they don't even know why their primary care doctor has

> said for them to talk to [me]. So I explain a lot of that, and I usually say that 'their medical doctor (who they usually see as the one who fixes their family problems for them) is thinking that a lot of the things you are experiencing physically can no longer be diagnosed by tests. He's sent you here, he's sent you there, she's scanned your body, she's scanned your blood tests.' So I explain psychosomatic presentation, and I say 'In our culture, it is easy to say I have a headache, I have a backache, everything in my body is hurting me, I'm nauseous.' I explain symptoms of anxiety, and they are usually nodding their head. I explain that those things are caused by stress. Their body is not functioning, and it is not something they will find on an MRI. 'If you've taken every MRI in the world, and they still find nothing, then you end up in my office.' That's what I say! They cry sometimes because they know that their lives are causing the pain, and there is not a single pill that is going to take the pain away...My goal is often going to be to get them off meds, as they are often on meds to quiet their anxiety or quiet their depression. I say 'let's try to talk it out, and maybe you will feel better, instead of just running and popping a pill every night.'

One therapist explained that providing an initial plan for treatment will legitimize treatment and reduce distress for Muslim clients:

> I found that it has been useful to present a cohesive organized structured plan to the South Asian clients and Arab clients to allay some of their anxieties. When they are generally coming, they are in a position of confusion because usually they will try to hold on, try to deal with these issues as long they possibly can and when their coping strategies…to deal with the problem fails, then they will come to seek help. And at that point in time, they are usually under significant stress and when you present things like this in a more organized way – okay, here is problem and here is how I will help you – what it serves as is kind of relieves their stress. Ok we've got some help and we have some answers…It buys them into the treatment process.

Other participants discuss the importance of explaining interventions that will be used in treatment and possibly giving references or materials to read. In addition, another participant suggested that the therapist provide one's clinical experience to demonstrate knowledge and skills.

The final category in the Psychoeducation area is to slow down the process. Four participants (26.67%) suggested that it might be helpful for clients to take time to

carefully review the consent and psychoeducational component of therapy. One therapist described the importance of going at a pace set by the client:

> I've had many early wakeup calls in my career that it is better to not presume anything. Then, you just wait and see what comes from their thoughts, and go with that, and progress at a pace that is very respectful of where they are at. And also respect their tolerance for more or less therapy. How much is enough is a big question in general for any patient honestly. But how much is enough for people from other cultures who are not integrated in the culture is even more important.

In Table 7, the main components found for the Psychoeducation about Therapy are summarized:

Table 7

Main Components of Psychoeducation

Categories	N (%)
Inform about Confidentiality, Boundaries, and Neutrality	12 (80)
Define the Limits of Therapy and Therapist's Role	10 (66.67)
Explain How the Process of Therapy will Work	9 (60)
Emphasize Collaboration	8 (53.33)
Provide Legitimacy of Therapy	7 (46.67)
Slow Down the Process	4 (26.67)

***Respect of religion*.** The second major way found in the study to build rapport with Muslim clients is in demonstrating a respect for their religion. Ten interviewees (66.67%) identified methods of showing respect for the client's religion. Therapists emphasized the importance of showing an interest and appreciation of the client's religion. As one clinician stated:

> There are a couple of things that I find important – one of the questions in here is about rapport building. One of them is I feel like I know very little about Islam but I do have an appreciation for a lot of it…I will ask people questions about their religiousness that suggests I know a little bit about what they are doing.

Another therapist agreed:

> I think some of it is just in terms of questioning, showing maybe an interest, showing that I am interested in learning. And making direct statements really that

> kind of make it clear that I understand the importance of their faith and their culture and their lifestyle…I think showing some knowledge even though, again I feel very tentative, I feel I know a very limited amount I think that that is, that can feel respectful to clients.

Both therapists emphasized the importance of showing through knowledge and language that there is a respect and appreciation for the religion, rather than judgment. Other participants reported the importance of exploring the role religion plays in their client's lives as well as consideration of religious practices in scheduling. One participant (6.67%) stated that it was crucial to inform clients that therapy was "not intended to change their religious or cultural beliefs." Further examples of incorporating religion into treatment will be discussed in a later section.

Normalizing the experience. The third way to build rapport with Muslim clients found is normalizing the clients' experience, which was cited by nine interviewees (60%). This is particularly important given the stigma and fears Muslim clients may have (as discussed previously). A therapist elaborated on this point:

> Again, a lot of normalizing what they are going through, normalizing the hesitation to come in, the stigma that they feel. For one...patient there was so much stigma around help, talking about her problems about her family outside of the family, so normalizing those concerns, the hesitations, the fear.

Another therapist described how important this is for clients. He stated:

> I would say to build the rapport at the beginning, the guiding principle is saving face. It takes I think a lot of energies and a toll on one's dignity to admit to having a problem…and it's a sense of shame I think that people from collective identities bring and that is not necessarily something that is discussed or talked about immediately. I think it's counterproductive to try to do it at the very beginning. But just an acknowledgment or keeping that in mind makes a big difference for them coming back. The fact that you are sensitive to the fact that it is hard for them to come to therapy, hard for them to talk about kind of the problems in the family.

Three additional therapists (20%) agree it is important to be aware of sensitive issues as well as give the client permission to not speak about particular topics until they are ready. One clinician recommended being flexible in scheduling given their hesitations to be in therapy. Another participant stated that he spends additional time on the phone to help reduce their fears. He explains why this extra time is helpful:

> It allows I think somebody to connect better in order to make the first appointment. It is often particularly hard for patients who are coming in for the first time, and most of the clients who I see are from cultures… [that] don't normally go into therapy. So, having them come in for a first appointment tends to be very difficult. They struggled for a while before they decide to call. Whatever I can do in order to facilitate them feeling comfortable to actually show up for the first appointment is you know I think is important. That is a little bit different from say someone who has been in therapy for years and switching therapist and so forth. Not that I wouldn't put in the same type of effort on the phone call but I am very sensitive to the fact that they're not usually exposed to therapy and how to make them feel comfortable even before coming in.

Hence, participants overall agreed that normalizing clients' experience, particularly how hard it is to come to treatment, is useful.

***Empathy and validation*.** Another significant element for building rapport with Muslim clients is providing empathy and validation of their experience. This was identified by seven participants (46.67%). Many participants spoke of the connection based on a feeling of trust between the client and the therapist. One clinician described the fundamental key to building rapport is to understand the client. He said,

> My general view is that it doesn't matter whether you acknowledge culture or not acknowledge culture. They want to know that you understand them, that you understand their problems, they want to know you have a clear plan to help them, and they need to see results. That's bottom line. It doesn't matter if you're maintaining eye contact, [etc.]. It doesn't, it doesn't really matter. You can do all of these things but if in the end, they don't feel that you understand their problems or…that they're perceiving if you're attacking them or not understanding their problems, all the other cultural things won't work out. You could take all of these cultural sensitivity classes in graduate school, all these books, all these piecemeal things to say and to do, it doesn't work…You don't want to insult their religious

> sensibilities but even then, they will educate you because they're anticipating that he doesn't know these things. I don't think that's a gross error. I think a bigger error is for the client to not feel understood.

He emphasized that the underlying purpose of building rapport is to demonstrate to clients that they are understood. One interviewee discussed the importance of validation for Muslim clients. She stated,

> Enormously important has been validation of…[their] experience. It feels like they have gone through their life without anyone validating their experience for them. Often it feels like the first time that anybody is validating…that their suffering is not abnormal. I see that as a very big piece. And also because there is a lot shame and secrecy, the trust building is extremely important because often they have not had the opportunity to build that level of trust and disclosure. I become that one first person that they tell things to, and one really has to provide that holding environment, without triggering that shame all over again and the fear all over again. So, trust building is enormously important… [by] listening and feeling for them, empathy, and just holding hands a bit, spiritually speaking… The culture around them very often does not want to validate it, and wants them to move on or forget. It wants them to look at a different perspective, and to just be okay with suffering.

This clinician underscores how validation has an enormous impact on building rapport. Another therapist described how she shows her empathy and validation by emphasizing her Muslim clients' strengths:

> If they come with kids, I play with the kids. And I always find something to, how do you say, compliment the women. Like even if she has good children, beautiful children. I ll say 'Wow, you really created beautiful children. They are so neat. You really care so much about them.' If she is dressed with something nice, I say 'wow' – it's really that you need to give compliments to the women – whether through her children or way she dress or way she say things or like when she tells you she finishes high school and then I went back to college – really compliment them about everything they have done so far. And I really did not have problem with rapport at all… [Clients] would say 'No, no, we want Dr. XX…because she is more simple, she is more reachable, more caring.' You really show a lot of empathy. Empathy is the key to these women, especially if they are immigrants. They have no social supports and if you speak their language, it's very important. Empathy and compliments.

This therapist believed that acknowledging clients' strengths was helpful to build rapport with her Muslim clients.

Convey openness to learning without judgments. Regarding rapport building, six participants (40%) discussed the value of approaching Muslim clients with an attitude of openness and without judgments. These therapists concur with the previous discussion above on common assumptions others may make about Muslim clients. However, it is noteworthy that judgments can greatly ruin the alliance, particularly for Muslims in this current political arena and therefore, interviewees mentioned this area again when discussing rapport building. One clinician discussed the importance of not displaying judgment below:

> [B]e wary of showing reactions on your face because Muslims I just feel are a lot more touchy no matter what the culture is because it's a religion you really have to defend so much more than you have to defend other religions…[because] there is just so many things being Muslim. There is like the way you dress, the way you present yourself, the way your family conceptualizes, the way your personal life will be, and its stuff that really deviates from the rest of the world and no matter where you live it's something that sets you a part because you wear it more than a lot of other religions wear stuff...There's just so many things that go along with being Muslim, like the way marriage is conceptualized, the way gender is conceptualized, the way sexuality is conceptualized. It's really important to know that to say 'Why don't you just come out to your parents?' because you can't come out to your parents…It's really, really, really important to be mindful of reactions to Muslims.

That clinician highlighted the criticalness of being open-minded to the unique way Muslims conceptualize their lives as well as the importance of monitoring our non-verbal judgmental reactions, which Muslim clients may be monitoring closely. Another therapist added to this crucial point:

> I know this is everything, the underlying premise of all psychology, was to be non-judgmental so our clients will be able to open up about anything to you, so that's absolutely nothing new. But this goes along with the defensiveness piece because so much in the religion is hard to express. If a girl is growing up in a

> White community here and she's second generation, third generation, and she's very mainstream and she's very Westernized, it may be so humiliating for her to have to admit to people that 'Yeah, I am a virgin at the age of 24 because in my religion…premarital sex is perhaps more frowned upon than other religions.' So, that it's almost like you have to be even more open and more non-judgmental. So, that even for a man, suppose a man is a virgin like at the age of 25 how hard is that for masculinity, for growing up here and stuff like that. So it's nothing new but I just feel like it still needs to be repeated that much more.

Therefore, it is important to not use Western or American values to judge Muslim clients, even if they appear Westernized. It is important to understand the client's point of view.

Another therapist provided an anecdote of how she demonstrates her nonjudgmental stance:

> I think once you see there is a Muslim in the household, asking about everyday practices and how the therapist can be more sensitive about these practices [is important]. I used to do home visits, and I would go to Muslim household where prayer is valued, and they would take their shoes off at the door. So I would know this is a value, so you kind of ask them about the shoes. I think that shows humility; it shows that I am not here to change you; I am not here to judge you; I am here to work with you.

Additionally, a key point that participants described is to convey openness to learn if they would like to share. One interviewee stated that,

> Even to ask something simple, like when I am asking about religiosity. They'll say 'Well, what do you mean?' And I'll say 'Do you fast? How many times a day do you pray?' The fact that I would know to ask meant that at least I have a little bit. And they are so used to being so misunderstood and so unappreciated, so that fact that I could ask about it, I think it makes a difference when I am just sort of asking the basic questions…I will readily admit [I don't know] but it tells them I know enough to know what I don't know. Or I am interested enough to know what I don't know. Maybe that is enough to do as the therapist, is to communicate that I am interested enough to know what I don't know. I think that is how it feels to them. That I am sort of interested it, that I am curious, appreciative and…it does allow them to be my teacher about it. They can teach me about what it means to them and how they experience it.

This therapist highlights the importance of having some knowledge, conveying this knowledge tentatively and admitting when the therapist does not know. Moreover, this

therapist emphasized that the client can inform the therapist of what it personally means to them. Another participant, however, warned to not think of clients as "cultural ambassadors." Asking them to teach you about their culture or religion may take away from their personal experience or the relevance to their lives.

Be less formal, more disclosing. It was reported by six interviewees (40%) that rapport is more easily built when the therapist is less formal and more disclosing. One therapist described this stance below:

> Simplicity, you know, be down to earth. There are a lot of therapists who really built so much boundaries, very strict boundaries, you know that really will not allow the client to penetrate. I care less about boundaries but I still was professional…To make them feel that not only am I therapist, but I'm also a human being. So this helps a lot. And maybe also helps with the rapport.

Another clinician described how she learned to be less formal with her Muslim clients. She said,

> Also, I find that I spend more time doing small talk with Muslim clients then non-Muslim. I found my sessions with Muslim clients were at least twenty-five percent longer than non-Muslim, because they wanted to engage in a certain way. I respected that space, because they are going to become very defensive if I just came off as a professional therapist who would only stick to the issues. I tried that in the beginning, but it did not get me anywhere. I can't argue with the results.

Interviewees seemed to believe that it was helpful to allow Muslim clients to feel comfortable by being more personable as it decreased the sense of strangeness of this process, the authoritative position of the therapist, and the client's vulnerability. This seemed particularly true given the stigma and hesitancy to come to treatment.

Incorporation of religion. Another major theme found in the general questions was the importance of considering the role of religion and incorporating religious beliefs and practices into treatment. Additionally, there were specific questions regarding this topic based on the literature. Below is a summary of the findings from this study.

Importance of including religion in therapy. All interviewees were asked if they believed it was helpful to include religion in the therapy process. Results are presented in Table 8:

Table 8

Is Including Religion Important in Therapy?

Response	N (%)
Yes, if it is important to the client	10 (66.67)
Yes	4 (26.67)
No	1 (6.67)

Most of the participants agreed that including religious beliefs and practices could be helpful in therapy. One therapist explained why he agreed with this idea:

> Yeah, if it is meaningful for the client, it is just amazing to see its impact because when it's something important to them, they are able to grasp onto it and they are much more motivated to engage in treatment. And it has much more meaning to them than just pop a few pills or whatever. But this is part of their worldview, how they see the world, how they interact with the world, how they think. And for someone who sees that kind of framework, it's helpful because it gets to who they are as opposed to kind of compartmentalizing things.

It is notable that the one therapist that responded "No" to this question directly provided many examples in which she included religious practices into treatment if religion was important to the client, particularly as a coping skill. However, she still feels hesitant to bring religion into therapy herself:

> I don't. I certainly don't feel qualified to talk about religious beliefs other than sort of having a brief conversation about the diversity within Islam and investigating that, suggesting that someone look into the various ways people have interpreted. But I don't bring in any religious things at all…[It is] partly because I am just uncomfortable with it. I don't feel I am knowledgeable to say something, say anything that would be of any profundity or use. And partly because I don't want to confuse the relationship…I don't want to be in the position as a spiritual teacher or spiritual anything.

Circumstances more likely to incorporate religion. Therapists were asked under what circumstances would it beneficial to incorporate religion into the treatment

process. All 15 therapists (100%) stated that it would be beneficial to incorporate religion if it was identified by the client as being important or helpful. 12 interviewees (80%) stated it would be useful to incorporate religion as a coping strategy. Participants believed that it was important to utilize spirituality and religious practices if it provided strength and support to the client. Additionally, four participants (26.67%) identified specific diagnoses or problems that incorporating religion could be helpful, including depression, suicidal ideation, and anxiety. Three participants (20%) stated that religion could be useful for problems outside the client's control, such as chronic life stress, unemployment, and bereavement.

***Circumstances less likely to incorporate religion*.** Interviewees were asked when they were less likely to use religion in therapy. Not surprisingly, 11 therapists (73.33%) stated that they would not include discussion of religion if the client did not want to do so or if it was unhelpful to the treatment. Furthermore, nine interviewees (60%) reported that they would not use religion in therapy if it negatively affects the therapeutic alliance, particularly if it makes the client feel judged. Five participants (33.33%) believed that they would be reluctant to discuss religious topics that they did not have knowledge about or where they feared they would make a mistake. One therapist added that they would not talk about religious topics that created conflict or distracted from therapeutic goals. Three participants (20%) noted that they usually do not discuss religious topics with their adolescent clients, who may interpret this type of discussion as aligning with the parents. Also, two participants (13.33%) who wore the *Hijab* (head covering) reported that they would not discuss if clients appeared defensive as it may be viewed as the therapist pursing their own personal value, rather than being a

therapeutic suggestion. Lastly, one participant (6.67%) reported that she may not include religion in therapy when Muslim clients are dealing with their sexuality or with a loss of faith (due to tragic events, such as natural disasters or loss of a child).

***Assessing level of religiosity*.** Interviewees were asked how they assess their Muslim clients' level of religiosity or the appropriateness of incorporating religion in treatment. Results are presented in the following table:

Table 9

Assessing Level of Religiosity

Techniques	N (%)
Observe/Listen for Religiosity in their Presentation	9 (60)
Ask about coping skills and if religion helps them cope	8 (53.33)
Ask as part of intake assessment	7 (46.67)
Ask about the role and meaning of religion in their life	5 (33.33)
Ask about specific Islamic practices and beliefs	5 (33.33)
Ask directly what is their level of religiosity	2 (13.33)
Ask directly if they would like religion to be incorporated in treatment	2 (13.33)

Therapists rely on both observation and questioning to assess the religiosity of clients. One therapist provides a summary of what she does:

> I think what I would say would be what I would say for any religious group, which is that it is often a strong source of strength and resilience for people, and if you are working with someone who has good capacity for abstract reasoning, one can use that very beneficially to help the client see a different perspective, and also to see a larger perspective. One should be tuned in and explore, and it is easier to ask in the initial sessions as you are already asking many questions. You can ask about income, you can ask about sexual activity, you can ask about how religious they are. Of course, you don't take that on face value, but you do stay tuned in. So if clients do bring it up, I feel that there are some therapists, especially here in the U.S. who may shy away from the religious. I don't think that [a therapist] needs to be religious themselves, but one needs to know that it is a point of resilience for many groups. If and when you can bring in religiosity and spirituality for Muslims, people become more open because you can talk about things like 'what does God say about it?' and 'what does Islam say about it?'…So I would say stay tuned in, do explore, and if it is relevant to the client's world view, then help them expand on it.

Another simple question suggested by a clinician was: "Is religion a supportive force or an oppressive force for you? Is this helping you or making you miserable?" This was used to help understand the role religion may play as a coping strategy and if appropriate to include in therapy. One therapist suggested asking about specific practices to understand the level of religiosity:

> I will ask [about religiosity]. It's not just in a direct way. It may be more about customs, involvement in a Mosque, community. Have they, if it's a child, is the child in religious school? What in terms of the pillars of Islam, what do they adhere to? Again if it is a child in school, has there been issues about being able to observe and practice in school in terms of diet? I am looking I guess for how integrated they are reporting practice in their daily lives.

Another way to assess Muslim clients is described below:

> I think usually what I do is I kind of leave it to the individual, so on our intake forms, it'll say religion: Are you spiritual? Are you religious? Those questions. So usually I use that as an opportunity to find out does this person want religion integrated into treatment or not. Some people I will ask in the beginning, some people I will ask in the middle. So with people who clearly identify with Islam and clearly indicate that this is important thing, I will ask them right off. There are individuals who may indicate that they are Muslim but when it comes to issues of being spiritual or not, they will say no, they do not feel religious, then I will hold off on asking them because I don't want them to feel that they are going to be pushed. Because the other thing for me is to realize is that I am visibly Muslim. I wear Hijaab [head covering]…So it's very clear my identification. But for someone who may not clearly identify, I have to realize that they may [see] the way I am dressed and project or assume things about me. And so I purposely will not bring up the issue unless they themselves bring it up. And when they bring it up, then I will kind of see and then it's something that resonates with them and then ask them if it's something important to you, if it's something they want to incorporate into treatment. And if they do depending on the issues, it will be a part of the treatment. I've had different issues in terms of different verses from the Qur'an in their treatment, different interventions related to Dhikr [recitation of religious phrases] or prayer. Using kind of a cognitive behavioral approach. But it has to be something that they themselves indicate is helpful to them.

The therapist underscores the importance of the client stating that it is helpful to integrate religion into treatment. However, she discussed the role her Islamic presentation plays in this assessment, whereby she may wait to see if clients would like to use Islam or not.

These examples highlight some of the ways therapists assess religiosity and appropriateness of integrating religion into therapy.

***Ways to incorporate religion in therapy*.** Participants were asked how they incorporated religion into therapy with their Muslim clients directly. Additionally, responses from the open-ended questions were integrated into this section. There were several ways religion was used in the therapeutic setting (see Table 10 below).

Table 10

Ways to Incorporate Religion into Therapy.

