Chapter 1
Muslim Worldviews:
Implications for Helping Professionals Providing Culturally Competent Care

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ABSTRACT

This chapter seeks to provide an overview of traditional and contemporary Muslim worldviews, specifically beliefs and attitudes that may relate to help-seeking and interaction with human services such as counseling, health services, educational systems, and social services. Traditional Islamic beliefs and views, combined with contemporary issues and the experiences of living as a religious minority, can impact successful interaction between members of the Muslim community and service providers. In addition, basic knowledge of Muslim worldviews can aid helping professionals in providing effective, culturally competent care. This chapter focuses on traditional Islamic concepts of health and illness, common lay beliefs that stem from traditional views, attitudes towards treatment, and help-seeking patterns. The interplay of religiosity, acculturation, gender, family dynamics, and other relevant factors on help-seeking and service utilization are also presented to provide the reader with a holistic perspective of prevalent Muslim worldviews.

INTRODUCTION

The area of culturally competent care is one that has been emerging not only for mental health professionals, but for all individuals involved in providing services within a multi-cultural, multi-religious society, including health care providers, mediators, educators, social workers, and providers of other social or community services. Cultural competence is an essential tool for helping professionals to effectively serve all facets of their community. Successful care relies on both the desire of the helping professional to learn about the cultural background and circumstances of the client, and the willingness of the client to share in an honest and open manner his or her perceptions of the situation leading him or her to uti-

DOI: 10.4018/978-1-7998-0018-7.ch001

lize a service. For Muslims, who have long been viewed as outsiders in non-Muslim majority countries, lack of cultural competency can impact willingness to utilize available services in their community. In addition, a negative encounter with a service or helping professional can significantly reduce the chance that an individual and others in their community will seek out services in the future.

Islam as a global religion provides a distinct cultural narrative that is based upon Islamic doctrine, but is also influenced by the cultures, languages, and countries in which the practice of Islam exists. Islam provides a foundation for those who identify as Muslim and plays a strong role in influencing attitudes and behaviors, as Muslims tend to view Islam as an entire way of life. The Muslim worldview, like other worldviews, consists of sets of beliefs and assumptions that shape reality and therefore influence individual thinking and behavior (Koltko-Rivera, 2004). However, Muslims are not a homogenous group and therefore there is not one definitive Muslim worldview, but rather multiple worldviews that are shaped by both the level of adherence to Islamic theological concepts and other cultural and social factors. Thus, it must be cautioned that there is a great deal of diversity that exists within this unity, just like in any population.

The following chapter provides an overview of key aspects of traditional and contemporary Muslim worldviews as they relate to health and illness, social problems, and help-seeking behaviors, as well as how these worldviews are influenced by the context in which Muslims live in Western society. Topics covered include traditional Islamic views of physical and mental illness, attitudes towards help-seeking, gender and family norms that may impact help-seeking, and traditional Islamic forms of treatment. The chapter describes the usage of both biomedical and psycho-spiritual models of health by contemporary Muslims, and how lay conceptions often differ or co-exist with theological concepts of health and wellness.

Potential factors that influence willingness to use available services and seek help within a country include immigration status, prevailing attitudes towards Muslims in that country, the person's level of religiosity, fear of stigma from both within and outside of their community, language barriers, and the availability of same gender, same culture, or same religion service provider (Vu, Azmat, Radejko & Padela, 2016; Shafi, 1998; Pilkington, Msetfi & Watson, 2012). The cultural, racial, socioeconomic and educational backgrounds of the client must therefore be assessed or taken into consideration by the service provider. Beliefs and attitudes that are shaped by an individual's background can influence Muslims' use of available services to address mental and physical illness, addiction, disability, childhood issues, and trauma. The chapter includes descriptions of common Muslim social norms that may be important to help a professional avoid bias or misunderstanding and increase rapport with Muslim clients.

Traditional Islamic Views of Health and Illness

Traditional Islamic beliefs about health illness can be divided into three categories: (a) theoretical concepts developed by Islamic philosophers, religious leaders, and scholars; (b) theologically derived positions based upon the Quran and prophetic traditions (*Sunnah* and *hadith*); and (c) the lay beliefs of individuals and groups in traditional Muslim societies. Traditional Islamic perspectives on symptoms that correspond to physical and mental illness tend to assume a psycho-spiritual origin for these problems (Athar, 1993; Husain, 2006; Shafii, 1988). These beliefs include definitions of illness, causes and predictors of illness, classification of symptoms, and prescribed treatment methods.

The Qur'anic concept of the self does not adhere to mind-body dualism. A person consists of not just the body but also the mind and soul. These do not exist as separate and distinct units. The Islamic concept of illness echoes these fundamental beliefs about the dimensions of the self and the position

of human beings within the context of creation. The Islamic conception of illness is that all mental and behavioral dysfunction has a psycho-spiritual root and can be directly tied to an individual's higher spiritual awareness of his or her Creator. An explanation of what constitutes dysfunction is elusive and has changed over time depending upon the cultural and social contexts.

"Sickness of the Heart" or "Diseases of the Heart" (in Arabic *amrad al-qalb*) are terms generally used in Islam to describe illnesses of a psycho-spiritual nature. A diseased heart results from desires and doubts that emerge when an individual fails to utilize knowledge of God, emerging as symptoms such as anger, ignorance, and greed. Within the Islamic mystical tradition, "Sickness of the Heart" refers not to the physical organ, but rather an aspect of the human spirit and personality (Nurbakhsh, 1992). Within traditional Islamic theology, all psychological disturbances are viewed as having a spiritual root. Emotional suffering originates from lack of spiritual consciousness (Shafii, 1988).