Categories	N (%)
Understand the impact of religion in their life and treatment	11 (73.33)
Suggest religious practices as a way to cope	9 (60)
Use religious beliefs/examples to counter unhelpful beliefs	7 (46.67)
Incorporate Islamic phrases and stories to build rapport	5 (33.33)
Consider religious values and requirements in treatment	4 (26.67)
Use religious consequence to deter maladaptive behaviors (i.e. suicide, cutting)	4 (26.67)
Monitor progress by assessing engagement of regular religious practices	2 (13.33)
Acknowledge religious prohibitions before inquiring (i.e. substance abuse, abortion)	2 (13.33)

First, 11 therapists (73.33%) reported that it was important to understand the impact of the client's religion in their life and in treatment process. Most recommended assessing this early on in treatment as discussed above. One therapist discussed importance of considering religiously based explanations for problems:

> I would probably, and this is not to say if someone wasn't religious I wouldn't do this, but I would be more curious as to their understanding of maybe how did something happen or whether there was a religious base explanation that they had verses another type of explanation. So, for example, I had another patient who was Muslim who was dealing with potentially being prodromal. I was trying to make sense of some of the things that he was struggling with, you know, Jinns [spirits] and how he understood some of that verses that there were other things biologically going on. Of course, then that had implications for treatment…I tend to try to understand it both very specifically but also then from a broader picture and look at it across the spectrum…I would throw it to them open-ended and sort of see where they go with that. If, for any reason, something like that doesn't work, I do go back and sort of talk about it in general. 'Sometimes people experience it this way. Or sometimes people do it this way, this way, this way.'

> So, it lays out a number of different things and usually at stage they are able to latch on and they have been, they feel comfortable enough to be like 'Oh they mentioned one of them.' And usually I'll have some hypothesis by that point and I'll include one of those. I know one of those will latch on to. But I tend to go more open-ended first to try to find others roots of why.

The therapist suggested inquiring about religious explanations for symptoms directly or by including in a list of possible explanations. Another therapist provided an example of how considering religion can be beneficial in helping clients. She stated,

> I think that it's very helpful for therapists to be aware of Ramadan. And aware of what it means, particularly when you are talking about course load. For example, there are some obvious things like Ramadan is going to be over the summer. Are you going to encourage someone to take two or three courses over the summer?...Are you going to do Ramadan? What are you going to do about that? How do you figure that? That has to be figured into internships, jobs, and classes and things like that…You know, there are family obligations when you are doing Ramadan, people get together, you have to go to Mosque, so where are you on that? How do you do Ramadan and how are you planning to do it this year if you're going to be taking physics in July? So, how is that going to play out for you?

Similarly, another clinician said,

> I think it is an area where therapists can be really helpful in terms of consultation to schools: How to help kids in terms of being able to pray in schools, dietary issues, fasting, modifying exam times, issues around modesty and dress like for girls in gym, in PE, how that gets handled. I think all of that could be very helpful.

Understanding the impact religion may have on Muslim clients' lives and considering it in treatment is valuable.

Second, nine clinicians (60%) identified suggesting religious practices as a way to cope for their Muslim clients. This includes recommending praying Salah, reading the Qur'an, making Du'ah (supplication), Dhikr (meditating on Islamic phrases), reciting the 99 names of God, etc. A therapist explained how she did this with her clients:

> For example, prayer is a meditative exercise. So when I'm teaching a stress-coping mechanism, and they usually are in a very high level stress life,

> emotionally, physically, and just in terms of the amount of chores and kids, I ask them what gives them solace, peace, or just a moment of relaxation, and they usually say prayer. So we examine why. If you really think about it, particularly in Islam, it is a physical activity first of all. Second, when one is reciting anything really, one is regulating breathing. We look at that and we look at the more modern meditative exercises, and I draw the parallels. They start understanding that they have those skills. They have these tools, but they just don't use them outside of prayer. So the idea is that if they use them outside of the more mandated times, it becomes an integrated part of how they can unwind or de-stress, or at least take a deep breath before shouting or yelling or cursing.

Another clinician shared how she might use the religious practice of prayer:

> [I suggest] prayer for when they don't have structure and need structure…or if they need meditation, or if they have things that they can't control and need to use prayer. You can use prayer as a way of dealing with anxiety and trying to improve focus. You can use it in specific issues or concerns.

A therapist also shared how she recommended the Islamic way of dealing with a problem:

> For example, somebody may have anger issues so what we'll talk about is there is a Hadith [saying] from the Prophet (S), who talked about what to do if you're getting angry. If you're standing, sit down. If you're sitting, lie down. If it still doesn't work, make Wudu [ritual cleansing]. Talking about how you'll change. For some people, they'll actually do those steps. Other people will try 'change what you're doing.' A lot of times what I'll do is talk about it. I'll say, 'What do you think would resonate with you in your lifestyle? What would be practical?'

This therapist demonstrated how she may use a religious practice literally, if it helped the client, or extrapolating by using the practice as springboard for discussing therapeutic interventions.

Third, seven therapists (46.67%) believed that it was helpful to use religious beliefs and examples to challenge unhelpful or maladaptive beliefs. A clinician explained the usefulness of this technique:

> Because I do think that the stories and religion have wisdom within them. When you teach people, even the cognitive behaviorists, you use metaphors to understand their lives and you can take ones from the culture that are much more power because they have been tested in a way. Instead of saying this is a cognitive

> distortion, you can say it's like …the story, the one your grandmother told you. Those things are important.

Several participants provided examples of how they utilize this intervention in therapy.

One therapist described how he used Islamic history to help a client shift her perspective:

> [For] a woman that is really struggling with the family that's always trying to keep her in her place, I may even raise that question: 'Isn't it ironic that they keep saying that is as a Muslim woman you have to, when Muhammad's intent was to raise the status of women and they are trying to use Islam to lower status of women?'

Another therapist used religious stories to help encourage positive interactions between parents and their children:

> So part of it is helping them understand and then helping them a lot with a lot of the parenting issues. A lot of Hadiths [sayings from the Prophet Muhammad(S)] about how the Prophet is playing with his kids and how it's really important and why it's important. We'll talk about how the zero to six age [range] is so important developmentally and why that might be the case. And also look at how some of the parents might be too strict and rigid about Islam. But also look towards Surah Luqman [a chapter from the Qur'an]…[where] gives advice to his son but also dissect it with them and look at what does he focus on. He focuses on Tawheed [spiritual concept of the Oneness of God] and the details of praying come at the end of the page. But the first thing is talking about the oneness of God, which kind of helps the parent reframe themselves and reframe the situation.

The therapist helps the parents see from religious viewpoint the importance of playing with your children and teaching them spirituality before rules and rituals, which is meant to better the relationship. Additionally, a clinician shared a couples case where he challenged the rigid position of the husband using Islamic beliefs:

> Another client, couples therapy, the wife just gave birth, the husband was not helping out, so the wife was filing for divorce. And she feels that rightly so, that he's perpetrating injustice to her because he's not helping out and she doesn't have any family here. She just came from the hospital and he's expecting her to cook and clean and to do all the usual things. She made a decision to divorce…[when] he put the bassinet outside the room door and closed the door. And she became enraged and she decided that she wanted to divorce… [T]his is a client who from our initial session, he infused religion in the sessions. Every session had religious themes, heavily influenced by Qur'an and Sunnah [traditions from Prophet Muhammad's time] and so on, it was a major part of sessions. We were able to

> talk about position of the mother in Islam where the Prophet said, the mother comes first three times. So operating from that Hadith [saying from the Prophet], to talk about why the man comes fourthly, the husband, the father comes fourthly and the mother comes three times firstly. And, secondly, the other Hadith of the Prophet that, where if the mother dies during childbirth that she is accorded the status of a martyr, someone who died an honorable way. From those two Hadiths was the basis for talking about, for garnering his empathy towards his wife and to talk about the childbirth and what it all entails and why the mother is accorded such a lofty position. It's amazing that grown men need to be educated on this but he was focusing on his wife's obligations towards him and he's quoting all kinds of Hadiths but from these two other Hadiths I was able to counteract his other justifications and it worked well. Reports are he's been helping out dramatically more, he's increased his participation at home. So it's a situation where this religiously inclined man is to justify his behavior from a religious perspective, which in this case would be cognitive distortion as he's distorting, he's engaging in dichotomous thinking. Some serious cognitive distortions where he's … garnering Hadith and Qur'anic ayahs to justify his behavior. Here by amassing other Hadiths we were able to shift his cognitions and increase empathy actually.

This example highlighted how a client may need clarification of religious beliefs to change behaviors he originally felt was justified. An interviewee shared another case example:

> I had a patient. He was struggling with compulsive masturbation and felt very guilty about it and very ashamed, very ashamed about it, about himself…[F]aith did play a role in his life. He was struggling having control over his obsessions and his compulsive behaviors. So part of therapy was actually coming up with strategies for competing behaviors, things that would help him that give him more control over the behavior. So, we mentioned prayers or Du'ah [supplication to God] or so these things have helped him in a more cognitive setting I suggested that as way of helping him gain more control and agency over his behaviors. But also in dealing with the guilt of the matter, not seeing it as a condemnation of one's being because of these behaviors. But actually using more of the Islamic principles of Judgment day and having all the good deeds and all the bad deeds all be counted. And God having more a flexible view and He sees everything. And in that sense it is comfort to know that there is more than one's own critical self that is so terrible. So, that I think is one example that it came up more acutely...I would look at coping skills and coping mechanisms and things that helped and encourage that as something that they find helpful. Not just anything but this is congruent with who they are, their self-image as a good person, and things of that sort. It reinforces not just behavior but reinforces a good self-image.

He used an Islamic viewpoint to help widen this client's perspective of himself as well as recommend Islamic practices to help curb his compulsive behaviors. Another therapist presented an example of helping a client make a difficult decision by using stories from the time of the Prophet Muhammad (S). She said,

> I had a situation where a husband was sexually abusing his wife, emotionally abuse and all that. she really felt the need to leave and felt really alone and was really troubled but then was stuck with the fact "How can I do this?" and so I took a story from the Seerah, the life of the Prophet and gave her an example of female companion…So she had migrated to Abyssinia with her husband who was [Muslim] at the time but then gave up Islam and became Christian. So she had the choice of "what do I do?" and she is in Abyssinia, a country with no relatives, no support system, nothing. And she had a daughter as well. And her struggle, so that kind of helped the individual realize that her situation is not new. She's not the only person who had gone through that and here's this example of this companion [friend of the Prophet (S)] who also struggled with this and how she was able to address this. And the fact that eventually she married the Prophet and so, the positive outcome of that. And so that was really helpful for the individual, to help her realize one that she wasn't doing anything wrong and then talking about what does Islam say about marital relationships and giving example of another companion [friend of the Prophet (S)]…where they decided to divorce and how that was totally acceptable. And the issue was she couldn't respect him because he wasn't of the similar background. Helping them realize that it's not the end of the world. Because often time people are hesitant to divorce because of the issue because there is such a negative thing associated with it. How the Hadith [saying of the Prophet] talk about how it's a hated thing but they don't hear the opposite thing.

Again, this clinician helped to balance the clients' perspective by providing religious stories to counter other religious points of view. Another therapist described helping her clients by emphasizing that God was merciful. She stated,

> I am thinking about these young women who are sexually active. They'll say I can't pray. And I really do try to explore that with them …[and] I will say 'God is compassionate and merciful.' Remind them of that and see whether they can take that in and you know some can't, particularly if they have been sexually active [or] had an abortion…[F]rom their point of view, they weren't doing what they were supposed to do and then were not able to get back to the prayers or were not able to do the prayers while they were feeling this way. And that's really sad.

In addition to using religion to help counter maladaptive thoughts and behaviors, five therapists (33.33%) explicitly stated that incorporating Islamic terminology, phrases, and stories was useful for rapport building. One therapist discussed using common Islamic phrases to connect to clients:

> You know one thing I would do with Muslim clients here is that I know that over here like because you see one of your own and you're a small number you band together and you get really excited about it so I feel like with Muslim clients here, I would throw something subtle like out there like 'God bless you' or 'God willing' [In Sha Allah] out there, you know, maybe just a phrase or a word or something, to let them know I know and give them something, and if they want to run with it, try to make a connection on that level so they know I'd be open to it.

A clinician describes some of the ways he builds a relationship with clients:

> One of the things I really believe in, I really believe it is important to read scriptures from different religions and I actually collect scriptures and folktales from all around the world. I have books and books and books about them and I actually read them to use as parables, sort of like teaching stories or use a metaphor in therapy. So, if I have an Islamic client, I might use, I might say a Sufi teaching story or Sufi proverb to illustrate something that they are struggling with…[For] example, say there might be a client who might be struggling with some issue around a sense of defectiveness, they feel like there is something profoundly wrong with them, and on the outside they feel like they're so terrible and I see on the inside they are a very good person…There is a simple proverb don't know where it's from but it's Sufi: 'Salt does not attract ants.' What does that mean? What attracts ants? Sugar. Does sugar look like salt? Absolutely but the chemical structure, the essence is different. And I can say to them, your essence is sweet, it's good yet maybe on the outside people see you like this. That is not who you are. And it's your essence that counts. And the fact that they might be – I don't know exactly where that came from it might be Persia or Afghanistan or India or in Pakistan but the fact that I could bring that up kind of allows, I think it allows them to both hear it and also hear the fact that I am interested enough to read stuff related to their own religion and I don't reject it in a way, that I have an appreciation for it. So, that is sort of part of the whole rapport building in that sense, to try to bring something in that might make sense to them.

Moreover, four participants (26.67%) stated that they believe it was important to consider religious requirements, practices, and values in therapeutic interventions. One therapist shared how this may come up in treatment:

> [Regarding] the issue of promiscuity amongst teens, a non-Muslim therapist would say 'well, that's normal' but the implication of that with a Muslim parent or a Muslim-individual is much more…I had a client one time who was really upset that she had kind of hung out with a guy, someone she had a crush on, and she liked. They had hung out at the library and she was extremely remorseful about it and somebody else would have been like 'what's the big deal.' But to understand what that means for the individual within the religious context and what that means in terms of how they see themselves is important. Same with substance abuse, there's a stigma attached with substance abuse…for an individual it's very different even if it's just experimentation. To be willing to tell the family about it and get help and if they do get help, there's always the fear of 'what if someone sees me.'

It is important to consider the differences in values and not assume that they may share a Western value system.

Another way identified by participants was using the religious consequence to maladaptive behavior (such as suicide or self-mutilation) to help motivate client to change. This was cited by four clinicians (26.67%).

> [I]f you've got someone who's a cutter, you might talk about how Islam frowns upon self-mutilation ...I remember my supervisor used to tell me that don't be scared throwing that out there with self-mutilation, that its frowned upon, [because] it works. It's kind of just using religion as leverage more than anything else; to always tip the scales in your favor.

Also, two participants (13.33%) stated that with Muslim clients, they may use frequency and engagement with religious practices as a diagnostic sign or marker of how well they are doing. One therapist described how she did this:

> [Inquiring about prayer] can be used as a diagnostic in lots of ways. First of all, the support it provides for them, the comfort it provides for them, the sense of connection it provides, the structure. I had one client who was really, I felt at times, he was seriously disturbed. Maybe moving into a kind of psychosis. He didn't, in the end, he didn't. But one of the key sort of diagnostics and I would ask him frequently, you know, is 'how is your prayers going?' The prayer was the structure thing that kept him through the day. He was severely depressed. And prayer got him up in the morning and sort of kept him going. And that was, I was frequently asking about the prayer, maybe every second session or something. How, so these are all the positives that there is, that prayer provides. It provides support, it provides structure, it provides continuity, it provides routine,

> consistency, and it provides people with a sense that someone cares. And so this is kind of when it's supportive. These are all the positives.

Lastly, two participants (13.33%) discussed the usefulness of acknowledging religious prohibitions before discussing "forbidden" behaviors (such as suicide, substance abuse, cutting, premarital sex, abortion, or pornography). One clinician described how she does this:

> I might try to say something to the effect that 'my understanding is that suicide is (whatever words I would use) is unacceptable, is forbidden, am I correct in that?' If they say yeah, I might ask: 'I am asking because I want to gauge with you if you feel like you could tell me thoughts like that, if you feel like I understand that.' So I want to check with my understanding first about anything I think I understand and use that as a prelude to giving them an in-depth assessment.

This may help reduce shame in disclosing these behaviors as the therapist acknowledges why the client may be reluctant to share. This section provided several ways religion can be incorporated into treatment to benefit the client.

***Comfort level*.** Therapists were asked how comfortable they felt incorporating religious beliefs and practices into treatment if it was helpful to clients. Of the 13 therapists who answered the question directly, six participants (46.15%) responded that they were comfortable discussing religion in the therapy setting. One participant explained the reason why he feels this topic can be appropriate:

> Very comfortable. I said that so many times. You know what? You cannot treat, you cannot apply a model, Western model on people that do not believe in Western values. You really need to speak the language they speak and that's why when they come to you and speak the religious language, then you have to use the religious language. So I feel very comfortable, very, very comfortable with Christians, Muslims, or Jews. So I didn't have a problem actually using religion in three different clients that I have had.

Seven participants (53.85%) responded that they were personally comfortable with including religion in therapy, but were careful in how they proceeded. They would only

be comfortable if the client was okay discussing having religious themes or including religious practices. One therapist shared:

> I'm comfortable if it is relevant to the client. If it is not, then I am not comfortable introducing it on my own. I would be more comfortable saying that you should consult a psychiatrist than you should start praying. That has a different connotation. Even though for me my religion and spirituality is very important, but I don't introduce it on my own and I am not comfortable bringing it from myself.

However, four participants (30.77%) stated that they would never include theological discussions. As mentioned previously, it may be important to acknowledge in the beginning what the therapist is comfortable discussing in therapy and what may be out of their expertise.

Inclusion of the Family. ***Importance of family*****.** Informed by the literature, participants were asked about the role of the family for Muslim clients. These responses were combined with results from the open-ended general questions. Overall, 10 participants (66.67%) stressed the importance of family for Muslim clients. Therapists believed that this was most likely due to the religious significance, the cultural influence, and the collectivists' values Muslim clients may have. As one clinician said,

> You know what, I want to tell you something and I always say that even based on studies, family is singled out as the most important factor in people's lives, especially in Muslims. So family has a very unique status in our lives. And since the Qur'an and the Hadiths always emphasize family…And we are coming from countries and a culture that really focuses on the collective rather than the individual. Your health is the family health, and the family health is your health. So it's very important. Family, family is always the most important.

This clinician highlights the huge impact families can have on the client's life. Another therapist noted that "There is a challenge…from a Western model of psychotherapy we have, all our views about the individual, about separation and individuation and that may not always be so helpful for clients." The therapist underscores the difference in the role

of the family for Western conceptualizations verses the Collectivist viewpoint, which may be important to consider when working with Muslim families.

Moreover, eight interviewees (53.33%) reported the role of the family as a major source of support for Muslim clients. Several therapists reported that they will include the family in treatment if the client finds it helpful, even if they can only be reached by phone. Therapists also noted the criticalness of including the family when working with children and adolescents. Some interviewees discussed the practical support the family gives to clients, such as paying for therapy or transporting them to the sessions, which may be needed by the client to receive help. Additionally, other therapists discuss the role of the extended family. They can provide additional support for clients. A therapist highlighted a unique role extended family members may play:

> I do want to know about the family, particularly in this project of trying to be Muslim, what it's like to be Muslim in America or what it's like to be Muslim and be an artist, what's it like to be Muslim and gay. So, I want to when someone is struggling with that, I want to I actually will do more conversations about the extended family. Tell me about the aunts and the uncles. I want to know how this family treats the person who is a little bit off the path, who is seen as a little bit unusual. If there is an unmarried aunt, well, this is a bit of an anomaly. What about her? Or the uncle who immigrated to Indonesia, sort of who are these people, and are you in contact with them, and how are they seen? Because at that point I am looking for are there any resources in this family. Who can you talk to in this family? Cousins – I want to know about cousins – do you have any contact, tell me about them, are you close to them, what do you talk about? And that is sort of around the marriage thing. Are any of your cousins married? Who did they marry? How's that working out? That kind of thing. So, I want to see how much experience is in this family that my client can draw on. You know, did your older cousin marry someone the parents picked? Or did she pick the person and then the parents went along? What happened there? How did she manage that? How did she do that? So, I want to know if any of these people are resources – aunts, uncles, cousins – whether they can be role models.

The therapist helps the client identify others in their family, who may not only provide support but also help the client create a path of their own. Overall, participants agreed that exploring the role of the family for Muslim clients is important.

Family conflict. Interviewees also identified family conflict to be a major concern for Muslim clients, most likely because family is an important part of their lives. As reported in the problems of Muslim clients section, 12 participants (80%) identified conflict with family members as being a major reason for entering treatment. Additionally, seven participants (46.67%) identified intergenerational conflict as being a more distinctive problem of Muslim clients. Therapists also noted marital conflict and problems with the extended family. Five interviewees (33.33%) stated that family could be a barrier to treatment if they are judgmental and unsupportive of the client seeking help. One clinician described this below:

> But sometimes, family could be a barrier, especially when there is mental health issues, not relationship. So [with] mental health issues, 'Oh my God, now my family will think I'm crazy' or 'Now my family will think, blame me for everything I do' or 'my family will stop me from pursuing divorce.' So family could be very supportive but at the same time, family could be a very big barrier. I always believe in that…If they are a barrier, I don't think I will include them in my therapy session. Absolutely not. If they are afraid of the family, they are not really included.

Participants were also asked how they worked with this family conflict with their Muslim clients. Seven participants (46.67%) reported strategies geared towards helping family members negotiate the conflict. Several therapists discussed looking for common ground between the family members and exploring everyone's perspective. A therapist described how she views it:

> When there isn't obvious abuse…I start from the assumption that the parents are doing their best. And they are in a hard situation. They may be completely bewildered by being here and even if they are not, they still just doing their best.

> And I try to start from that assumption. And help them see where there is room for negotiation. Is there room for maneuver here? Is there any room for maneuver in this system at all? … Is there any overlap between what the [client] says they want and what they think the parents want? What can you discuss? What is open for discussion? So that is one.

The therapist is helping the client explore ways to broaden the possibilities of negotiating with their families and understanding that the family is trying their best. Another therapist stated that it was critical "to make clear to everyone that the system is broken and not the person." In this way, again, the therapist is trying to find commonality. A clinician added to the discussion:

> I do a lot of exploring…I do want to set aside any assumptions or biases, and explore with them to see what the experience is like for them. I try to be encouraging, and acknowledge that it might be difficult to talk negatively about something that your parents or family [does]…I acknowledge that they might have some guilt talking about their family members and talking about the conflicts that they have, but I want to introduce the idea of talking about the negative feelings that they may have, and how they balance the feelings of love and respect they have for them. They seem to respond well to that. Sometimes I feel like they may be asking 'What should I do, who's right and who's wrong?' That's not really what I want to focus on or what I want them to focus on. It's really about how they feel about it, how they handle it, what they do with the support regarding this conflict, what helps.

In addition to discussing how to negotiate, the clinician notes the difficulty some Muslim clients may have talking negatively about family members to an outsider. A therapist discussed the importance of clarification of roles in the family:

> In terms of conflicts, clarifying positions…expectations, and rules. The husband-and-wife conflict again here, clarifying positions, what is appropriate, inappropriate. Again, here tact and good therapeutic judgment [are] essential because you don't want, especially for South Asians and Arabs, to feel as though they are being attacked. It is negotiating conflicts with the parents and adolescents has to be skillfully negotiated because you are treating the adolescents on multitude of issues, you need to gain their confidence, their trust, but you don't want it to so in a way that will isolate the parents. You want to also make them feel supported. It's a very difficult task, a very daunting, very challenging task. I think more so the Arabs, the South Asians, the Sub-Saharan population, they are sensitive to that. 'Is the therapist against me? Are they here to help me, are taking her side, his side?' Not sure where this comes from but it seems to be more

> salient, because I worked with other cultures - Hispanics and African American. It seems to be in some ways more pronounced with this population. I think if it's not negotiated well, it could actually increase dropout rates. I've actually had families who have dropped out. They tried therapy and they've actually dropped out of therapy after session or two, because they felt as though their therapist did not really understand them or didn't understand their problems. What I imagine is that they didn't feel supported because quite often, the therapist would join the adolescents against the parents. That is a daunting task. It takes effort to maintain the balance. It is even more critical when it's a couple, a husband and wife. There the big elephant in the room is, one, always thinking the therapist is siding with the other. So their good judgment has to be at the established. It is very, very critical. Especially the husband because you want to get his buy-in to the change process to try to change perceptions, expectations, and try to increase his positive behaviors. If you don't get his buy-in, then change will be very short lived. So that has to be skillfully negotiated.

This clinician summarized several important points echoed by other therapists in the study. He noted that it was helpful to clarify positions and expectations of each family member. He also discussed the significance of therapists remaining neutral in conflicts, particularly with adolescents. Finally, the engagement of husbands was valuable in the treatment process. Others have also noted that inclusion of fathers was also helpful to resolving conflict. As noted before, therapists reported that finding support for family members is useful, including during times of conflicts. Another therapist discussed emphasizing the positives of each family member:

> For example, there was a very big conflict between a mother and her daughter…if she generalizes things…'she does this, she does that'…I said 'Do you remember ever that your mom said something that really pleases you?' Because I have to focus on the positive. They…[say] 'Oh yeah, of course.' I say, 'Can you please name them?' So they name them. And I say 'Well, wow, she must really love you so much! Or care about you so much! But maybe you don't see that when you are angry or frustrated. How about you notice other things that your mom says to you that really shows some care?' So I really make them be observant of other behaviors than the negative ones. So this takes a while. It's not really easy. It's easy to say that now, but it takes so much work for them to notice the positives. Because they are so overwhelmed with criticism and negativity around themselves so they won't see the positive side. Or if they say something [like] 'my mom told me that.' [I say,] 'Oh so she must care so much about you to tell you don't do this maybe because she doesn't want you to be hurt.' So you really

> paraphrase things from the negative to the positive. And they really look at me….sometimes with silence. 'Really? You think so? Wow I never thought about it in that way'…I love this dynamics where you switch the negative to the positive and make them really notice.

The therapist helps families balance their views on each other to build a way to a common ground. In sum, these therapists suggest acknowledging each family member's side and finding ways to negotiate within the family.

Participants also discussed the importance of helping individual Muslim clients find ways to define themselves within the family. This was cited by five participants (33.33%). One therapist stated,

> Well, this is something that I just tell people in general: 'You can't change other people necessarily, and it is hard to change one's self. The best you can you do is to look at yourself and the role you play, and what you can do to change yourself and start there.' You are legitimizing the fact that not everything that happens is them or their fault. 'What we are here to do is figure out what part of it works for you, and what part you can change' and help them feel more comfortable talking about themselves.

Another clinician discussed the possibility of viewing the conflict as more of an internal struggle:

> I think it is a conflict but life is all about conflicts...If you take that sense that the conflict is all externalize to begin with and there is a mother's interest and a father's interest and collective interest and then there is the son, the identified patient, that has their own interest and they all battle and fight each other. That is a Western conceptualization of the problem…But I look at any conflict that a patient brings as two different voices or what have you as an internalized one, as one that exist within us. I talk about the idea of the self…as basically a field where you have different parts of one's self that are disconnected from each other and you are able to live in harmony despite the disconnection between all those separate areas of our lives. But at times there is a conflict when it comes to an awareness of what I want doesn't fit with what somebody else wants. It's a conflict within one, those parts that wants to please and get approval of the father/mother verses wanting to be yourself and be more independent. So, if you look at it from that perspective you are actually seeing the self as a much larger picture of one's own community or one's own family. You can kind of embody all the different identities within the families by the roles you play in them so they are part of you and that's the part that conflicts with each other, sometimes

> doesn't fit because you outgrew your role as a son and you're trying to do something else or you are trying to develop a new identity. So it's not between internal and external. That is not how I see it. I think it simplifies the problem and misses the point. The point is we all live with conflict. It is just the matter of managing and you don't get rid of the conflict at the end of therapy. You just retain that capacity to transmute it or change it or transform it to something more adaptive or something that works better for the patient. And redraw the lines internally so they can, because they have managed it before, they were able to do it. You are not reinventing the wheel. You're just helping them find that equilibrium again in some ways…I didn't realize it at the time but there is a concept of the median in Islam that is very much, that I think relates very much to what I am saying. They're finding the median path between like strong desires and fears. The median is seen as a virtue of the Muslim to be able to temper one's desire, one's anger, one's fears and to walk in the middle and manage all of this. I think in many ways that is a metaphor of what works in patients.

With this perspective, the therapist suggested helping the client redefine themselves in relation to others to find a way to manage the conflict. He also highlighted the concept of balance for Muslims, which may help clients find ways to manage the conflict.

Finally, four participants (26.67%) discussed the importance of helping individual Muslim clients to accept the limits of their families. Several therapists discussed the importance of helping clients maintain safety if there is violence or abuse in the family and searching for outside resources. Others described the value in helping clients consider the implications of their decisions when accounting for the reality of their family's expectations. A clinician described a case she worked with:

> The other is the piece I already said is trying to help the client find their own way within the context of the family…You know sometimes that is the reality. So you talk with them. You realize that if you change your major they are not going to pay for your education. So, what are you going to do? You have to decide. So, let's talk about the implications of this if you are going to quit. I think I can remember this one girl in sciences and then wanted to do journalism and the parents were saying we are not going to pay for journalism degree. So, are you ready to take on loans? Are you ready to take longer to go to school? And what's going to happen to your relationship if you do this? How are you going to feel about that? How are you going to maintain contact with them? You know, do you want to maintain contact with them if they refuse to pay for your education? And that it's not economic reasons, its control issues. So when there is conflict like

> that it's really, really have to draw out the implications of it and just go down to the nitty-gritty…[And] what she wanted help with was 'how can I change my major without my parents knowing', even though they open up her grades every semester, they open up all her mail. So, how are you are going to do this? How are you going to explain you don't have chemistry on your transcript, even though she was going into pharmacy? That's what she wanted help with…So, in terms of dealing with the conflict, helping to really talk through the implications of any decisions they are making.

The therapist noted that it is helpful to guide clients through the implications of their decisions, given the way their family may react, with the goal of helping them to find themselves within the family.

Domestic violence. There were five participants (33.33%) who discussed domestic violence in the course of the interview. Additionally, as reported previously, three participants (20%) specifically named domestic violence as a reason for Muslims clients to seek treatment. The main message these therapists provided was that Islam does not support domestic violence and should not be used as an excuse for it to occur. As one clinician stated,

> When I see that religion is just teaching people to tolerate more than they need to, to the point where it is abuse, I like to make the point that religion - any religion - does not encourage abuse. None of the scriptures encourage abusive behaviors. It is all about love, tolerance, helping the needy, wisdom, and higher forces that are guiding our lives. It is not about who can dominate who, and who can rape who. When I see that it is being used to tolerate abuse that should not be tolerated. I make a point they need to distinguish the idea of faith is different from forcing them to accept things that they don't need to accept.

Hence, this therapist noted the importance of recognizing that religion does not support abuse of any kind. A therapist discussed a case she had:

> There was a woman that I worked with that was a victim of domestic violence. She had grown up here in the States, but for at least twenty years, she was isolated from the mainstream society. She had a lot of family, so she didn't speak much English, but spoke Urdu, so our sessions were in that language. She had two beautiful kids, and she did not finish high school. She married a man, and between him and his parents, they were emotionally, verbally, financially, and

> getting to be physically abusive. When I started working with her, he picked up and abandoned her…A big part of my work was to help her deal with this abandonment, and get back on her feet emotionally and financially. We are going through this and making progress, but he shows up again all the sudden. She is shocked, confused and doesn't know what to do. I tried to remind her of her rights in this situation, and that a decision had to be made. We talked a lot about that, but she was under the pressure of culture and believed she had to take him back. So she did, and in the beginning, was getting better. I was meeting with both of them and the mom, and was able to make progress on certain things. He was still kind of emotionally abusive though. One day, he told her that he had to take a trip for work and would be back in a day or so. It had seemed like there was a possibility that things had gotten better at this point. She had hope and was feeling better about it, but I was not loving it, but I impressed that things had seemed to get better. There seemed to be some movement in a positive direction. So the trip comes up, and…he abandoned her again…She was distraught, and felt like her life was over. Empowering her as a woman became a task, but letting her know and reminding her that she was getting a divorce and normalizing it by letting her know that is okay and that she has a right to it in Islam. This is grounds for divorce and that she is not committing a sin, and that in the eyes of God, this is the best thing for her to do. Just because it is her husband doesn't mean she is expected to tolerate that. I think that was a very important time to use religion, because that is a cultural idea. I can't change the heart of the culture, and she was so isolated that [we needed] to create that option. It created a connection for her with God.

The therapist described the work she did with this client by first, helping to stop the abusive behaviors and then, by empowering this woman to get a divorce and know it was not against her religion. Another clinician described her work with clients in this situation:

> One woman told me that this is the first time after maybe thirty seven years of abuse that I am able to talk about it. Thirty seven years! And it's really [that] you really provide safe environment for them to say that. And maybe they feel very comfortable talking to another Muslim. This is a major factor for them to reveal the issue. And also I'm using a lot of their language, especially [with] a very religious woman who is wearing the veil, (Hijaab). I cite the Qur'an, I cite the Hadith in many ways and I said 'you know, don't believe that the Qur'an allows men to hit women.' And I go to this Ayah [verse from the Qur'an] … I simplify the verses to them. I explain it to them. And then, they become very powerful. This woman, for example, her husband was [an] Imam. And when she left my session, she was so empowered. She came back to another session and she said he was about to hit me and I said 'dare if you lay your hand down on my body again. You will leave the house and you will never see my face.' And she said he was

> shocked, 'to hear me saying that.' And then she said 'You are not [an] Imam. If you are Imam, you [should] know your book very well.' So, she really used the same Qur'an and Ayah to tell him that 'what you are doing is the wrong thing.' So, that was really like one of the approaches that I used to use with my clients. It was very helpful…[Also,] if they have a misconception about certain things…'that God wants us to obey our husbands.' And those women, especially Muslim women, don't really know their rights in the Qur'an. I really listen to them, the way they perceive these verses. [Then, I say,] 'You know what? I really have a different understanding of these verses. My understanding is such and such. And I believe God is forgiving, God is like Raheem, God is Merciful. How would you think that God wants to punish you if he is really merciful?' So I really take this word and we play with it first. As I said, my understanding is different from what you just told me. And we discuss, so really talking about it…And you want to take them to the basic, to the core values. 'When did you learn that?' 'When my mom told me that. We all know that, the whole Muslim world knows that.' 'Okay, where did you hear it the first time?' And I myself, my mom used to say [it]. And I tell them, my mom used to say to my sister-in-law, when her husband, my brother, hit her the first time, she said 'it's okay, it's okay'. Like it was in front of my eyes. 'It's okay. He loves you. He cares about you, that's why he hits you'. I said, 'No, you cannot say that.' It's really like how a woman perceives relationships based on their beliefs, or own religious beliefs that were told to them or learned by their parents. So we really have to go step by step backwards and see where the core of these values are coming from, or the beliefs. So it's not really easy, especially when people are so rigid with their understanding of religion.

These therapists emphasized the importance of helping to clarify for the client that Islam does not endorse domestic violence and that what they may have learned from their family may be wrong. These therapists used the Islamic beliefs and the Qur'an verses to help counter the maladaptive beliefs that these clients have. Another clinician described how he worked in this way with both the victim and perpetrator of domestic violence:

> [This way] works very effective because I conceptualize that perspective as their world belief, their cultural position. However, it doesn't operate, it doesn't fit well to present environment and it's getting them to a lot of legal troubles, a lot of legal problems, and its harmful. Even within their own culture, it would be harmful for them when try to kill a woman. So, I can counter using cognitive behavioral principles. I can counter those cognitions by presenting accurate religious positions…[and it's] very effective. From both, it terms of the victim alleviating some of the guilt and from the, I treat both perpetrators as well as the victim. And from the perpetrator's position that this is unacceptable. That these expectations they have of women and wives, that it is more of a cultural thing,

> cultural position rather than a religious position. They actually, it gains potency and saliency – additional potency I must say – when in their mind it has some religious sanctions. So, once you can decouple that, the goal, the primary goal in treatment is to decouple that and progress, I have observed progress when the problem becomes one of the goal of therapy is to frame the problems of cultural understanding…[W]ith the perpetrator that I'm treating it is a court ordered domestic violence treatment, this man…[has the] view are that the women should follow their rules. It's the women's role and responsibilities to do all of these duties and tasks for the husband to be a good wife. And he uses that whenever the woman falls short and that is used to project blame onto the woman and to deny his own involvement, his own roles, his own responsibilities into the conflict. Over a series of sessions, and this was a very religious man, I consider him a very educated intelligent Muslim man, he studied formally their religion, so we were able to counter that with some very basic Islamic positions from the Sunnah, where repeated statements of the Hadith that the Prophet said, "the best man are those of you who are best to their women." And we were able to have a good amount of discussion over substantial amount of sessions of what it meant to be best to women…Once we set up these counter arguments so repeatedly over time it begins to move some of these faulty cognitions. And it depends on how religiously astute the client is and in this case, the client was very religiously astute so we can talk about additional concept, like the Qur'anic Concept of Zhulimah (Oppression) and so on and how that all relates to husband and wife relationships.

In this case example, the therapist used religious evidence to counter the perpetrator's faulty belief that he had the right to hit his wife. In sum, these therapists highlight that domestic violence cannot be justified by religion and may be important to inform clients or suggest that clients' explore this further.

Consideration of the community. There were several interviewees that discussed the role of the community for Muslim clients. Specifically, seven therapists (46.67%) noted that they would recommend Muslim clients seek help with an Imam or look for support in their Masjid or Muslim community. They discussed that it may be helpful for clients to access support and resources from within the community. Participants, however, also noted that there may times it can create difficulties for the client (similar to families). One therapist summarized the role of the community:

> [The community] has both been a source of support but also the source of difficulty. So, sometimes it's somebody within the community where there are other Muslim students on campus or belong to the MSA [Muslim Student Association] or something like that where they can find some kind of support there or they try to get it through religious leaders and so forth. And other times, it's because they are a part of that, that's the difficulty because they are struggling with their religiosity or trying to find ways to fit in or they are feeling judged or so forth. So, again, it's double.

Hence, the therapist noted that clients may find the community is supportive or judgmental, depending on the client. This may also be true regarding support of treatment. A therapist said that the community "is probably a barrier in general in forms of treatment, because it is seen as not something that people should do unless they have really severe issues. If people do have severe issues, then the community can be important in getting them into treatment."

***Role of Imams*.** There were several participants that discussed the usefulness of referring Muslim clients to Imams (religious leader) for concerns of religion or spirituality. However, four participants (26.67%) discussed the criticalness in referring clients to Imams who are known to be open and understanding. One clinician summarized how she may include an Imam:

> One thing that I didn't mention is that when patients come from this culture to me…and usually it is after they have exhausted all other means; they have gone to the authority figures, they have gone to the elderly in their family, they have gone to the Sheikh or several Sheikhs…they have exhausted all of those channels. They have gone to the primary care doctor, told the whole family the story, etc. Usually when they end up in my office, it is because they have exhausted all other options and are at a loss of what to do. So what I do is respect that journey of theirs, and ask for it to be continued in parallel to my work. I don't claim to them for my therapy to work. I say to go back to the Sheikh, go back to check with your Imam again. Obviously, it is not always easier to find an Imam who is not going to be on the same wavelength, especially with domestic violence situations. So I may tell them that sometimes, the Imam will say [one thing] and I will have to tell you another. It is up to you then to decide if you want to follow their guidance, and I will be respectful of that, or do you want to start protecting yourself and your children...But I don't go and say your spiritual leader is a moron. I don't shake

> your foundations in any way. I try to find whether they find some wisdom in their Imam, and whether their wisdom is supportive in this kind of way, and if there is another way instead of violence. So that is another part that I feel has to be respected, particularly if they feel attached to what their Imam was saying. I poke holes into it whenever I feel it is appropriate, especially if I feel it is a life or death situation.

Another therapist discussed when she would advise clients to seek out an Imam:

> I think I would [refer to an Imam], especially if it were a complicated case. I am certainly not well-versed in other religious knowledge, so I think I would turn to my Imam, he has quite a bit of knowledge. He is second generation, and understands the cultural implications, so yeah, I would, especially in cases of end of life or reproductive technology, that's some complicated stuff. So if a client came to me with those issues, asking "Is this allowed in Islam," I wouldn't know. That's a complicated question. If I felt uncomfortable, I would go to other folks in the community.

This therapist discusses how she assessed if the Imam is a helpful source:

> If I think the Imam is going to read some party line, then I am not going to encourage that. I wouldn't say they can't do it or should do it. I would just say nothing. And if they do go, talk about it, what does this mean for you? So, I mean I certainly don't believe that people have to make major sacrifices in order to be a good Muslim…Now this is when I would truly talk to someone about this to their Imam. Of course, I would want to know what their Imam was like…[I would say,] 'tell me about this person. Have you been going to this Mosque? How long have you known this person? Is this the Mosque you're going to? Is the Mosque your parents go to? What is your parents' relationship with this person? What kind of things have you talked to this person before? What kinds of things have they said to you? Have you followed up on the things they have said to you?

These therapists highlight the usefulness of referring Muslim clients back to their Imams but believe it is better if the Imam is known to be open and responsive.

Need for psychoeducation and research. Four participants (26.67%) reported that it would be useful to have more collaboration between the Mental Health community and the Muslim community. Specifically, therapists stated that the community could benefit from psychoeducation about relevant issues. One therapist described the work she did in the community:

> We did a lot of community outreach. We explained to people about psychology, mental health issues, [and] their physical health. In the Quran, they talk about three things: the mental health, the physical health and the soul. How they are all connected to each other. It's okay if you seek counseling. We really did a lot of work…And also because we try to approach them from Qur'an, they were more receptive and accepting of the counseling we had.

They also believed that the Muslim community is in need of further research and treatment. One clinician said,

> But what there is a need for is research, is a massive need for accurate data. In my limited time I've been working with this population my general impression is that this is a community suffering in silence. More often the way it works, the more I see these clients, the more they tell me about their families, about people and their communities, the more I become alarmed because some of these problems are really, really serious and severe. This need, especially in this community, a lot more work to be done.

It appears that more research could be valuable to further understand the Muslim community, the problems they face, and how to best help them.

Evaluation of Recommendations in the Literature

This section provides a summary of responses from the participants on the self-report survey, *Assessment of Therapists' Practices with Muslim Clients.* The main purpose of the survey was to ask therapists to evaluate recommendations found in the literature regarding working with Muslim clients. The results of the survey are presented in the following tables below. It is noted that one participant refused to complete most of the survey, stating it was "very lengthy" and felt that it forced her to view Muslims as a homogeneous group, which was contrary to her opinion.

Regarding the questions eliciting their general opinions, most participants reported that they are comfortable discussing religion in therapy, find it important to include religion in therapy, and believe that it is the client's responsibility to bring up religion in therapy, which is concurrent with the open-ended interview responses (see

Table 11). Additionally, the majority of therapists reported being very competent (53.33%) or somewhat competent (40%) to treat Muslim clients, which matched their experience level with these clients and reason for being selected to participate in the study. Interestingly, most participants (53.33%) said they believed it was important to adjust their theoretical approach when working with Muslim clients. This appeared to correspond to the findings that most therapists identified as Integrative/Eclectic and adjusted their approach to the individual client's needs.

The next major section of the survey assessed the participants' professional opinion on the recommendations found in the literature (see Tables 12, 13, & 14). The only recommendation to be endorsed by 100% of participants as very relevant, very effective, and very likely to use was Recommendation #7, which was to "make building rapport an essential task using empathetic qualities such as genuineness, respect, support, and warmth, and pacing treatment according to client's comfort level." 93.33% of participants rated Recommendation #6, which was to "be aware of and avoid imposing one's own values or judgments onto the client," as very relevant, very effective, and very likely to use. Another highly rated recommendation was Recommendation #4, which stated "use basic knowledge only as a starting point for engaging Muslim clients and recognize that there is considerable diversity in Muslim community." It was rated as very relevant by 100% of participants, very effective by 93.33%, and very likely to be used by 80%.

There were a few recommendations that were considered to be less relevant, less effective, and less likely to be used, which was determined by combining the responses for the two possible choices (i.e. somewhat irrelevant and not at all relevant).

Recommendation #15, which stated "maintain a stance of being assertive and advisory (as it may be likely a Muslim client may take a more passive, non-confrontational stance, assigning a great deal of authority to the therapist and generally conforming to what is advised or prescribed)" was viewed to be irrelevant by 60% of participants, less effective by 46.67%, and not likely to be used by 66.67%. Also, Recommendation #39, which suggested having a Muslim leader or community member make the first introduction to the therapist, was viewed as irrelevant by 40% of respondents, less effective by 40%, and not likely to be used by 80%. Another low-rated recommendation was #23, which stated "try to include elder members of the family as they are respected for their experience and wisdom" and was viewed as less relevant by 40% of participants, less effective by 46.67%, and less likely to be used by 80%. Additionally, Recommendation #29 (be careful of addressing couple related issues if the presenting problem is child-focused) and Recommendation #24 (which suggested focusing on family goals & unity over individual goals) were viewed as less relevant by 26.67% of therapists, less effective by 46.67%, and not likely to be used by 53.33%.

The last parts of the survey assessed therapists' knowledge of common Islamic practices and beliefs and if therapists would incorporate them into therapy (see Tables 15, 16, 17, & 18). The majority of participants (73.33% or greater) knew of the listed Islamic practices. Similarly, most (80% or greater) were familiar with the Islamic beliefs included on the survey. The top three Islamic practices they would recommend to their clients if it enhanced treatment goals were: Du'ah or Supplication to God (80%), Salaah or the Five Daily Prayers (73.33%), and Reading the Qur'an (73.33%). Regarding utilizing Islamic beliefs in therapy, 80% of respondents would use "focusing on the blessings of Allah

(God)," which can help with worries and distress. Additionally, 73.33% of therapists would use the following Islamic beliefs: One must fully trust and rely on Allah, "After hardship, there will be ease," and remembering that Allah is compassionate and merciful. Interestingly, therapists said they would not use these beliefs: Focusing on the Afterlife (73.33%) and that life is temporary (60%). In sum, the results of the survey provide additional information on the participants' opinion on the recommendations from the literature.

Table 11

Therapist's General Opinions

Questions	N (%)
Overall, how competent do you feel you are to treat Muslim clients?	
Very Competent	8 (53.33)
Somewhat Competent	6 (40)
Somewhat Incompetent	0 (0)
Not Competent	0 (0)
No Answer Provided	1 (6.67)
Do you believe it is necessary to adjust your theoretical approach when working with Muslim clients?	
Yes	8 (53.33)
No	6 (40)
No Answer Provided	1(6.67)
Do you think including spiritual or religious issues into therapy is important?	
Very Important	5 (33.33)
Somewhat Important	9 (60)
Somewhat Unimportant	0 (0)
Not Important	0 (0)
No Answer Provided	1 (6.67)
How important, in your experience, is including religious beliefs and practices into therapy for Muslim clients?	
Very Important	6 (40)
Somewhat Important	8 (53.33)
Somewhat Unimportant	0 (0)
Not Important	0 (0)
No Answer Provided	1 (6.67)
Whose responsibility is it to bring up religion in treatment?	
The Client's	8 (53.33)
The Therapist's	3 (20)
Both the Client's and Therapist's	3 (20)

Table 11 cont.

No Answer Provided	1 (6.67)
How comfortable do you feel discussing religion in therapy with your Muslim clients?	
Very Comfortable	10 (66.67)
Somewhat Comfortable	4 (26.67)
Somewhat Uncomfortable	0 (0)
Not Comfortable	0 (0)
No Answer Provided	1 (6.67)
How likely would you be to include religious beliefs and practices with your Muslim clients?	
Very Likely	5 (33.33)
Somewhat Likely	7 (46.67)
Somewhat Unlikely	1 (6.67)
Not Likely	0 (0)
No Answer Provided	2 (13.33)

Table 12

Relevance of Recommendations to Therapists' Treatment Approach

Recommendations	N (%)
Recommendation 1: Obtain and maintain knowledge about Muslims	
Very Relevant	11 (73.33)
Somewhat Relevant	3 (20)
Somewhat Irrelevant	0 (0)
Not at all Relevant	0 (0)
No Answer Provided	1 (6.67)
Recommendation 2: Elicit knowledge one does not know about the client's religion or culture from the client.	
Very Relevant	9 (60)
Somewhat Relevant	6 (40)
Somewhat Irrelevant	0 (0)
Not at all Relevant	0 (0)
No Answer Provided	0 (0)
Recommendation 3: Acknowledge one's limitations to the client about one's knowledge about Muslims.	
Very Relevant	8 (53.33)
Somewhat Relevant	5 (33.33)
Somewhat Irrelevant	2 (13.33)
Not at all Relevant	0 (0)
No Answer Provided	0 (0)
Recommendation 4: Use basic knowledge only as a starting point for engaging Muslim clients and recognize that there is considerable diversity in Muslim community.	
Very Relevant	15 (100)
Somewhat Relevant	0 (0)

Table 12 cont.

Somewhat Irrelevant	0 (0)
Not at all Relevant	0 (0)
No Answer Provided	0 (0)
Recommendation 5: Avoid attempting to alter the religious beliefs, values, and practices of the client.	
Very Relevant	11 (73.33)
Somewhat Relevant	2 (13.33)
Somewhat Irrelevant	2 (13.33)
Not at all Relevant	0 (0)
No Answer Provided	0 (0)
Recommendation 6: Be aware of and avoid imposing one's own values or judgments onto the client, such as using Western or ethnocentric values	
Very Relevant	14 (93.33)
Somewhat Relevant	1 (6.67)
Somewhat Irrelevant	0 (0)
Not at all Relevant	0 (0)
No Answer Provided	0 (0)
Recommendation 7: Make building rapport an essential task using empathetic qualities such as genuineness, respect, support, and warmth, and pacing treatment according to client's comfort level.	
Very Relevant	15 (100)
Somewhat Relevant	0 (0)
Somewhat Irrelevant	0 (0)
Not at all Relevant	0 (0)
No Answer Provided	0 (0)
Recommendation 8: Provide information about the therapeutic process, including the functions of therapy and counseling, the issues for which therapy could be helpful, the procedures which clients should expect during sessions, the expected outcome of counseling, and the practical considerations such as session times and financial liability.	
Very Relevant	12 (80)
Somewhat Relevant	2 (13.33)
Somewhat Irrelevant	0 (0)
Not at all Relevant	0 (0)
No Answer Provided	1 (6.67)
Recommendation 9: Address clients' attitudes about seeking therapy and about their perceptions of stigma attached to therapy.	
Very Relevant	7 (46.67)
Somewhat Relevant	6 (40)
Somewhat Irrelevant	1 (6.67)
Not at all Relevant	0 (0)
No Answer Provided	1 (6.67)
Recommendation 10: Be aware of negative stereotypes about Islam and Muslims and provide a place for Muslim clients to discuss their experiences of prejudice and discrimination.	

Table 12 cont.

Very Relevant	13 (86.67)
Somewhat Relevant	2 (13.33)
Somewhat Irrelevant	0 (0)
Not at all Relevant	0 (0)
No Answer Provided	0 (0)
Recommendation 11: Examine your sources of information on Islam (i.e. the media, parents, friends) and how they affect your attitudes toward Muslims.	
Very Relevant	8 (53.33)
Somewhat Relevant	5 (33.33)
Somewhat Irrelevant	1 (6.67)
Not at all Relevant	1 (6.67)
No Answer Provided	0 (0)
Recommendation 12: Demonstrate one's expertise by informing clients about one's educational background, general knowledge of Muslim cultures, special training you might have had with respect to Muslims, and successful cases with Muslim clients.	
Very Relevant	4 (26.67)
Somewhat Relevant	7 (46.67)
Somewhat Irrelevant	2 (13.33)
Not at all Relevant	1 (6.67)
No Answer Provided	1 (6.67)
Recommendation 13: Be sensitive to first impressions clients may have of you based on your appearance, including professional dress, immodest clothes, cleanliness of your office, and organization of desk and room.	
Very Relevant	4 (26.67)
Somewhat Relevant	9 (60)
Somewhat Irrelevant	1 (6.67)
Not at all Relevant	0 (0)
No Answer Provided	1 (6.67)
Recommendation 14: Maintain a moderate balance of self-disclosure, where too little disclosure could be perceived as distant while too much disclosure may be perceived negatively as incompetence.	
Very Relevant	6 (40)
Somewhat Relevant	8 (53.33)
Somewhat Irrelevant	0 (0)
Not at all Relevant	0 (0)
No Answer Provided	1 (6.67)
Recommendation 15: Maintain a stance of being assertive and advisory (as it may be likely a Muslim client may take a more passive, non-confrontational stance, assigning a great deal of authority to the therapist and generally conforming to what is advised or prescribed).	
Very Relevant	2 (13.33)
Somewhat Relevant	3 (20)
Somewhat Irrelevant	7 (46.67)
Not at all Relevant	2 (13.33)

Table 12 cont.

No Answer Provided	1 (6.67)
Recommendation 16: Be aware of gender preference for therapist selection, particularly for female Muslim clients.	
Very Relevant	12 (80)
Somewhat Relevant	1 (6.67)
Somewhat Irrelevant	1 (6.67)
Not at all Relevant	0 (0)
No Answer Provided	1 (6.67)
Recommendation 17: Conduct a thorough assessment, including physical health, psychological state, social status of the client, spiritual condition, and religious inclinations and beliefs.	
Very Relevant	12 (80)
Somewhat Relevant	2 (13.33)
Somewhat Irrelevant	0 (0)
Not at all Relevant	0 (0)
No Answer Provided	1 (6.67)
Recommendation 18: Create a genogram of at least three generations to understand the family and their culture.	
Very Relevant	6 (40)
Somewhat Relevant	7 (46.67)
Somewhat Irrelevant	1 (6.67)
Not at all Relevant	0 (0)
No Answer Provided	1 (6.67)
Recommendation 19: Assess and address acculturation or immigration issues.	
Very Relevant	13 (86.67)
Somewhat Relevant	1 (6.67)
Somewhat Irrelevant	0 (0)
Not at all Relevant	0 (0)
No Answer Provided	1 (6.67)
Recommendation 20: Conduct an assessment of religious and cultural issues, such as client's level of religiosity, to determine the appropriateness of incorporating spiritual or religious techniques.	
Very Relevant	9 (60)
Somewhat Relevant	3 (20)
Somewhat Irrelevant	1 (6.67)
Not at all Relevant	1 (6.67)
No Answer Provided	1 (6.67)
Recommendation 21: Aim interventions to be practical, immediate, and attainable in contrast to interventions that focus on the historical development of the problem or is too abstract or philosophical in nature.	
Very Relevant	5 (33.33)
Somewhat Relevant	7 (46.67)
Somewhat Irrelevant	2 (13.33)
Not at all Relevant	0 (0)
No Answer Provided	1 (6.67)

Table 12 cont.

Recommendation 22: Keep therapeutic goals congruent with the goals and values of the family in particular and their religious ideology in general.	
Very Relevant	9 (60)
Somewhat Relevant	2 (13.33)
Somewhat Irrelevant	3 (20)
Not at all Relevant	0 (0)
No Answer Provided	1 (6.67)
Recommendation 23: Try to include elder members of the family as they are respected for their experience and wisdom	
Very Relevant	0 (0)
Somewhat Relevant	7 (46.67)
Somewhat Irrelevant	4 (26.67)
Not at all Relevant	2 (13.33)
No Answer Provided	2 (13.33)
Recommendation 24: Use interventions that maintain the unity of the family as well as emphasize the goals of the family unit above the goals of an individual member, especially if the goals are conflicting.	
Very Relevant	0 (0)
Somewhat Relevant	9 (60)
Somewhat Irrelevant	3 (20)
Not at all Relevant	1 (6.67)
No Answer Provided	2 (13.33)
Recommendation 25: Respect the valued covert and indirect communication style of Muslim clients and families, which avoids the confrontation and direct criticism associated more with open and direct communication.	
Very Relevant	5 (33.33)
Somewhat Relevant	4 (26.67)
Somewhat Irrelevant	4 (26.67)
Not at all Relevant	1 (6.67)
No Answer Provided	1 (6.67)
Recommendation 26: Respect the hierarchical structure of the Muslim family by understanding the power structure of the family, including the role of the father.	
Very Relevant	7 (46.67)
Somewhat Relevant	6 (40)
Somewhat Irrelevant	1 (6.67)
Not at all Relevant	0 (0)
No Answer Provided	1 (6.67)
Recommendation 27: Utilize interventions that emphasize education and advancement of children in the family to be aligned with the family's goals.	
Very Relevant	3 (20)
Somewhat Relevant	9 (60)
Somewhat Irrelevant	1 (6.67)
Not at all Relevant	1 (6.67)
No Answer Provided	1 (6.67)

Table 12.cont

Recommendation 28: Help clients explore and access resources within their own communities, such as Masjids (Mosques) or Muslim community centers.	
Very Relevant	8 (53.33)
Somewhat Relevant	6 (40)
Somewhat Irrelevant	0 (0)
Not at all Relevant	0 (0)
No Answer Provided	1 (6.67)
Recommendation 29: Be careful of addressing couple related issues if the presenting problem is child-focused.	
Very Relevant	2 (13.33)
Somewhat Relevant	6 (40)
Somewhat Irrelevant	3 (20)
Not at all Relevant	1 (6.67)
No Answer Provided	3 (20)
Recommendation 30: Take time to understand the meaning of somatic symptoms, which may be a more common presenting problem than psychological distress.	
Very Relevant	6 (40)
Somewhat Relevant	8 (53.33)
Somewhat Irrelevant	0 (0)
Not at all Relevant	0 (0)
No Answer Provided	1 (6.67)
Recommendation 31: Avoid encouraging confrontation as it may be considered selfish and insulting to the family or community.	
Very Relevant	4 (26.67)
Somewhat Relevant	6 (40)
Somewhat Irrelevant	2 (13.33)
Not at all Relevant	2 (13.33)
No Answer Provided	1 (6.67)
Recommendation 32: Because Muslim clients may be unwilling or reluctant to confront the therapist directly, be aware that they may only conform to requests and treatment plans on a superficial level.	
Very Relevant	5 (33.33)
Somewhat Relevant	7 (46.67)
Somewhat Irrelevant	0 (0)
Not at all Relevant	2 (13.33)
No Answer Provided	1 (6.67)
Recommendation 33: Avoid using Western standards for defining problems or goals. For example, families may feel too distant from members (such as children) and desire more closeness or “enmeshment”.	
Very Relevant	9 (60)
Somewhat Relevant	2 (13.33)
Somewhat Irrelevant	2 (13.33)
Not at all Relevant	1 (6.67)
No Answer Provided	1 (6.67)

Table 12 cont.

Recommendation 34: Use open-ended inquiry to engage in a discussion about the role of religion in the client's life. For example, use the question: "What does Islam mean to you?"	
Very Relevant	7 (46.67)
Somewhat Relevant	5 (33.33)
Somewhat Irrelevant	2 (13.33)
Not at all Relevant	0 (0)
No Answer Provided	1 (6.67)
Recommendation 35: Utilize Islamic principles and practices according to client's level of religiosity and belief in its efficacy.	
Very Relevant	8 (53.33)
Somewhat Relevant	4 (26.67)
Somewhat Irrelevant	1 (6.67)
Not at all Relevant	1 (6.67)
No Answer Provided	1 (6.67)
Recommendation 36: Identify and use phrases and language accepted in the local Islamic community in therapy.	
Very Relevant	5 (33.33)
Somewhat Relevant	6 (40)
Somewhat Irrelevant	3 (20)
Not at all Relevant	0 (0)
No Answer Provided	1 (6.67)
Recommendation 37: Encourage use of religious practices, such as prayer, fasting, and reading the Qur'an, which may be considered useful means for healing distress according to Islam.	
Very Relevant	5 (33.33)
Somewhat Relevant	8 (53.33)
Somewhat Irrelevant	0 (0)
Not at all Relevant	1 (6.67)
No Answer Provided	1 (6.67)
Recommendation 38: Incorporate Islamic beliefs to cognitive techniques, where unproductive beliefs are identified and then modified or replaced with beliefs derived from the Islamic principles.	
Very Relevant	3 (20)
Somewhat Relevant	9 (60)
Somewhat Irrelevant	1 (6.67)
Not at all Relevant	1 (6.67)
No Answer Provided	1 (6.67)
Recommendation 39: Have a Muslim service provider or community member make the first introduction to the client to build trust.	
Very Relevant	0 (0)
Somewhat Relevant	8 (53.33)
Somewhat Irrelevant	4 (26.67)
Not at all Relevant	2 (13.33)
No Answer Provided	1 (6.67)

Table 12 cont.

Recommendation 40: When faced with value conflicts, consult with an Imam, a religious leader, or a respected devout member of the local community.	
Very Relevant	5 (33.33)
Somewhat Relevant	7 (46.67)
Somewhat Irrelevant	2 (13.33)
Not at all Relevant	0 (0)
No Answer Provided	1 (6.67)

Table 13

Perceived Effectiveness of Recommendations

Recommendations	N (%)
Recommendation 1: Obtain and maintain knowledge about Muslims	
Very Effective	9 (60)
Somewhat Effective	5 (33.33)
Somewhat Ineffective	0 (0)
Not at all Effective	0 (0)
No Answer Provided	1 (6.67)
Recommendation 2: Elicit knowledge one does not know about the client's religion or culture from the client.	
Very Effective	9 (60)
Somewhat Effective	6 (40)
Somewhat Ineffective	0 (0)
Not at all Effective	0 (0)
No Answer Provided	0 (0)
Recommendation 3: Acknowledge one's limitations to the client about one's knowledge about Muslims.	
Very Effective	6 (40)
Somewhat Effective	6 (40)
Somewhat Ineffective	3 (20)
Not at all Effective	0 (0)
No Answer Provided	0 (0)
Recommendation 4: Use basic knowledge only as a starting point for engaging Muslim clients and recognize that there is considerable diversity in Muslim community.	
Very Effective	14 (93.33)
Somewhat Effective	1 (6.67)
Somewhat Ineffective	0 (0)
Not at all Effective	0 (0)
No Answer Provided	0 (0)
Recommendation 5: Avoid attempting to alter the religious beliefs, values, and practices of the client.	

Table 13 cont.

Very Effective	10 (66.67)
Somewhat Effective	4 (26.67)
Somewhat Ineffective	1 (6.67)
Not at all Effective	0 (0)
No Answer Provided	0 (0)
Recommendation 6: Be aware of and avoid imposing one's own values or judgments onto the client, such as using Western or ethnocentric values	
Very Effective	14 (93.33)
Somewhat Effective	1 (6.67)
Somewhat Ineffective	0 (0)
Not at all Effective	0 (00
No Answer Provided	0 (0)
Recommendation 7: Make building rapport an essential task using empathetic qualities such as genuineness, respect, support, and warmth, and pacing treatment according to client's comfort level.	
Very Effective	15 (100)
Somewhat Effective	0 (0)
Somewhat Ineffective	0 (0)
Not at all Effective	0 (0)
No Answer Provided	0 (0)
Recommendation 8: Provide information about the therapeutic process, including the functions of therapy and counseling, the issues for which therapy could be helpful, the procedures which clients should expect during sessions, the expected outcome of counseling, and the practical considerations such as session times and financial liability.	
Very Effective	9 (60)
Somewhat Effective	5 (33.33)
Somewhat Ineffective	0 (0)
Not at all Effective	0 (0)
No Answer Provided	1 (6.67)
Recommendation 9: Address clients' attitudes about seeking therapy and about their perceptions of stigma attached to therapy.	
Very Effective	7 (46.67)
Somewhat Effective	5 (33.33)
Somewhat Ineffective	1 (6.67)
Not at all Effective	0 (0)
No Answer Provided	2 (13.33)
Recommendation 10: Be aware of negative stereotypes about Islam and Muslims and provide a place for Muslim clients to discuss their experiences of prejudice and discrimination.	
Very Effective	11 (73.33)
Somewhat Effective	4 (26.67)
Somewhat Ineffective	0 (0)
Not at all Effective	0 (0)
No Answer Provided	0 (0)

Table 13 cont.

Recommendation 11: Examine your sources of information on Islam (i.e. the media, parents, friends) and how they affect your attitudes toward Muslims.	
Very Effective	8 (53.33)
Somewhat Effective	5 (33.33)
Somewhat Ineffective	0 (0)
Not at all Effective	0 (0)
No Answer Provided	2 (13.33)
Recommendation 12: Demonstrate one's expertise by informing clients about one's educational background, general knowledge of Muslim cultures, special training you might have had with respect to Muslims, and successful cases with Muslim clients.	
Very Effective	5 (33.33)
Somewhat Effective	5 (33.33)
Somewhat Ineffective	3 (20)
Not at all Effective	1 (6.67)
No Answer Provided	1 (6.67)
Recommendation 13: Be sensitive to first impressions clients may have of you based on your appearance, including professional dress, immodest clothes, cleanliness of your office, and organization of desk and room.	
Very Effective	3 (20)
Somewhat Effective	11 (73.33)
Somewhat Ineffective	0 (0)
Not at all Effective	0 (0)
No Answer Provided	1 (6.67)
Recommendation 14: Maintain a moderate balance of self-disclosure, where too little disclosure could be perceived as distant while too much disclosure may be perceived negatively as incompetence.	
Very Effective	3 (20)
Somewhat Effective	11 (73.33)
Somewhat Ineffective	0 (0)
Not at all Effective	0 (0)
No Answer Provided	1 (6.67)
Recommendation 15: Maintain a stance of being assertive and advisory (as it may be likely a Muslim client may take a more passive, non-confrontational stance, assigning a great deal of authority to the therapist and generally conforming to what is advised or prescribed).	
Very Effective	1 (6.67)
Somewhat Effective	6 (40)
Somewhat Ineffective	4 (26.67)
Not at all Effective	3 (20)
No Answer Provided	1 (6.67)
Recommendation 16: Be aware of gender preference for therapist selection, particularly for female Muslim clients.	
Very Effective	9 (60)
Somewhat Effective	3 (20)

Table 13 cont.

Somewhat Ineffective	2 (13.33)
Not at all Effective	0 (0)
No Answer Provided	1 (6.67)
Recommendation 17: Conduct a thorough assessment, including physical health, psychological state, social status of the client, spiritual condition, and religious inclinations and beliefs.	
Very Effective	12 (80)
Somewhat Effective	2 (13.33)
Somewhat Ineffective	0 (0)
Not at all Effective	0 (0)
No Answer Provided	1 (6.67)
Recommendation 18: Create a genogram of at least three generations to understand the family and their culture.	
Very Effective	6 (40)
Somewhat Effective	7 (46.67)
Somewhat Ineffective	1 (6.67)
Not at all Effective	0 (0)
No Answer Provided	1 (6.67)
Recommendation 19: Assess and address acculturation or immigration issues.	
Very Effective	12 (80)
Somewhat Effective	2 (13.33)
Somewhat Ineffective	0 (0)
Not at all Effective	0 (0)
No Answer Provided	1 (6.67)
Recommendation 20: Conduct an assessment of religious and cultural issues, such as client's level of religiosity, to determine the appropriateness of incorporating spiritual or religious techniques.	
Very Effective	9 (60)
Somewhat Effective	3 (20)
Somewhat Ineffective	1 (6.67)
Not at all Effective	1 (6.67)
No Answer Provided	1 (6.67)
Recommendation 21: Aim interventions to be practical, immediate, and attainable in contrast to interventions that focus on the historical development of the problem or is too abstract or philosophical in nature.	
Very Effective	5 (33.33)
Somewhat Effective	8 (53.33)
Somewhat Ineffective	1 (6.67)
Not at all Effective	0 (0)
No Answer Provided	1 (6.67)
Recommendation 22: Keep therapeutic goals congruent with the goals and values of the family in particular and their religious ideology in general.	
Very Effective	8 (53.33)
Somewhat Effective	2 (13.33)
Somewhat Ineffective	4 (26.67)

Table 13 cont.

Not at all Effective	0 (0)
No Answer Provided	1 (6.67)
Recommendation 23: Try to include elder members of the family as they are respected for their experience and wisdom	
Very Effective	0 (0)
Somewhat Effective	6 (40)
Somewhat Ineffective	6 (40)
Not at all Effective	1 (6.67)
No Answer Provided	1 (6.67)
Recommendation 24: Use interventions that maintain the unity of the family as well as emphasize the goals of the family unit above the goals of an individual member, especially if the goals are conflicting.	
Very Effective	0 (0)
Somewhat Effective	7 (46.67)
Somewhat Ineffective	6 (40)
Not at all Effective	1 (6.67)
No Answer Provided	1 (6.67)
Recommendation 25: Respect the valued covert and indirect communication style of Muslim clients and families, which avoids the confrontation and direct criticism associated more with open and direct communication.	
Very Effective	4 (26.67)
Somewhat Effective	6 (40)
Somewhat Ineffective	4 (26.67)
Not at all Effective	0 (0)
No Answer Provided	1 (6.67)
Recommendation 26: Respect the hierarchical structure of the Muslim family by understanding the power structure of the family, including the role of the father.	
Very Effective	4 (26.67)
Somewhat Effective	8 (53.33)
Somewhat Ineffective	2 (13.33)
Not at all Effective	0 (0)
No Answer Provided	1 (6.67)
Recommendation 27: Utilize interventions that emphasize education and advancement of children in the family to be aligned with the family's goals.	
Very Effective	2 (13.33)
Somewhat Effective	9 (60)
Somewhat Ineffective	3 (20)
Not at all Effective	0 (0)
No Answer Provided	1 (6.67)
Recommendation 28: Help clients explore and access resources within their own communities, such as Masjids (Mosques) or Muslim community centers.	
Very Effective	6 (40)
Somewhat Effective	7 (46.67)
Somewhat Ineffective	1 (6.67)

Table 13 cont.

Not at all Effective	0 (0)
No Answer Provided	1 (6.67)
Recommendation 29: Be careful of addressing couple related issues if the presenting problem is child-focused.	
Very Effective	2 (13.33)
Somewhat Effective	3 (20)
Somewhat Ineffective	5 (33.33)
Not at all Effective	2 (13.33)
No Answer Provided	3 (20)
Recommendation 30:Take time to understand the meaning of somatic symptoms, which may be a more common presenting problem than psychological distress.	
Very Effective	7 (46.67)
Somewhat Effective	6 (40)
Somewhat Ineffective	1 (6.67)
Not at all Effective	0 (0)
No Answer Provided	1 (6.67)
Recommendation 31: Avoid encouraging confrontation as it may be considered selfish and insulting to the family or community.	
Very Effective	3 (20)
Somewhat Effective	7 (46.67)
Somewhat Ineffective	2 (13.33)
Not at all Effective	2 (13.33)
No Answer Provided	1 (6.67)
Recommendation 32: Because Muslim clients may be unwilling or reluctant to confront the therapist directly, be aware that they may only conform to requests and treatment plans on a superficial level.	
Very Effective	4 (26.67)
Somewhat Effective	6 (40)
Somewhat Ineffective	1 (6.67)
Not at all Effective	1 (6.67)
No Answer Provided	3 (20)
Recommendation 33: Avoid using Western standards for defining problems or goals. For example, families may feel too distant from members (such as children) and desire more closeness or “enmeshment”.	
Very Effective	7 (46.67)
Somewhat Effective	5 (33.33)
Somewhat Ineffective	2 (13.33)
Not at all Effective	0 (0)
No Answer Provided	1 (6.67)
Recommendation 34: Use open-ended inquiry to engage in a discussion about the role of religion in the client's life. For example, use the question: “What does Islam mean to you?”	
Very Effective	6 (40)
Somewhat Effective	6 (40)

Table 13 cont.

Somewhat Ineffective	2 (13.33)
Not at all Effective	0 (0)
No Answer Provided	1 (6.67)
Recommendation 35: Utilize Islamic principles and practices according to client's level of religiosity and belief in its efficacy.	
Very Effective	8 (53.33)
Somewhat Effective	5 (33.33)
Somewhat Ineffective	0 (0)
Not at all Effective	0 (0)
No Answer Provided	1 (6.67)
Recommendation 36: Identify and use phrases and language accepted in the local Islamic community in therapy.	
Very Effective	6 (40)
Somewhat Effective	4 (26.67)
Somewhat Ineffective	3 (20)
Not at all Effective	0 (0)
No Answer Provided	1 (6.67)
Recommendation 37: Encourage use of religious practices, such as prayer, fasting, and reading the Qur'an, which may be considered useful means for healing distress according to Islam.	
Very Effective	3 (20)
Somewhat Effective	10 (66.67)
Somewhat Ineffective	0 (0)
Not at all Effective	1 (6.67)
No Answer Provided	1 (6.67)
Recommendation 38: Incorporate Islamic beliefs to cognitive techniques, where unproductive beliefs are identified and then modified or replaced with beliefs derived from the Islamic principles.	
Very Effective	3 (20)
Somewhat Effective	9 (60)
Somewhat Ineffective	1 (6.67)
Not at all Effective	1 (6.67)
No Answer Provided	1 (6.67)
Recommendation 39: Have a Muslim service provider or community member make the first introduction to the client to build trust.	
Very Effective	0 (0)
Somewhat Effective	8 (53.33)
Somewhat Ineffective	4 (26.67)
Not at all Effective	2 (13.33)
No Answer Provided	1 (6.67)
Recommendation 40: When faced with value conflicts, consult with an Imam, a religious leader, or a respected devout member of the local community.	
Very Effective	2 (13.33)
Somewhat Effective	11 (73.33)
Somewhat Ineffective	1 (6.67)

Table 13 cont.

Not at all Effective	0 (0)
No Answer Provided	1 (6.67)

Table 14

The Likelihood of Therapists Using Recommendations

Recommendations	N (%)
Recommendation 1: Obtain and maintain knowledge about Muslims	
Highly Likely to Use	11 (73.33)
Likely to Use	3 (20)
Unlikely to Use	0 (0)
Would Not Use	0 (0)
No Answer Provided	1 (6.67)
Recommendation 2: Elicit knowledge one does not know about the client's religion or culture from the client.	
Highly Likely to Use	7 (46.67)
Likely to Use	7 (46.67)
Unlikely to Use	0 (0)
Would Not Use	0 (0)
No Answer Provided	1(6.67)
Recommendation 3: Acknowledge one's limitations to the client about one's knowledge about Muslims.	
Highly Likely to Use	5 (33.33)
Likely to Use	7 (46.67)
Unlikely to Use	1 (6.67)
Would Not Use	2 (13.33)
No Answer Provided	0 (0)
Recommendation 4: Use basic knowledge only as a starting point for engaging Muslim clients and recognize that there is considerable diversity in Muslim community.	
Highly Likely to Use	12 (80)
Likely to Use	3 (20)
Unlikely to Use	0 (0)
Would Not Use	0 (0)
No Answer Provided	0 (0)
Recommendation 5: Avoid attempting to alter the religious beliefs, values, and practices of the client.	
Highly Likely to Use	12 (80)
Likely to Use	2 (13.33)
Unlikely to Use	1 (6.67)
Would Not Use	0 (0)
No Answer Provided	0 (0)
Recommendation 6: Be aware of and avoid imposing one's own values or judgments onto the client, such as using Western or ethnocentric values	

Table 14 cont.

Highly Likely to Use	14 (93.33)
Likely to Use	1 (6.67)
Unlikely to Use	0 (0)
Would Not Use	0 (0)
No Answer Provided	0 (0)
Recommendation 7: Make building rapport an essential task using empathetic qualities such as genuineness, respect, support, and warmth, and pacing treatment according to client's comfort level.	
Highly Likely to Use	15 (100)
Likely to Use	0 (0)
Unlikely to Use	0 (0)
Would Not Use	0 (0)
No Answer Provided	0 (0)
Recommendation 8: Provide information about the therapeutic process, including the functions of therapy and counseling, the issues for which therapy could be helpful, the procedures which clients should expect during sessions, the expected outcome of counseling, and the practical considerations such as session times and financial liability.	
Highly Likely to Use	10 (66.67)
Likely to Use	3 (20)
Unlikely to Use	1 (6.67)
Would Not Use	0 (0)
No Answer Provided	1 (6.67)
Recommendation 9: Address clients' attitudes about seeking therapy and about their perceptions of stigma attached to therapy.	
Highly Likely to Use	7 (46.67)
Likely to Use	6 (40)
Unlikely to Use	1 (6.67)
Would Not Use	0 (0)
No Answer Provided	1 (6.67)
Recommendation 10: Be aware of negative stereotypes about Islam and Muslims and provide a place for Muslim clients to discuss their experiences of prejudice and discrimination.	
Highly Likely to Use	9 (60)
Likely to Use	5 (33.33)
Unlikely to Use	0 (0)
Would Not Use	0 (0)
No Answer Provided	1 (6.67)
Recommendation 11: Examine your sources of information on Islam (i.e. the media, parents, friends) and how they affect your attitudes toward Muslims.	
Highly Likely to Use	7 (46.67)
Likely to Use	5 (33.33)
Unlikely to Use	1 (6.67)
Would Not Use	0 (0)
No Answer Provided	1 (6.67)

Table 14 cont.

Recommendation 12: Demonstrate one's expertise by informing clients about one's educational background, general knowledge of Muslim cultures, special training you might have had with respect to Muslims, and successful cases with Muslim clients.	
Highly Likely to Use	3 (20)
Likely to Use	5 (33.33)
Unlikely to Use	5 (33.33)
Would Not Use	1 (6.67)
No Answer Provided	1 (6.67)
Recommendation 13: Be sensitive to first impressions clients may have of you based on your appearance, including professional dress, immodest clothes, cleanliness of your office, and organization of desk and room.	
Highly Likely to Use	3 (20)
Likely to Use	10 (66.67)
Unlikely to Use	1 (6.67)
Would Not Use	0 (0)
No Answer Provided	1 (6.67)
Recommendation 14: Maintain a moderate balance of self-disclosure, where too little disclosure could be perceived as distant while too much disclosure may be perceived negatively as incompetence.	
Highly Likely to Use	4 (26.67)
Likely to Use	10 (66.67)
Unlikely to Use	0 (0)
Would Not Use	0 (0)
No Answer Provided	1 (6.67)
Recommendation 15: Maintain a stance of being assertive and advisory (as it may be likely a Muslim client may take a more passive, non-confrontational stance, assigning a great deal of authority to the therapist and generally conforming to what is advised or prescribed).	
Highly Likely to Use	1 (6.67)
Likely to Use	3 (20)
Unlikely to Use	6 (40)
Would Not Use	4 (26.67)
No Answer Provided	1 (6.67)
Recommendation 16: Be aware of gender preference for therapist selection, particularly for female Muslim clients.	
Highly Likely to Use	8 (53.33)
Likely to Use	3 (20)
Unlikely to Use	3 (20)
Would Not Use	0 (0)
No Answer Provided	1 (6.67)
Recommendation 17: Conduct a thorough assessment, including physical health, psychological state, social status of the client, spiritual condition, and religious inclinations and beliefs.	
Highly Likely to Use	10 (66.67)

Table 14 cont.

Likely to Use	4 (26.67)
Unlikely to Use	0 (0)
Would Not Use	0 (0)
No Answer Provided	1 (6.67)
Recommendation 18: Create a genogram of at least three generations to understand the family and their culture.	
Highly Likely to Use	3 (20)
Likely to Use	4 (26.67)
Unlikely to Use	7 (46.67)
Would Not Use	0 (0)
No Answer Provided	1 (6.67)
Recommendation 19: Assess and address acculturation or immigration issues.	
Highly Likely to Use	10 (66.67)
Likely to Use	4 (26.67)
Unlikely to Use	0 (0)
Would Not Use	0 (0)
No Answer Provided	1 (6.67)
Recommendation 20: Conduct an assessment of religious and cultural issues, such as client's level of religiosity, to determine the appropriateness of incorporating spiritual or religious techniques.	
Highly Likely to Use	8 (53.33)
Likely to Use	4 (26.67)
Unlikely to Use	1 (6.67)
Would Not Use	1 (6.67)
No Answer Provided	1 (6.67)
Recommendation 21: Aim interventions to be practical, immediate, and attainable in contrast to interventions that focus on the historical development of the problem or is too abstract or philosophical in nature.	
Highly Likely to Use	5 (33.33)
Likely to Use	7 (46.67)
Unlikely to Use	2 (13.33)
Would Not Use	0 (0)
No Answer Provided	1 (6.67)
Recommendation 22: Keep therapeutic goals congruent with the goals and values of the family in particular and their religious ideology in general.	
Highly Likely to Use	7 (46.67)
Likely to Use	4 (26.67)
Unlikely to Use	2 (13.33)
Would Not Use	1 (6.67)
No Answer Provided	1 (6.67)
Recommendation 23: Try to include elder members of the family as they are respected for their experience and wisdom	
Highly Likely to Use	0 (0)
Likely to Use	2 (13.33)

Table 14 cont.

Unlikely to Use	10 (66.67)
Would Not Use	2 (13.33)
No Answer Provided	1 (6.67)
Recommendation 24: Use interventions that maintain the unity of the family as well as emphasize the goals of the family unit above the goals of an individual member, especially if the goals are conflicting.	
Highly Likely to Use	0 (0)
Likely to Use	5 (33.33)
Unlikely to Use	7 (46.67)
Would Not Use	1 (6.67)
No Answer Provided	1 (6.67)
Recommendation 25: Respect the valued covert and indirect communication style of Muslim clients and families, which avoids the confrontation and direct criticism associated more with open and direct communication.	
Highly Likely to Use	4 (26.67)
Likely to Use	6 (40)
Unlikely to Use	4 (26.67)
Would Not Use	0 (0)
No Answer Provided	1 (6.67)
Recommendation 26: Respect the hierarchical structure of the Muslim family by understanding the power structure of the family, including the role of the father.	
Highly Likely to Use	1 (6.67)
Likely to Use	8 (53.33)
Unlikely to Use	4 (26.67)
Would Not Use	0 (0)
No Answer Provided	1 (6.67)
Recommendation 27: Utilize interventions that emphasize education and advancement of children in the family to be aligned with the family's goals.	
Highly Likely to Use	3 (20)
Likely to Use	6 (40)
Unlikely to Use	5 (33.33)
Would Not Use	0 (0)
No Answer Provided	1 (6.67)
Recommendation 28: Help clients explore and access resources within their own communities, such as Masjids (Mosques) or Muslim community centers.	
Highly Likely to Use	6 (40)
Likely to Use	7 (46.67)
Unlikely to Use	1 (6.67)
Would Not Use	0 (0)
No Answer Provided	1 (6.67)
Recommendation 29: Be careful of addressing couple related issues if the presenting problem is child-focused.	
Highly Likely to Use	2 (13.33)

Table 14 cont.

Likely to Use	2 (13.33)
Unlikely to Use	7 (46.67)
Would Not Use	1 (6.67)
No Answer Provided	3 (20)
Recommendation 30:Take time to understand the meaning of somatic symptoms, which may be a more common presenting problem than psychological distress.	
Highly Likely to Use	8 (53.33)
Likely to Use	4 (26.67)
Unlikely to Use	2 (13.33)
Would Not Use	0 (0)
No Answer Provided	1 (6.67)
Recommendation 31: Avoid encouraging confrontation as it may be considered selfish and insulting to the family or community.	
Highly Likely to Use	4 (26.67)
Likely to Use	3 (20)
Unlikely to Use	4 (26.67)
Would Not Use	3 (20)
No Answer Provided	1 (6.67)
Recommendation 32: Because Muslim clients may be unwilling or reluctant to confront the therapist directly, be aware that they may only conform to requests and treatment plans on a superficial level.	
Highly Likely to Use	4 (26.67)
Likely to Use	7 (46.67)
Unlikely to Use	1 (6.67)
Would Not Use	2 (13.33)
No Answer Provided	1 (6.67)
Recommendation 33: Avoid using Western standards for defining problems or goals. For example, families may feel too distant from members (such as children) and desire more closeness or "enmeshment".	
Highly Likely to Use	5 (33.33)
Likely to Use	5 (33.33)
Unlikely to Use	2 (13.33)
Would Not Use	0 (0)
No Answer Provided	2 (13.33)
Recommendation 34: Use open-ended inquiry to engage in a discussion about the role of religion in the client's life. For example, use the question: "What does Islam mean to you?"	
Highly Likely to Use	5 (33.33)
Likely to Use	6 (40)
Unlikely to Use	3 (20)
Would Not Use	0 (0)
No Answer Provided	1 (6.67)
Recommendation 35: Utilize Islamic principles and practices according to client's level of religiosity and belief in its efficacy.	

Table 14 cont.

Highly Likely to Use	6 (40)
Likely to Use	6 (40)
Unlikely to Use	1 (6.67)
Would Not Use	1 (6.67)
No Answer Provided	1 (6.67)
Recommendation 36: Identify and use phrases and language accepted in the local Islamic community in therapy.	
Highly Likely to Use	5 (33.33)
Likely to Use	6 (40)
Unlikely to Use	2 (13.33)
Would Not Use	1 (6.67)
No Answer Provided	1 (6.67)
Recommendation 37: Encourage use of religious practices, such as prayer, fasting, and reading the Qur'an, which may be considered useful means for healing distress according to Islam.	
Highly Likely to Use	3 (20)
Likely to Use	7 (46.67)
Unlikely to Use	3 (20)
Would Not Use	1 (6.67)
No Answer Provided	1 (6.67)
Recommendation 38: Incorporate Islamic beliefs to cognitive techniques, where unproductive beliefs are identified and then modified or replaced with beliefs derived from the Islamic principles.	
Highly Likely to Use	3 (20)
Likely to Use	9 (60)
Unlikely to Use	1 (6.67)
Would Not Use	1 (6.67)
No Answer Provided	1 (6.67)
Recommendation 39: Have a Muslim service provider or community member make the first introduction to the client to build trust.	
Highly Likely to Use	0 (0)
Likely to Use	2 (13.33)
Unlikely to Use	10 (66.67)
Would Not Use	2 (13.33)
No Answer Provided	1 (6.67)
Recommendation 40: When faced with value conflicts, consult with an Imam, a religious leader, or a respected devout member of the local community.	
Highly Likely to Use	3 (20)
Likely to Use	6 (40)
Unlikely to Use	4 (26.67)
Would Not Use	1 (6.67)
No Answer Provided	1 (6.67)

Table 15

Familiarity with Islamic Practices

Islamic Practice	N (%)
Salaat – The Five Daily Prayers	
Have Heard of this Practice	14 (93.33)
Have Not Heard of this Practice	0 (0)
No Answer Provided	1 (6.67)
Sa'um – Fasting	
Have Heard of this Practice	14 (93.33)
Have Not Heard of this Practice	0 (0)
No Answer Provided	1 (6.67)
Zakaat – Charity	
Have Heard of this Practice	14 (93.33)
Have Not Heard of this Practice	0 (0)
No Answer Provided	1 (6.67)
Du'ah – Supplication to God	
Have Heard of this Practice	13 (86.67)
Have Not Heard of this Practice	1 (6.67)
No Answer Provided	1 (6.67)
Reading the Qur'an	
Have Heard of this Practice	14 (93.33)
Have Not Heard of this Practice	0 (0)
No Answer Provided	1 (6.67)
Dhikr –Repeating Islamic Phrases Several Time in a Meditative Way	
Have Heard of this Practice	12 (80)
Have Not Heard of this Practice	2 (13.33)
No Answer Provided	1 (6.67)
Meditate on the 99 Names of Allah	
Have Heard of this Practice	11 (73.33)
Have Not Heard of this Practice	3 (20)
No Answer Provided	1 (1)
Hadiths – Customs and Advice from the Prophet Muhammad	
Have Heard of this Practice	14 (93.33)
Have Not Heard of this Practice	0 (0)
No Answer Provided	1 (6.67)
Tawbah – Process of Repentance	
Have Heard of this Practice	11 (73.33)
Have Not Heard of this Practice	3 (20)
No Answer Provided	1 (6.67)

Table 16

Likelihood of Therapists Recommending Islamic Practices

Islamic Practice	N (%)
Salaat – The Five Daily Prayers	
Would Recommend this Practice	11 (73.33)
Would Not Recommend this Practice	3 (20)
No Answer Provided	1 (6.67)
Sa'um – Fasting	
Would Recommend this Practice	7 (46.67)
Would Not Recommend this Practice	6 (40)
No Answer Provided	2 (13.33)
Zakaat – Charity	
Would Recommend this Practice	8 (53.33)
Would Not Recommend this Practice	5 (33.33)
No Answer Provided	2 (13.33)
Du'ah – Supplication to God	
Would Recommend this Practice	12 (80)
Would Not Recommend this Practice	2 (13.33)
No Answer Provided	1 (6.67)
Reading the Qur'an	
Would Recommend this Practice	11 (73.33)
Would Not Recommend this Practice	3 (20)
No Answer Provided	1 (6.67)
Dhikr –Repeating Islamic Phrases Several Time in a Meditative Way	
Would Recommend this Practice	8 (53.33)
Would Not Recommend this Practice	6 (40)
No Answer Provided	1 (6.67)
Meditate on the 99 Names of Allah	
Would Recommend this Practice	6 (40)
Would Not Recommend this Practice	6 (40)
No Answer Provided	3 (20)
Hadiths – Customs and Advice from the Prophet Muhammad	
Would Recommend this Practice	8 (53.33)
Would Not Recommend this Practice	4 (26.67)
No Answer Provided	3 (20)
Tawbah – Process of Repentance	
Would Recommend this Practice	7 (46.67)
Would Not Recommend this Practice	5 (33.33)
No Answer Provided	3 (20)

Table 17

Familiarity of Islamic Beliefs

Islamic Belief	N (%)
The belief that one must fully trust and rely on Allah (God), which can be used for feelings that one cannot cope anymore, that life is too difficult, or that no one is there for me.	
Have Heard of this Belief	14 (93.33)
Have Not Heard of this Belief	0 (0)
No Answer Provided	1 (6.67)
The belief that this life is only temporary and therefore, one must look forward to the next life, which can be used to counter hopelessness and feeling overwhelmed with life.	
Have Heard of this Belief	13 (86.67)
Have Not Heard of this Belief	1 (6.67)
No Answer Provided	1 (6.67)
Focusing on Hereafter or Afterlife, which can be used for those with significant worries and stress, those that find it difficult to focus, or tend to procrastinate.	
Have Heard of this Belief	13 (86.67)
Have Not Heard of this Belief	1 (6.67)
No Answer Provided	1 (6.67)
Viewing difficulties as a test from Allah, which can be used to remind clients that everyone is tested and it will expiate sins and increase rewards.	
Have Heard of this Belief	14 (93.33)
Have Not Heard of this Belief	0 (0)
No Answer Provided	1 (6.67)
Remembering that sins are forgiven and good deeds are increased during distress and afflictions, which can be used to counter negative thoughts such as “Why is this happening to me?” or “Am I being punished for my disobedience?”	
Have Heard of this Belief	12 (80)
Have Not Heard of this Belief	2 (13.33)
No Answer Provided	1 (6.67)
Understanding that “After Hardship there will be Ease.” This can be used for feelings of hopelessness & helplessness.	
Have Heard of this Belief	12 (80)
Have Not Heard of this Belief	2 (13.33)
No Answer Provided	1 (6.67)
Focusing on the Blessings of Allah, which can be used to relieve worries and distress.	
Have Heard of this Belief	14 (93.33)
Have Not Heard of this Belief	0 (0)
No Answer Provided	1 (6.67)
Remembering that Allah is compassionate and merciful, which can be used to relieve guilt and depression.	

Table 17 cont.

Have Heard of this Belief	13 (86.67)
Have Not Heard of this Belief	0 (0)
No Answer Provided	2 (13.33)

Table 18

Likelihood of Therapists Using Islamic Beliefs in Treatment

Islamic Belief	N (%)
The belief that one must fully trust and rely on Allah (God), which can be used for feelings that one cannot cope anymore, that life is too difficult, or that no one is there for me.	
Would Use this Belief in Treatment	11 (73.33)
Would Not Use this Belief in Treatment	2 (13.33)
No Answer Provided	2 (13.33)
The belief that this life is only temporary and therefore, one must look forward to the next life, which can be used to counter hopelessness and feeling overwhelmed with life.	
Would Use this Belief in Treatment	4 (26.67)
Would Not Use this Belief in Treatment	9 (60)
No Answer Provided	2 (13.33)
Focusing on Hereafter or Afterlife, which can be used for those with significant worries and stress, those that find it difficult to focus, or tend to procrastinate.	
Would Use this Belief in Treatment	2 (13.33)
Would Not Use this Belief in Treatment	11 (73.33)
No Answer Provided	2 (13.33)
Viewing difficulties as a test from Allah, which can be used to remind clients that everyone is tested and it will expiate sins and increase rewards.	
Would Use this Belief in Treatment	8 (53.33)
Would Not Use this Belief in Treatment	5 (33.33)
No Answer Provided	2 (13.33)
Remembering that your sins are forgiven and your good deeds are increased during distress and afflictions, which can be used to counter negative thoughts such as “Why is this happening to me?” or “Am I being punished for my disobedience?”	
Would Use this Belief in Treatment	7 (46.67)
Would Not Use this Belief in Treatment	6 (40)
No Answer Provided	2 (13.33)
Understanding that “After Hardship there will be Ease.” This can be used for feelings of hopelessness & helplessness.	
Would Use this Belief in Treatment	11 (73.33)
Would Not Use this Belief in Treatment	2 (13.33)
No Answer Provided	2 (13.33)

Table 18 cont.

Focusing on the Blessings of Allah, which can be used to relieve worries and distress.	
Would Use this Belief in Treatment	12 (80)
Would Not Use this Belief in Treatment	2 (13.33)
No Answer Provided	1 (6.67)
Remembering that Allah is compassionate and merciful, which can be used to relieve guilt and depression.	
Would Use this Belief in Treatment	11 (73.33)
Would Not Use this Belief in Treatment	1 (6.67)
No Answer Provided	3 (20)

Chapter V

Discussion

Based on these results, this exploratory study has indeed met its objective of uncovering information for working with Muslim clients from experienced therapists to contribute to the current psychology literature. Specifically, several overarching themes were found in this study. First, specialized knowledge was identified as key for treating Muslim clients. Second, therapists believed that building rapport was the most essential task in the therapy process. Third, it was revealed that the participants believed that including religion in therapy is valuable, particularly as a way to communicate to Muslim clients in their "language." Fourth, interviewees underscored the reality of how diverse Muslim clients are. In addition to discussion of these themes, the limitations of this study are described. Lastly, implications for therapists working with Muslim clients and for future research are considered.

Knowledge is the Key

All of the therapists interviewed stated that knowledge is the key for working with Muslim clients. They emphasized the importance of being familiar with the religion and multiple cultures of Muslim clients. This served several main purposes. They discussed that demonstrating this knowledge to Muslim clients will allow them to feel understood, appreciated, and respected. Furthermore, when therapists are informed, they are less likely to make assumptions about their clients and less likely to be judgmental. The majority of participants noted the detrimental effects assumptions can have on the client and treatment process. This may range from ruining the therapeutic alliance to

misdiagnosing clients. Most importantly, knowledge will allow clinicians to provide the best treatment for their clients, which is the ultimate purpose of the profession.

This finding that knowledge is important for working with Muslim clients is consistent with the literature (Abu-Raiya & Pargament, 2010; Ahmed & Amer, 2012; Ali et al., 2004; Daneshpour, 1998; Carolan et al., 2000; Graham et al., 2008, 2009; Hamdan, 2007; Hedayat-Diba, 2000; Hodge & Nadir, 2008; Keshavarzi & Haque, 2013; Kobeisy, 2004; Springer et al., 2009; Williams, 2005). The participants of this study concurred with these authors on why knowledge is important. For example, Amer and Bagasra (2013) and Ali et al. (2004) highlighted the role negative stereotypes have in this current political climate and therefore, that they may impact therapy. On one hand, therapists may hold these judgments of Islam and Muslims. On the other hand, Muslims may assume that therapists have these negative assumptions about them and be hesitant to come to treatment. Therefore, it becomes the therapist's responsibility to first engage in self-education and then, demonstrate this knowledge to their clients to allay their fears.

Results from both the open-ended interview and the self-report survey noted the criticalness of knowing and respecting the possible value differences between the therapist and Muslim clients. The literature emphasized this point as well (Abu-Raiya & Pargament, 2010; Hamdan, 2007; Hodge & Nadir, 2008; Kelly et al., 1996; Kobeisy, 2004). Hodge and Nadir (2008) discussed the differences between the Muslim value system and the Western value system. Participants in the study noted that many Muslim clients enter treatment with family and intergenerational conflicts as well as struggles to define the self. In considering the appropriate interventions, knowledge of the values important to clients will be critical as it may contrast from Western values, such as the

value of independence or separation-individuation. Participants also echoed the literature about being respectful of the possible implications of decisions Muslim clients may contemplate, such as coming out as homosexual or getting a divorce (Kobeisy, 2004). Contrastingly, the participants also discussed the importance of knowing what true Islamic values are to counter misconceptions of clients, especially in the case of domestic violence. Assuming that the religion or culture condones an unacceptable behavior can be destructive to clients' well-being. Consequently, knowledge is the key for working Muslim clients.

Building Rapport: "The Bottom Line"

The majority of participants emphasized the importance of building rapport with Muslim clients. In fact, on the self-report survey, it was the only recommendation listed that was endorsed as very relevant, very effective, and most likely to be used by all participants. Therapists recognized how difficult it may be for Muslim clients to seek help from a stranger, the stigma attached to coming to therapy, and the vulnerability of admitting there is a problem. One clinician stated that understanding the client was "the bottom line" above all else. His response concurred with other participants' recommendation that focusing on the rapport was the most important therapeutic task. Thus, they provided numerous ways for building rapport with Muslim clients. These findings reflected what is recommended in the literature (Carolan et al., 2000; Daneshpour, 1998; Graham et al., 2008; Keshavarzi & Haque, 2013; Kobeisy, 2004; Springer et al., 2009).

Specifically, the techniques offered by the respondents were similar to Kobeisy's (2004) suggestions in his book, *Counseling American Muslims: Understanding the Faith*

and Helping the People, where he explained the importance of being non-judgmental, explaining the process of therapy and having a moderate level of disclosure. Providing psychoeducation about therapy to Muslim clients was found to have the highest percentage of respondents identifying it as a means for building rapport. Because therapy is often a new experience for Muslim clients, it was found to be helpful to assure them of confidentiality and to explain how therapy will proceed. This sets the basis for developing a safe, trusting, and supportive relationship. Furthermore, therapists discussed the importance of respecting the client's religion, normalizing the experience, being empathic and validating, and conveying openness to learning. Interestingly, these recommendations for building rapport are similar to the ways therapists generally build rapport with all clients. However, both the participants of this study and the literature stressed that therapists should pay extra special attention to the therapeutic alliance with these clients, particularly to avoid premature termination (Carolan et al., 2000; Keshavarzi & Haque, 2013). Both the respondents and the literature stated the importance of being more disclosing as a therapist to build closeness in the relationship, which is a notable distinction from general therapeutic practices.

Beyond the stigma of coming to therapy, one important consideration is the possible presentation style of Muslim clients. It was noted by participants that Muslims may treat the therapist as family. Additionally, according to the literature and respondents, Muslims tend to seek help first from family members, friends, and religious leaders before coming to therapy. If viewed from the Muslim client's perspective, it may be hypothesized that they would like to feel close to the therapist, which will help them feel safe to disclose their difficulties. This perspective thus highlights the vital function of

building a strong therapeutic alliance. However, therapists in this study also stated that it was important to clarify the role of the therapist and maintain boundaries, which becomes a delicate balance. It is noteworthy that this unique presentation should not be viewed as defective or abnormal. Instead, it is helpful to view this presentation style as the Muslim client's way to connect and make sense of this new experience of seeking help. As one participant highlighted, clients may appear passive but are being respectful and honoring the other person. It seems then that it is the therapist's duty to help clients acclimate to the process of therapy in a way that honors their style balanced with what is known to help clients (such as maintaining boundaries).

Discussing Religion: Using their Language

Most of the interviewees stated that it was helpful to include religion in therapy, especially if it was important to the client. This was reiterated in the responses of the self-report survey. Therapists believed that discussing religion in therapy for religiously identified clients was powerful. They noted that it was useful for connecting to Muslim clients, providing ways to cope, challenging unhelpful beliefs, and understanding their worldview better. These findings were consistent with the literature (Abu-Raiya and Pargament, 2011; Ahmed & Amer, 2012; Ahmed & Reddy, 2007; Al-Krenawi & Graham, 2000; Ali et al., 2004; Azhar et al., 1994, 1995a, 1995b; Carolan et al., 2000; Daneshpour, 1998; Graham et al., 2008; Hamdan, 2007, 2008; Hodge & Nadir, 2008; Johansen, 2005; Keshavarzi & Haque, 2013; Kobeisy, 2004; Rezali et al., 1998, 2002; Springer et al., 2009; Williams, 2005).

Azhar et al. (1994, 1995a, 1995b) conducted several randomized controlled trials in Malaysia comparing standard treatment (CBT plus medication) with religiously

enhanced treatment. They found greater improvement in the religious enhanced treatment in the short-term but those differences evened out by the end of the study. These studies as well as responses from the interview suggest that incorporating religion into the therapy process for religious Muslim clients appears to help build rapport, increase engagement and investment in treatment, and support positive changes in clients. However, both in the literature and this study, therapists relied on their treatment approach for leading the change process, such as using CBT techniques or family therapy.

Therefore, it seems that discussing religion in therapy is a way to use the client's "language" in the process. For religiously identified Muslim clients, it helps to translate the therapy process into a form they can understand and resonate with because religion is valued by them. Their worldview is shaped by their religion, their culture and their upbringing. Thus, their conceptualization of their problem as well as the way it should be treated is also influenced by this worldview. Integrating phrases, beliefs, practices, and stories from the Islamic tradition into therapy may allow religiously identified clients to feel that the therapist understands them, respects them, and values their view of the problem, as noted by the participants of this study. For example, both the literature and respondents in this study cited instances where they incorporated Islamic beliefs to challenge cognitive distortions or recommended prayer as a form of meditation and stress relief. Both of those psychological interventions could have been done effectively without incorporating religion. However, it was found to be helpful for Muslim clients who value religion because it was translated to the "language" they understood.

Accordingly, discussing religion in the treatment process becomes an important therapeutic tool.

Complexity of Muslims Clients

The majority of participants in the study emphasized the extensive differences within the Muslim population. This was also reflected in the self-report survey, in which therapists endorsed that knowledge is only a starting point for understanding Muslim clients, given the diversity. In the literature, many authors raised this point (Abu-Raiya & Pargament, 2011; Ahmed & Amer, 2012; Amer & Bagasra, 2013; Carolan et al., 2000; Daneshpour, 1998; Graham et al., 2009; Hedayat-Diba, 2000; Hodge, 2005; Hodge & Nadir, 2008; Khan, 2006; Keshavarzi & Haque, 2013; Kobeisy, 2006; Williams, 2005). The reality is that Muslims can vary on a number of factors, including but not limited to sect of Islam, level of religiosity, race, ethnicity, culture, country of origin, immigration history, acculturation level, age, gender, socioeconomic status, education, family history, and personal values (Springer et al., 2009). Therefore, it is impossible and imprudent to generalize from the literature and this study to a specific client. It is particularly harmful to hold assumptions about Muslim clients based on broad generalizations.

On this point, the literature and the therapists in the study recommended conducting a thorough assessment at the beginning of treatment, which considers all of the above factors. It may also be wise to continually monitor and assess clients on these attributes throughout treatment. Regarding religiosity, participants provided several ways to discern the appropriateness of integrating religion in therapy, particularly developing an understanding of the role and meaning religion plays in the client's life. Both the literature and study findings stress the significance of only discussing religion in therapy

if it is important to the client. As noted above, it can be used as a common language if it is valued by the client.

Correspondingly, participants suggested that therapists working with Muslim clients view them from multiple levels. For example, clinicians may consider the uniqueness of the individual, the influence of the family, the impact of culture and religion, and the effect of the sociopolitical culture. Other participants noted the value of viewing the knowledge on Muslim clients as possible considerations that therapists should be aware of when working with this population, rather than strict "Do's" and "Don'ts." The idea is reflected in the literature as well (Hamdan, 2008). It may be helpful to envision the therapeutic process as viewing the client from the different lens of a telescope. There may be times it is useful to zoom in and notice the unique features of the client (like the rings of Saturn). Other times, it is helpful to zoom out a little to notice the immediate circumstances or stressors in the client's life (such as noticing the moons orbiting Saturn). Then, it may useful to understand the systems to which the person belongs, like their family system or their peer group (similar to understanding our solar system of which Saturn is a part of). Once in a while, it is helpful to understand the larger picture of the person, including their religion, their culture, and the socio-political history (similar to looking out onto other solar systems or the universe as a whole). However, ultimately, our goal is to help the person and so we focus on individual while considering all the other levels that impact the client. In sum, with Muslim clients, it is important to understand all the factors that may influence their lives and use what will help treatment the most.

Limitations

There are several important limitations to this study. First, due to the low sample size, the findings of this study cannot be generalized to all therapists of Muslim clients. Relatedly, the sample was recruited using a networking sample, which may have led to selection bias. In particular, there are a high number of Muslim therapists in the study, which may have affected the responses. Therefore, the recommendations may not be appropriate for all therapists or for all treatment approaches. Similarly, the sample size of the survey results is also small and results cannot be generalized. Furthermore, as noted above, it is important to consider the differences within the Muslim population when working with individual clients. Also, the interviews were all conducted by the principal investigator, which may lead to researcher bias. Specifically, there was a presupposition that working with Muslim clients required specialized knowledge and techniques.

However, there are advantages of the qualitative research design. Information gathered from participants is detailed and provides rich descriptions of what the therapists are doing in their sessions with Muslim clients. For example, it provided specific examples on how therapists include religion in therapy, assess religiosity, and build rapport. Also, it allowed for information to be spontaneously discovered through the open-ended questions, which provided recommendations beyond was what specifically asked and opened up numerous possibilities for future research studies.

Implications for Therapists Working with Muslim Clients

This study found several important themes that are relevant to therapists working with Muslim clients. It is imperative to obtain knowledge regarding Muslim clients, including on their religion, their cultures, and their values. This was highlighted to be

significant to dispel negative assumptions and stereotypes of Muslim clients, which may be more prominent given the current sociopolitical climate. Accordingly, demonstrating this knowledge to Muslim clients will be important to building rapport and helping them to feel respected, understood, and appreciated. Concurrently, rapport building was found to be an essential task in therapy for Muslim clients. Therapists are advised to devote time and energy to helping clients feel safe to disclose their difficulties, given the stigma of seeking help. Additionally, in attempting to acclimate to the therapeutic process, Muslim clients may believe that closeness is required for disclosure (and may treat the therapist as family). Moreover, it may be helpful for religiously identified Muslim clients to discuss religion as a way of speaking a common "language" and considering their worldview. Specifically, religious knowledge and practices can be used as therapeutic tools to enhance established psychological interventions. Last but not least, it is strongly recommended that clinicians are aware of the diversity within the Muslim population. It seems that therapists must maintain a delicate balance of acknowledging the unique factors of Muslim clients while appreciating the universality of all clients they treat.

Implications for Future Research

There are several important considerations for future research. First, given the limitations of this study, it would be imperative to research this area with a larger sample size with the power to generalize more readily. In particular, it would be valuable to examine how therapists who are not Muslim or from a culture with Islamic influences would work with Muslim clients. Additionally, this exploratory study focused on the therapist's perspective. It would be critical to research these topics from the point of view of Muslims in the general population as well as Muslim clients. From the general Muslim

population, it will be helpful to have further information on the complex relationship between culture and religion as well as to understand their views on therapy and the barriers to seeking mental health services, especially because both the literature and study participants noted that Muslim face psychological problems similar to the population as a whole. It will also be valuable to understand from the Muslim client's perspective what really helps to build rapport and whether including religion in therapy is important, given that most of the research is derived from a therapist's view point. For example, Yalom's classic book, *Every Day Gets a Little Closer* (1974) which was co-written with his client Ms. Elkin, demonstrated the wide divergence between the therapist's experience and the client's experience. Therefore, our knowledge will remain incomplete without studying Muslim clients' perspectives.

Another interesting area that was not directly examined but may be important is the role of gender factors in working with Muslim clients. For example, it was found on the survey that preference for same gender therapists may be important, with 80% of participants reporting that it was very relevant, 60% noted it was very effective, and 53.33% noted it was highly likely to be used. The literature has also noted gender differences in expression of spirituality (Ghaffari &Çiftçi, 2010), which may affect how therapists integrate religious discussions and practices into treatment. There may be also be gender differences in the likelihood of seeking therapy, ways of building rapport and how they resolve family conflict. It may also be helpful to outline specific practices that may offend Muslim clients (such as shaking hands or being alone in a room with the opposite gender).

Additionally, it may be useful to explore the modern ways Muslim clients, particularly younger generations, find support and comfort. Though some therapists recommended seeking guidance from Imams, it was found in a study surveying Muslims in the community that 45.5 percent of respondents never seek comfort from a religious leader (Khan, 2006). Given the popularity of the internet, Muslim clients may seek information online. For example, some Muslims may view videos on YouTube on religious topics from progressive Muslim speakers, like Yasmin Mogahed or Imam Khalid Latif. These speakers are known to discuss psychological topics from a spiritual perspective. This may be a resource for therapists, who have clients that are uncomfortable going to an Imam but are looking for spiritual guidance. Additionally, Muslim clients may receive support from online groups, such as on Facebook. Further research would be helpful in identifying these alternative resources for Muslim clients.

Conclusion

This dissertation aimed to discern the important considerations for working with Muslim clients. There is a dearth of information in this area, particularly research studies on therapists' practices with Muslim clients. In this exploratory study, fifteen experienced therapists were interviewed. In addition to looking for general themes, there were two areas identified by the current literature that were critical to study: building rapport and discussing religion in therapy. Participants were also surveyed on their opinion regarding 40 recommendations found in the literature as well as the common Islamic practices and beliefs. The qualitative results were analyzed through the Grounded Theory Methodology.

There were several important themes discovered in the open-ended interviews. Therapists first provided general information about the Muslim clients they treated. Muslim clients entered therapy with both common psychological problems and unique concerns, including a higher level of intergenerational conflict. Participants also noted the stigma attached to coming to treatment for their Muslim clients, including hiding it from their families and communities. The main misconceptions some Muslim clients have had were described. Next, there were several major themes found. All the participants agreed that knowledge was the key for working with Muslim clients. It was also found that assumptions held about Muslim clients can negatively affect the therapeutic alliance and treatment progress. Rapport building was emphasized as the essential task in therapy. Specifically, it was found that providing psychoeducation about therapy, respecting the client's religion, normalizing the experience, being empathic and validating, conveying openness to learning and being less formal and more disclosing were the important ways to build rapport. Additionally, it was found that inclusion of religion in therapy was believed to be beneficial, particularly as a way to create a common "language" between therapist and client as well as a way to further understand their worldview. Participants also noted the importance of family for Muslim clients, which may result in more family conflicts as clients attempt to balance their individual wishes and the wishes of their family. Moreover, it was found that the community may be a source of support for Muslim clients, especially if the Imam is known to be open and responsive.

These results were echoed by the self-report survey, which found the recommendations from the literature regarding rapport building, acknowledging the diversity of Muslim clients, and respecting Muslim clients' values to be very relevant,

very effective, and highly likely to be used by therapists. There were several recommendations that were considered less useful by respondents, including taking on an advisory role as therapist. It was also found that the majority of therapists were familiar with common Islamic beliefs and practices. They listed several of them that they would integrate into treatment if it enhanced the process, including supplication to God, the five daily prayers, reading the Qur'an, remember that "After hardship comes ease," and focusing on the blessings and mercifulness of God. Participants were less likely to use beliefs that focused on the temporary nature of life or the Afterlife. In sum, the survey provided the opinions of therapists on the recommendations in the literature and which ones they would utilize.

Overall, the findings of this study provide important implications for therapists who are working with Muslim clients. It is advised that therapists try to be knowledgeable on Muslim clients while acknowledging the diversity within the Muslim population. Because of the stigma and presentation style of Muslim clients, building rapport is the most essential therapeutic task. Discussing religion in therapy allows the therapist to speak in a "language" that may resonate with their worldview and values. Ultimately, the goal is to help these clients and maintain the delicate balance between considering the unique factors of working with Muslim clients and respecting the universality of all clients. Future research would be greatly improved by studying these areas from the perspective of Muslim clients.

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Appendix A

Consent Forms

Consent for Participation in a Research Study

Title of Study: An Exploratory Study on Therapists' Practices with Muslim Clients: Rapport Building and Discussing Religion in Therapy

Principal Investigator: Zaynab Khan, Psy.M.

INVITATION TO PARTICIPATE:
You are invited to participate in research that is being conducted by Zaynab Khan, Psy.M., who is an advanced doctoral candidate in the Clinical Psychology Psy.D. Program at the Graduate School of Applied and Professional Psychology (GSAPP) at Rutgers University. This consent form contains information about the study that the Principal Investigator will go over with you. **Before you agree to participate in this study, you should know enough about it to make an informed decision. If you have any questions, ask the investigator. You should be satisfied with the answers before you agree to be in the study.**

PURPOSE:
The purpose of the study is to explore what the important considerations are when working with Muslim clients in therapy from the perspective of experienced therapists. This includes what practices are used with Muslim clients to engage them in treatment. The current treatment literature on Muslim clients offers a number of recommendations for service providers. This study will examine these recommendations. It will also explore whether discussing religious beliefs and practices may be beneficial as well as what Islamic beliefs and traditions are known by therapists. In the future, this information will be used to provide knowledge for therapists treating Muslim clients and provide direction for future research on this understudied population. Approximately ten to twenty individuals will participate in this study.

SUBJECT SELECTION:
You must be an adult between the ages of 18 and 80 to participate in this study. You must be a service provider, such as a therapist, social worker, psychologist, counselor, psychiatrist, or advanced graduate student clinician. In addition, you must have treated at least two adult clients (from any ethnic or cultural background) who openly identify as Muslim. Each client must have been seen for at least five therapy sessions. If you do not have this experience, you will not be eligible to participate in the study.

PROCEDURES:
Your participation in this study will last for approximately two to two and half hours. Study procedures are as follows:

1. The investigator will ask you several questions about yourself and your experience with clients, such as your treatment approach, how many clients you have seen, and how many Muslim clients you have seen.

2. You will then participate in an interview, where the investigator will ask you open-ended questions about your professional opinion on what is helpful for working with Muslim clients, what recommendations you would provide, and your view on whether discussing religion can be beneficial.

3. At the end of the interview, you will be given a self-report survey to complete. The survey is the *Assessment of Therapists' Practices with Muslim Clients*, which asks you to rate recommendations obtained from the literature on several dimensions. It will also ask whether you know common Islamic beliefs and practices.

Interviews will be audio-taped to contribute to the authenticity of the study. Interviews will be transcribed and tapes will be destroyed after the transcription. Any tape recordings, transcripts of interviews, or other data collected from you will be maintained in confidence by the investigator in a locked file cabinet and destroyed three years after the end of the study.

BENEFITS:

There is no direct benefit from participating in this study. However, it may provide you with an opportunity to examine your therapeutic work with Muslim clients and clients in general and possibly enhance your treatment approach by increasing your use of techniques you may recommend or trying new techniques you discovered while discussing your therapeutic work. In addition, your participation will provide valuable knowledge to the treatment of Muslim clients, which may be utilized by other therapists, as well as provide direction for future research with this understudied population.

RISK:

The risk in participating in this study is minimal. However, there is a possibility that you may have an unexpected reaction to the interview and may question whether you are providing the best treatment to your clients. If this occurs, the investigator will end the interview if you wish. If you would like, an appropriate referral for therapy will be given to you upon request.

COMPENSATION:

There is no compensation to you for participating in this study.

COST:

There is no cost to you for participating in this study.

ALTERNATIVES:

There is no alternative for this study. You may not participate if you choose.

CONFIDENTIALITY:

This research is confidential. Confidential means that the research records will include some information about you, such as your professional title, type of employers, ethnicity,

or religion. The research records will include some information about you and this information will be stored in such a manner that some linkage between your identity and the response in the research exists. The investigator will keep this information confidential by limiting access to the research data and keeping it in locked filing cabinet in a secure location. In addition, you will be given an identification code and a pseudonym, in which only the researcher will have access to the code key. The research team and the Institutional Review Board at Rutgers University are the only parties that will be allowed to see the data, except as may be required by law. If a report of this study is published, or the results are presented at a professional conference, only group results will be stated or your information will be disguised to not have any identifiable information. Dissertation, including results, will be available upon request.

WITHDRAWAL:
Participation in this study is voluntary. You may withdraw from the study at any time, and you may refuse to answer any questions that you are not comfortable with. *If you decide not to participate, or if you decide later to stop participating, all data collected will be destroyed and there will be no penalty in any way.*

RESEARCH QUESTIONS:
If you have any questions about the study, you may contact the principal investigator or the investigator's dissertation chairperson at any time at the addresses, telephone numbers or emails listed below:

Zaynab Khan, Psy.M. (Investigator)
Rutgers University
GSAPP
152 Frelinghuysen Rd
Piscataway, NJ 08854-8085
Email: zaynab.khan@yahoo.com

Brenna H. Bry, Ph.D. (Chairperson)
Rutgers University
GSAPP
152 Frelinghuysen Rd
Piscataway, NJ 08854-8085
Email: bbry@rci.rutgers.edu

SUBJECT RIGHTS:
If you have any questions about your rights as a research subject, you may contact the IRB Administrator at Rutgers University at:

Rutgers University Institutional Review Board for the Protection of Human Subjects
Office of Research and Sponsored Programs
ASB III, 3 Rutgers Plaza
New Brunswick, NJ 08901-8559
Email: humansubjects@orsp.rutgers.edu

****

You have been given the opportunity to ask questions and have them answered. By signing below, you agree to participate in this research study.

_____
Subject Name (Print)

_____ _____
Signature of Subject Date

_____ _____
Signature of Investigator Date

Title of Study: An Exploratory Study on Therapists' Practices with Muslim Clients: Rapport Building and Discussing Religion in Therapy
Principal Investigator: Zaynab Khan, Psy.M.

Audiotape Addendum to Consent Form

You have already agreed to participate in a research study entitled: "An Exploratory Study on Therapists' Practices with Muslim Clients: Rapport Building and Discussing Religion in Therapy" conducted by Zaynab Khan, Psy.M. We are asking for your permission to allow us to audiotape the interview as part of that research study. You do not have to agree to be recorded in order to participate in the main part of the study.

The recording(s) will be transcribed to ensure authenticity of your responses, which is important for data analysis. This analysis includes reviewing the transcripts to discover common themes, similarities, and differences across all subjects.

The recording(s) will include some information about you, such as your professional title, type of employers, ethnicity, or religion. It will not include your name. Instead, you will be given an identification code and a pseudonym, in which only the researcher will have access to the code in a password secured database. The investigator will keep this information confidential by limiting access to the research data. The recordings will be stored on password protected laptop and the transcriptions will be stored in locked filing cabinet in a secure location. This information will be permanently erased and destroyed three years after the study ends.

Your signature on this form grants the investigator named above permission to record you as described above during participation in the above-referenced study. The investigator will not use the recording(s) for any other reason than that stated in the consent form without your written permission.

Subject Name (Print)_____

Subject Signature _____ Date _____

Principal Investigator Signature _____ Date _____

Appendix B

Email advertisement

Dear Participant,

Thank you for taking time to read this email. My name is Zaynab Khan and I am an advanced doctoral student in the Clinical Psy.D. Program at the Graduate School of Applied and Professional Psychology (GSAPP) at Rutgers University. I am currently looking for therapists who have experience working with Muslim clients to participate in an interview.

This study aims at exploring what are the important considerations when working with Muslim clients in therapy from the perspective of experienced therapists. This study will also examine the current recommendations found in the literature. In the future, this information will be used to provide knowledge for therapists treating Muslim clients as well as provide direction for future research on this understudied population.

If you have worked with at least two adult clients who openly identify as Muslim (from any ethnic or cultural background) for at least five therapy sessions each and you are interested in participating in an interview, please contact me at zaynab.khan@yahoo.com.

I would greatly appreciate your help in learning more about treating Muslim clients. Thank you for your time and consideration.

Sincerely,

Zaynab Khan, Psy.M.

This was approved by the Rutgers University Institutional Review Board for the protection of human subjects on November 23, 2010; approval of this expires on November 22, 2011.

Appendix C

Interview Protocol

Basic Information

1. What is your professional title?
2. What settings do you work in?
3. Approximately how many clients have you seen?
4. What are the cultures, racial or ethnic groups that your clients identify with?
5. What religions do your clients identify?
6. How many Muslim clients have you seen for at least five sessions?
7. With what cultures, racial or ethnic groups do they identify?
8. How did you know your clients were Muslim? Self-disclosed? Asked based on your guess?
9. What is your gender, ethnicity or race, religion, level of religiosity?
10. What is your theoretical orientation or treatment approach?

Open-ended Questions

11. What problems do your Muslim clients bring to treatment? Have you noticed any unique ways they present in treatment?
12. In working with Muslim clients, what have you found to be important for treatment?
13. What have you found to be important to build rapport with your Muslim clients?
14. How do you explain the process of therapy to your Muslim clients?
15. Have you noticed any assumptions or misconceptions about therapy that your Muslim clients have?

16. What treatment approach do you believe is best for working with Muslim clients?
17. What role does the family play in treatment? What role does the community play in treatment?
18. Do you think considering religious beliefs or using religious practices into treatment could be helpful? If so, how?
19. How do you assess the level of religiosity or appropriateness of including religion in therapy?
20. How do you incorporate religious beliefs or practices into therapy with your Muslim clients?
21. Under what circumstances, do you think it would be beneficial to incorporate religion into treatment? When would you be less likely to use religion in therapy?
22. How comfortable do you feel incorporating religion in therapy?
23. Where does your information for working with Muslim clients come from?
24. What recommendations would give for treating with Muslim clients?
25. Is there anything else that you would like to add that I did not ask about?

Appendix D

Assessment of Therapist's Practices with Muslim Clients

Subject Id:_____ **Date: _____**

Part I:

Please choose the response that best reflects your professional opinion:

Overall, how competent do you feel you are to treat Muslim clients?

□*Very Competent* □*Somewhat Competent* □*Somewhat incompetent* □*Not Competent*

Do you believe it is necessary to adjust your theoretical approach when working with Muslim clients?

□*Yes* □*No*

Do you think including spiritual or religious issues into therapy is important?

□*Very Important* □*Somewhat Important* □*Somewhat Not Important* □*Not Important*

How important, in your experience, is including religious beliefs and practices into therapy for Muslim clients?

□*Very Important* □*Somewhat Important* □*Somewhat Not Important* □*Not Important*

Whose responsibility is it to bring up religion in treatment?

□*Client's* □ *Therapist's*

Please feel free to further expand on any of the above questions:

Part II:

There are several recommendations found in the literature for treating Muslims clients. Please evaluate each recommendation below based on your professional opinion on these dimensions:

- How relevant do you find the recommendation in terms of your treatment approach with Muslim clients?
- How effective do you perceive the recommendation to be in working with Muslim clients?
- How likely would you be to use the recommendation in your treatment with Muslim clients?

Recommendation 1: Obtain and maintain knowledge about Muslims

Is this recommendation relevant to your treatment approach with Muslim clients?
□*Very Relevant* □*Somewhat Relevant* □*Somewhat Irrelevant* □*Not Relevant*

Would this recommendation in your opinion be effective for working Muslim clients?
□*Very Effective* □*Somewhat Effective* □*Somewhat Ineffective* □*Not Effective*

How likely would you use this recommendation in treatment with your Muslim clients?
□*Highly likely to use* □*Likely to use* □*Unlikely to use* □*Would not use*

Recommendation 2: Elicit knowledge one does not know about the client's religion or culture from the client.

Is this recommendation relevant to your treatment approach with Muslim clients?
□*Very Relevant* □*Somewhat Relevant* □*Somewhat Irrelevant* □*Not Relevant*

Would this recommendation in your opinion be effective for working Muslim clients?
□*Very Effective* □*Somewhat Effective* □*Somewhat Ineffective* □*Not Effective*

How likely would you use this recommendation in treatment with your Muslim clients?
□*Highly likely to use* □*Likely to use* □*Unlikely to use* □*Would not use*

Recommendation 3: Acknowledge one's limitations to the client about one's knowledge about Muslims.

Is this recommendation relevant to your treatment approach with Muslim clients?
□*Very Relevant* □*Somewhat Relevant* □*Somewhat Irrelevant* □*Not Relevant*

Would this recommendation in your opinion be effective for working Muslim clients?
□*Very Effective* □*Somewhat Effective* □*Somewhat Ineffective* □*Not Effective*
How likely would you use this recommendation in treatment with your Muslim clients?
□*Highly likely to use* □*Likely to use* □*Unlikely to use* □*Would not use*

Recommendation 4: Use basic knowledge only as a starting point for engaging Muslim clients and recognize that there is considerable diversity in Muslim community.

Is this recommendation relevant to your treatment approach with Muslim clients?
□*Very Relevant* □*Somewhat Relevant* □*Somewhat Irrelevant* □*Not Relevant*

Would this recommendation in your opinion be effective for working Muslim clients?
□*Very Effective* □*Somewhat Effective* □*Somewhat Ineffective* □*Not Effective*

How likely would you use this recommendation in treatment with your Muslim clients?
□*Highly likely to use* □*Likely to use* □*Unlikely to use* □*Would not use*

Recommendation 5: Avoid attempting to alter the religious beliefs, values, and practices of the client.

Is this recommendation relevant to your treatment approach with Muslim clients?
□*Very Relevant* □*Somewhat Relevant* □*Somewhat Irrelevant* □*Not Relevant*

Would this recommendation in your opinion be effective for working Muslim clients?
□*Very Effective* □*Somewhat Effective* □*Somewhat Ineffective* □*Not Effective*

How likely would you use this recommendation in treatment with your Muslim clients?
□*Highly likely to use* □*Likely to use* □*Unlikely to use* □*Would not use*

Recommendation 6: Be aware of and avoid imposing one's own values or judgments onto the client, such as using Western or ethnocentric values.

Is this recommendation relevant to your treatment approach with Muslim clients?
□*Very Relevant* □*Somewhat Relevant* □*Somewhat Irrelevant* □*Not Relevant*

Would this recommendation in your opinion be effective for working Muslim clients?
□*Very Effective* □*Somewhat Effective* □*Somewhat Ineffective* □*Not Effective*

How likely would you use this recommendation in treatment with your Muslim clients?
□*Highly likely to use* □*Likely to use* □*Unlikely to use* □*Would not use*

Recommendation 7: Make building rapport an essential task using empathetic qualities such as genuineness, respect, support, and warmth, and pacing treatment according to client's comfort level.

Is this recommendation relevant to your treatment approach with Muslim clients?
□*Very Relevant* □*Somewhat Relevant* □*Somewhat Irrelevant* □*Not Relevant*

Would this recommendation in your opinion be effective for working Muslim clients?
□*Very Effective* □*Somewhat Effective* □*Somewhat Ineffective* □*Not Effective*

How likely would you use this recommendation in treatment with your Muslim clients?

□*Highly likely to use* □*Likely to use* □*Unlikely to use* □*Would not use*

Recommendation 8: Provide information about the therapeutic process, including the functions of therapy and counseling, the issues for which therapy could be helpful, the procedures which clients should expect during sessions, the expected outcome of counseling, and the practical considerations such as session times and financial liability.

Is this recommendation relevant to your treatment approach with Muslim clients?
□*Very Relevant* □*Somewhat Relevant* □*Somewhat Irrelevant* □*Not Relevant*

Would this recommendation in your opinion be effective for working Muslim clients?
□*Very Effective* □*Somewhat Effective* □*Somewhat Ineffective* □*Not Effective*

How likely would you use this recommendation in treatment with your Muslim clients?
□*Highly likely to use* □*Likely to use* □*Unlikely to use* □*Would not use*

Recommendation 9: Address clients' attitudes about seeking therapy and about their perceptions of stigma attached to therapy.

Is this recommendation relevant to your treatment approach with Muslim clients?
□*Very Relevant* □*Somewhat Relevant* □*Somewhat Irrelevant* □*Not Relevant*

Would this recommendation in your opinion be effective for working Muslim clients?
□*Very Effective* □*Somewhat Effective* □*Somewhat Ineffective* □*Not Effective*

How likely would you use this recommendation in treatment with your Muslim clients?
□*Highly likely to use* □*Likely to use* □*Unlikely to use* □*Would not use*

Recommendation 10: Be aware of negative stereotypes about Islam and Muslims and provide a place for Muslim clients to discuss their experiences of prejudice and discrimination.

Is this recommendation relevant to your treatment approach with Muslim clients?
□*Very Relevant* □*Somewhat Relevant* □*Somewhat Irrelevant* □*Not Relevant*

Would this recommendation in your opinion be effective for working Muslim clients?
□*Very Effective* □*Somewhat Effective* □*Somewhat Ineffective* □*Not Effective*

How likely would you use this recommendation in treatment with your Muslim clients?
□*Highly likely to use* □*Likely to use* □*Unlikely to use* □*Would not use*

Recommendation 11: Examine your sources of information on Islam (i.e. the media, parents, friends) and how they affect your attitudes toward Muslims.

Is this recommendation relevant to your treatment approach with Muslim clients?
□*Very Relevant* □*Somewhat Relevant* □*Somewhat Irrelevant* □*Not Relevant*

Would this recommendation in your opinion be effective for working Muslim clients?

□*Very Effective* □*Somewhat Effective* □*Somewhat Ineffective* □*Not Effective*

How likely would you use this recommendation in treatment with your Muslim clients?
□*Highly likely to use* □*Likely to use* □*Unlikely to use* □*Would not use*

Recommendation 12: Demonstrate one's expertise by informing clients about one's educational background, general knowledge of Muslim cultures, special training you might have had with respect to Muslims, and successful cases with Muslim clients.

Is this recommendation relevant to your treatment approach with Muslim clients?
□*Very Relevant* □*Somewhat Relevant* □*Somewhat Irrelevant* □*Not Relevant*

Would this recommendation in your opinion be effective for working Muslim clients?
□*Very Effective* □*Somewhat Effective* □*Somewhat Ineffective* □*Not Effective*

How likely would you use this recommendation in treatment with your Muslim clients?
□*Highly likely to use* □*Likely to use* □*Unlikely to use* □*Would not use*

Recommendation 13: Be sensitive to first impressions clients may have of you based on your appearance, including professional dress, immodest clothes, cleanliness of your office, and organization of desk and room.

Is this recommendation relevant to your treatment approach with Muslim clients?
□*Very Relevant* □*Somewhat Relevant* □*Somewhat Irrelevant* □*Not Relevant*

Would this recommendation in your opinion be effective for working Muslim clients?
□*Very Effective* □*Somewhat Effective* □*Somewhat Ineffective* □*Not Effective*

How likely would you use this recommendation in treatment with your Muslim clients?
□*Highly likely to use* □*Likely to use* □*Unlikely to use* □*Would not use*

Recommendation 14: Maintain a moderate balance of self-disclosure, where too little disclosure could be perceived as distant while too much disclosure may be perceived negatively as incompetence.

Is this recommendation relevant to your treatment approach with Muslim clients?
□*Very Relevant* □*Somewhat Relevant* □*Somewhat Irrelevant* □*Not Relevant*

Would this recommendation in your opinion be effective for working Muslim clients?
□*Very Effective* □*Somewhat Effective* □*Somewhat Ineffective* □*Not Effective*

How likely would you use this recommendation in treatment with your Muslim clients?
□*Highly likely to use* □*Likely to use* □*Unlikely to use* □*Would not use*

Recommendation 15: Maintain a stance of being assertive and advisory (as it may be likely a Muslim client may take a more passive, non-confrontational stance, assigning a great deal of authority to the therapist and generally conforming to what is advised or prescribed).

Is this recommendation relevant to your treatment approach with Muslim clients?
□*Very Relevant* □*Somewhat Relevant* □*Somewhat Irrelevant* □*Not Relevant*

Would this recommendation in your opinion be effective for working Muslim clients?
□*Very Effective* □*Somewhat Effective* □*Somewhat Ineffective* □*Not Effective*

How likely would you use this recommendation in treatment with your Muslim clients?
□*Highly likely to use* □*Likely to use* □*Unlikely to use* □*Would not use*

Recommendation 16: Be aware of gender preference for therapist selection, particularly for female Muslim clients.

Is this recommendation relevant to your treatment approach with Muslim clients?
□*Very Relevant* □*Somewhat Relevant* □*Somewhat Irrelevant* □*Not Relevant*

Would this recommendation in your opinion be effective for working Muslim clients?
□*Very Effective* □*Somewhat Effective* □*Somewhat Ineffective* □*Not Effective*

How likely would you use this recommendation in treatment with your Muslim clients?
□*Highly likely to use* □*Likely to use* □*Unlikely to use* □*Would not use*

Recommendation 17: Conduct a thorough assessment, including physical health, psychological state, social status of the client, spiritual condition, and religious inclinations and beliefs.

Is this recommendation relevant to your treatment approach with Muslim clients?
□*Very Relevant* □*Somewhat Relevant* □*Somewhat Irrelevant* □*Not Relevant*

Would this recommendation in your opinion be effective for working Muslim clients?
□*Very Effective* □*Somewhat Effective* □*Somewhat Ineffective* □*Not Effective*

How likely would you use this recommendation in treatment with your Muslim clients?
□*Highly likely to use* □*Likely to use* □*Unlikely to use* □*Would not use*

Recommendation 18: Create a genogram of at least three generations to understand the family and their culture.

Is this recommendation relevant to your treatment approach with Muslim clients?
□*Very Relevant* □*Somewhat Relevant* □*Somewhat Irrelevant* □*Not Relevant*

Would this recommendation in your opinion be effective for working Muslim clients?
□*Very Effective* □*Somewhat Effective* □*Somewhat Ineffective* □*Not Effective*

How likely would you use this recommendation in treatment with your Muslim clients?
□*Highly likely to use* □*Likely to use* □*Unlikely to use* □*Would not use*

Recommendation 19: Assess and address acculturation or immigration issues.

Is this recommendation relevant to your treatment approach with Muslim clients?
□*Very Relevant* □*Somewhat Relevant* □*Somewhat Irrelevant* □*Not Relevant*

Would this recommendation in your opinion be effective for working Muslim clients?
□*Very Effective* □*Somewhat Effective* □*Somewhat Ineffective* □*Not Effective*

How likely would you use this recommendation in treatment with your Muslim clients?
□*Highly likely to use* □*Likely to use* □*Unlikely to use* □*Would not use*

Recommendation 20: Conduct an assessment of religious and cultural issues, such as client's level of religiosity, to determine the appropriateness of incorporating spiritual or religious techniques.

Is this recommendation relevant to your treatment approach with Muslim clients?
□*Very Relevant* □*Somewhat Relevant* □*Somewhat Irrelevant* □*Not Relevant*

Would this recommendation in your opinion be effective for working Muslim clients?
□*Very Effective* □*Somewhat Effective* □*Somewhat Ineffective* □*Not Effective*

How likely would you use this recommendation in treatment with your Muslim clients?
□*Highly likely to use* □*Likely to use* □*Unlikely to use* □*Would not use*

Recommendation 21: Aim interventions to be practical, immediate, and attainable in contrast to interventions that focus on the historical development of the problem or is too abstract or philosophical in nature.

Is this recommendation relevant to your treatment approach with Muslim clients?
□*Very Relevant* □*Somewhat Relevant* □*Somewhat Irrelevant* □*Not Relevant*

Would this recommendation in your opinion be effective for working Muslim clients?
□*Very Effective* □*Somewhat Effective* □*Somewhat Ineffective* □*Not Effective*

How likely would you use this recommendation in treatment with your Muslim clients?
□*Highly likely to use* □*Likely to use* □*Unlikely to use* □*Would not use*

Recommendation 22: Keep therapeutic goals congruent with the goals and values of the family in particular and their religious ideology in general.

Is this recommendation relevant to your treatment approach with Muslim clients?
□*Very Relevant* □*Somewhat Relevant* □*Somewhat Irrelevant* □*Not Relevant*

Would this recommendation in your opinion be effective for working Muslim clients?
□*Very Effective* □*Somewhat Effective* □*Somewhat Ineffective* □*Not Effective*

How likely would you use this recommendation in treatment with your Muslim clients?
□*Highly likely to use* □*Likely to use* □*Unlikely to use* □*Would not use*

Recommendation 23: Try to include elder members of the family as they are respected for their experience and wisdom.

Is this recommendation relevant to your treatment approach with Muslim clients?
□*Very Relevant* □*Somewhat Relevant* □*Somewhat Irrelevant* □*Not Relevant*

Would this recommendation in your opinion be effective for working Muslim clients?
□*Very Effective* □*Somewhat Effective* □*Somewhat Ineffective* □*Not Effective*

How likely would you use this recommendation in treatment with your Muslim clients?
□*Highly likely to use* □*Likely to use* □*Unlikely to use* □*Would not use*

Recommendation 24: Use interventions that maintain the unity of the family as well as emphasize the goals of the family unit above the goals of an individual member, especially if the goals are conflicting.

Is this recommendation relevant to your treatment approach with Muslim clients?
□*Very Relevant* □*Somewhat Relevant* □*Somewhat Irrelevant* □*Not Relevant*

Would this recommendation in your opinion be effective for working Muslim clients?
□*Very Effective* □*Somewhat Effective* □*Somewhat Ineffective* □*Not Effective*

How likely would you use this recommendation in treatment with your Muslim clients?
□*Highly likely to use* □*Likely to use* □*Unlikely to use* □*Would not use*

Recommendation 25: Respect the valued covert and indirect communication style of Muslim clients and families, which avoids the confrontation and direct criticism associated more with open and direct communication.

Is this recommendation relevant to your treatment approach with Muslim clients?
□*Very Relevant* □*Somewhat Relevant* □*Somewhat Irrelevant* □*Not Relevant*

Would this recommendation in your opinion be effective for working Muslim clients?
□*Very Effective* □*Somewhat Effective* □*Somewhat Ineffective* □*Not Effective*

How likely would you use this recommendation in treatment with your Muslim clients?
□*Highly likely to use* □*Likely to use* □*Unlikely to use* □*Would not use*

Recommendation 26: Respect the hierarchical structure of the Muslim family by understanding the power structure of the family, including the role of the father.

Is this recommendation relevant to your treatment approach with Muslim clients?
□*Very Relevant* □*Somewhat Relevant* □*Somewhat Irrelevant* □*Not Relevant*

Would this recommendation in your opinion be effective for working Muslim clients?
□*Very Effective* □*Somewhat Effective* □*Somewhat Ineffective* □*Not Effective*

How likely would you use this recommendation in treatment with your Muslim clients?
□*Highly likely to use* □*Likely to use* □*Unlikely to use* □*Would not use*

Recommendation 27: Utilize interventions that emphasize education and advancement of children in the family to be aligned with the family's goals.

Is this recommendation relevant to your treatment approach with Muslim clients?
□*Very Relevant* □*Somewhat Relevant* □*Somewhat Irrelevant* □*Not Relevant*

Would this recommendation in your opinion be effective for working Muslim clients?
□*Very Effective* □*Somewhat Effective* □*Somewhat Ineffective* □*Not Effective*

How likely would you use this recommendation in treatment with your Muslim clients?
□*Highly likely to use* □*Likely to use* □*Unlikely to use* □*Would not use*

Recommendation 28: Help clients explore and access resources within their own communities, such as Masjids (Mosques) or Muslim community centers.

Is this recommendation relevant to your treatment approach with Muslim clients?
□*Very Relevant* □*Somewhat Relevant* □*Somewhat Irrelevant* □*Not Relevant*

Would this recommendation in your opinion be effective for working Muslim clients?
□*Very Effective* □*Somewhat Effective* □*Somewhat Ineffective* □*Not Effective*

How likely would you use this recommendation in treatment with your Muslim clients?
□*Highly likely to use* □*Likely to use* □*Unlikely to use* □*Would not use*

Recommendation 29: Be careful of addressing couple related issues if the presenting problem is child-focused.

Is this recommendation relevant to your treatment approach with Muslim clients?
□*Very Relevant* □*Somewhat Relevant* □*Somewhat Irrelevant* □*Not Relevant*

Would this recommendation in your opinion be effective for working Muslim clients?
□*Very Effective* □*Somewhat Effective* □*Somewhat Ineffective* □*Not Effective*

How likely would you use this recommendation in treatment with your Muslim clients?
□*Highly likely to use* □*Likely to use* □*Unlikely to use* □*Would not use*

Recommendation 30: Take time to understand the meaning of somatic symptoms, which may be a more common presenting problem than psychological distress.

Is this recommendation relevant to your treatment approach with Muslim clients?
□*Very Relevant* □*Somewhat Relevant* □*Somewhat Irrelevant* □*Not Relevant*

Would this recommendation in your opinion be effective for working Muslim clients?
□*Very Effective* □*Somewhat Effective* □*Somewhat Ineffective* □*Not Effective*

How likely would you use this recommendation in treatment with your Muslim clients?
□*Highly likely to use* □*Likely to use* □*Unlikely to use* □*Would not use*

Recommendation 31: Avoid encouraging confrontation as it may be considered selfish and insulting to the family or community.

Is this recommendation relevant to your treatment approach with Muslim clients?
□*Very Relevant* □*Somewhat Relevant* □*Somewhat Irrelevant* □*Not Relevant*

Would this recommendation in your opinion be effective for working Muslim clients?
□*Very Effective* □*Somewhat Effective* □*Somewhat Ineffective* □*Not Effective*

How likely would you use this recommendation in treatment with your Muslim clients?
□*Highly likely to use* □*Likely to use* □*Unlikely to use* □*Would not use*

Recommendation 32: Because Muslim clients may be unwilling or reluctant to confront the therapist directly, be aware that they may only conform to requests and treatment plans on a superficial level.

Is this recommendation relevant to your treatment approach with Muslim clients?
□*Very Relevant* □*Somewhat Relevant* □*Somewhat Irrelevant* □*Not Relevant*

Would this recommendation in your opinion be effective for working Muslim clients?
□*Very Effective* □*Somewhat Effective* □*Somewhat Ineffective* □*Not Effective*

How likely would you use this recommendation in treatment with your Muslim clients?
□*Highly likely to use* □*Likely to use* □*Unlikely to use* □*Would not use*

Recommendation 33: Avoid using Western standards for defining problems or goals. For example, families may feel too distant from members (such as children) and desire more closeness or "enmeshment".

Is this recommendation relevant to your treatment approach with Muslim clients?
□*Very Relevant* □*Somewhat Relevant* □*Somewhat Irrelevant* □*Not Relevant*

Would this recommendation in your opinion be effective for working Muslim clients?
□*Very Effective* □*Somewhat Effective* □*Somewhat Ineffective* □*Not Effective*

How likely would you use this recommendation in treatment with your Muslim clients?
□*Highly likely to use* □*Likely to use* □*Unlikely to use* □*Would not use*

Recommendation 34: Use open-ended inquiry to engage in a discussion about the role of religion in the client's life. For example, use the question: "What does Islam mean to you?".

Is this recommendation relevant to your treatment approach with Muslim clients?
□*Very Relevant* □*Somewhat Relevant* □*Somewhat Irrelevant* □*Not Relevant*

Would this recommendation in your opinion be effective for working Muslim clients?
□*Very Effective* □*Somewhat Effective* □*Somewhat Ineffective* □*Not Effective*

How likely would you use this recommendation in treatment with your Muslim clients?
□*Highly likely to use* □*Likely to use* □*Unlikely to use* □*Would not use*

Recommendation 35: Utilize Islamic principles and practices according to client's level of religiosity and belief in its efficacy.

Is this recommendation relevant to your treatment approach with Muslim clients?
□*Very Relevant* □*Somewhat Relevant* □*Somewhat Irrelevant* □*Not Relevant*

Would this recommendation in your opinion be effective for working Muslim clients?
□*Very Effective* □*Somewhat Effective* □*Somewhat Ineffective* □*Not Effective*

How likely would you use this recommendation in treatment with your Muslim clients?
□*Highly likely to use* □*Likely to use* □*Unlikely to use* □*Would not use*

Recommendation 36: Identify and use phrases and language accepted in the local Islamic community in therapy.

Is this recommendation relevant to your treatment approach with Muslim clients?
□*Very Relevant* □*Somewhat Relevant* □*Somewhat Irrelevant* □*Not Relevant*

Would this recommendation in your opinion be effective for working Muslim clients?
□*Very Effective* □*Somewhat Effective* □*Somewhat Ineffective* □*Not Effective*

How likely would you use this recommendation in treatment with your Muslim clients?
□*Highly likely to use* □*Likely to use* □*Unlikely to use* □*Would not use*

Recommendation 37: Encourage use of religious practices, such as prayer, fasting, and reading the Qur'an, which may be considered useful means for healing distress according to Islam.

Is this recommendation relevant to your treatment approach with Muslim clients?
□*Very Relevant* □*Somewhat Relevant* □*Somewhat Irrelevant* □*Not Relevant*

Would this recommendation in your opinion be effective for working Muslim clients?
□*Very Effective* □*Somewhat Effective* □*Somewhat Ineffective* □*Not Effective*

How likely would you use this recommendation in treatment with your Muslim clients?
□*Highly likely to use* □*Likely to use* □*Unlikely to use* □*Would not use*

Recommendation 38: Incorporate Islamic beliefs to cognitive techniques, where unproductive beliefs are identified and then modified or replaced with beliefs derived from the Islamic principles.

Is this recommendation relevant to your treatment approach with Muslim clients?
□*Very Relevant* □*Somewhat Relevant* □*Somewhat Irrelevant* □*Not Relevant*

Would this recommendation in your opinion be effective for working Muslim clients?

□*Very Effective* □*Somewhat Effective* □*Somewhat Ineffective* □*Not Effective*

How likely would you use this recommendation in treatment with your Muslim clients?
□*Highly likely to use* □*Likely to use* □*Unlikely to use* □*Would not use*

Recommendation 39: Have a Muslim service provider or community member make the first introduction to the client to build trust.

Is this recommendation relevant to your treatment approach with Muslim clients?
□*Very Relevant* □*Somewhat Relevant* □*Somewhat Irrelevant* □*Not Relevant*

Would this recommendation in your opinion be effective for working Muslim clients?
□*Very Effective* □*Somewhat Effective* □*Somewhat Ineffective* □*Not Effective*

How likely would you use this recommendation in treatment with your Muslim clients?
□*Highly likely to use* □*Likely to use* □*Unlikely to use* □*Would not use*

Recommendation 40: When faced with value conflicts, consult with an Imam, a religious leader, or a respected devout member of the local community.

Is this recommendation relevant to your treatment approach with Muslim clients?
□*Very Relevant* □*Somewhat Relevant* □*Somewhat Irrelevant* □*Not Relevant*

Would this recommendation in your opinion be effective for working Muslim clients?
□*Very Effective* □*Somewhat Effective* □*Somewhat Ineffective* □*Not Effective*

How likely would you use this recommendation in treatment with your Muslim clients?
□*Highly likely to use* □*Likely to use* □*Unlikely to use* □*Would not use*

Part III:

Below are common Islamic practices that religious Muslim clients may use to feel better. For each practice answer the following questions: Have you heard of this practice? Would you recommend that your client use the practice if it enhanced treatment goals?

Islamic Practices	Heard of?	Recommend?
Salaat – the five daily prayers	Yes/No	Yes/No
Sa'um – Fasting	Yes/No	Yes/No
Zakaat – Charity	Yes/No	Yes/No
Du'ah – supplication to God	Yes/No	Yes/No
Reading the Qur'an	Yes/No	Yes/No
Dhikr – repeating Islamic phrases several times in meditative way	Yes/No	Yes/No
Meditate on the 99 names of Allah	Yes/No	Yes/No

Hadiths – Customs and Advice from the Prophet Muhammad	Yes/No	Yes/No
Tawbah – Process of repentance	Yes/No	Yes/No

Below is a selection of core Islamic beliefs that describe religious Muslim clients' perspective on life. These beliefs may be used to help clients feel better, as described. For each belief answer the following questions: Have you heard of the belief? Would you use this belief in treatment if it enhanced treatment goals?

Islamic Beliefs	**Utility of Belief**	**Heard of?**	**Use?**
Belief that one must fully trust and rely on Allah (God).	Can be used for feeling that one cannot cope anymore, that life is too difficult, or that no one is there for me	Yes/No	Yes/No
Belief that this life is only temporary and therefore, one must look forward to the next life.	Can be used to counter hopelessness and feeling overwhelmed with life	Yes/No	Yes/No
Focusing on Hereafter or Afterlife	Can be used for those with significant worries and stress, those that find it difficult to focus, or tend to procrastinate	Yes/No	Yes/No
Viewing difficulties as a test from Allah	Can be used to remind clients that everyone is tested and it will expiate sins and increase rewards	Yes/No	Yes/No
Remember that sins are forgiven and good deeds are increased during distress and afflictions.	Can be used to counter negative thoughts such as "Why is this happening to me? Am I being punished for my disobedience?"	Yes/No	Yes/No
Understand that "After Hardship there will be Ease"	Can be used for feelings of hopelessness & helplessness	Yes/No	Yes/No
Focusing on the Blessings of Allah	Can be used to relieve worries and distress	Yes/No	Yes/No
Remembering that Allah is compassionate and merciful.	Can be used to relieve guilt and depression.	Yes/No	Yes/No

Follow-up Questions

How important do you find it to discuss religion in therapy with your Muslim clients?
□*Very important* □ *Somewhat important* □ *Somewhat unimportant* □*Not important*

How comfortable do you feel discussing religion into therapy with your Muslim clients?
□*Very comfortable* □*Somewhat comfortable* □*Somewhat uncomfortable* □*Very uncomfortable*

How likely would you be to include religious beliefs and practices with your Muslim clients?
□*Very likely* □*Somewhat likely* □*Somewhat unlikely* □*Not likely*

Please feel free to comment on any of the questions presented above as well as add anything that was not asked that you feel is important:

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