Competing ideas about illness arose in medieval times, around the 10th century, as Muslim physicians incorporated the Greek medical model into the diagnosis and treatment of illness in Muslim societies (Al-Issa, 2000). During this period, a combination of medical, psychotherapeutic, and Islamic treatments were utilized, as the conception of illness included humoral theories, the role of fear, grief, and obsessions in symptomology, in addition to spiritual and supernatural causes established in the early Islamic period.

"Mental illness," within the conception of early Islamic philosophers and spiritual figures, stems from desires that are in opposition to the spiritual potential of a human being and can result in behavior that fulfills animal impulses rather than the higher potentials of a human being. "Mental illness," affects emotions, thinking, intention, and behavior, resulting in undesirable actions that go against divine commandments. This mental and spiritual conflict causes deviance and a disintegration of mental health (Alawi, 1992). These traditional Islamic understandings of illness bear little resemblance to modern day problems that are categorized in contemporary Western texts as mental illness, with the exception of melancholia and symptoms such as obsessions, anxiety, depression, delusions, hallucinations, and hypochondria (Alawi, 1992; Al-Issa, 2000b; Husain, 2006; Shafii, 1988). However, they have similar outcomes such as social deviance, distress, and dysfunction for the individual and their social circle.

Islam also acknowledges environmental stresses caused by injury, traumatic events, and outside stressors as causes of illness, particularly anxiety and stress (Al-Munajjid, 2003; Athar, 1993; Husain, 2006). Distress, according to Al-Munajjid (2003), can result from mistreatment by relatives, chronic or serious diseases, and relationship problems.

Islamic tradition recognizes supernatural connections to mental illness. Prophet traditions (the *hadith* and *sunnah*) record various stories and activities that involve *jinn*, evil eye, and black magic. In at least one tradition, the Prophet Muhammad is recorded as treating a young boy for jinn possession, and in several traditions, it is recorded that he recited particular prayers to ward off evil *jinn,* the evil eye, and black magic. In addition, tradition records at least one instance where magic was used against the Prophet Muhammad during his life. The presence of these traditions has been, and continue to be, the legitimizing factor for supernatural causes of illness. In Islamic tradition, when an issue is discussed or acted upon by the Prophet Muhammad, the existence cannot be disputed.

Jinn possession, the use of black magic, and the evil eye (*nazar*, *Al-'Ayn*), are often attributed to severe symptoms of psychopathology, including hallucinations, nightmares, extreme lethargy, and physical symptoms with no known physical causes, as well as physical afflictions (Husain, 1998). The two life forms described in the Quran in addition to human beings are angels and *jinn*. Angels are often described as created from light and possessing no free will. The creation of *jinn* is often described as prior to that of man, with man's creation from mud or clay, and *jinn* created from smokeless fire. Quran and *hadith*

identify the *jinn* as spirit entities capable of appearing in different forms, and of acting according to their own choice to torment or assist humankind, as well as choose to worship Allah or to deny Him. Islam teaches that the *jinn* can take the form of various life forms including birds, dogs, bees, and humans (Ameen, 2005). *Jinn* possession has been tied to delusions, depression, and anxiety (Ameen, 2005; Bali, 2004). Ameen (2005) describes the symptoms of *jinn* possession which include erratic behavior, seizures, paralysis of a limb with no medical cause, short temper, frequent crying, frequent headaches, nightmares, insomnia, and sleep talking. Speziale (2003) notes that despite the existence of medically grounded interpretations of psychiatric illnesses since the 10th century, supernatural interpretations of mental illness continue to co-exist with physical, environmental, and spiritual explanations within Muslim societies. The attribution of mental illness to possession by *jinn*, evil eye, and magic has been documented in the contemporary Arab Muslim population as well (Al-Adawi et al., 2002; Al-Issa, 2000).

In regards to preservation of life in the face of illness or disability, preservation of life is considered paramount. In the Muslim worldview the paramount purpose or meaning of life is to worship Allah. Within this context, Muslims should do everything possible to maintain their own well-being in order to achieve this purpose. Self-mutilation and self-harm of any form is not allowed. Euthanasia, physician-assisted suicide, and suicide are forbidden within the Islamic context. Providing artificial nutrition or hydration is decided in consultation with religious scholars, based on whether the efforts are causing harm or constitute a futile attempt at lifesaving (Alsolamy, 2014). Suicide is particularly stigmatized within Muslims societies. This may make it difficult for clients to discuss suicidal ideation or suicide attempts with a counselor, health care professional, or social worker, as the topic is still very taboo. In Western countries, as more campaigns seek to address mental health, Muslims have also started to address mental illness and suicide, though not on the same level as seen within other ethnic and religious minority groups. Despite the emphasis on preservation of life and the sacredness of human life within Islam, this has not translated to open discussion of disease prevention among religious leaders or lay Muslims, including public health campaigns for cancer screenings, and dietary or lifestyle changes. Muslims in Western countries have not benefitted in the same way from public health initiatives that have partnered with other faith-based communities. A service provider, working with a religious client, could frame behavioral changes within light of the worldview that life is sacred, the body should be taken care of, and the ultimate purpose of life is worship of the creator. Within this framework, it may be easier to convince a client to comply with treatment, engage in behavior change, or make healthier decisions.

Core Islamic beliefs, such as fasting during the month of Ramadan, can have important implications for health care providers and end of life care for Muslim patients. Devout Muslims fast from sunrise to sunset during the month of Ramadan, abstaining from food, drink, sexual activity, and smoking. Most Muslims would also include abstaining from any other bad behavior or bad speech as part of the fasting requirement. Usually fasting begins once an individual starts puberty. In some families, children will start fasting for a half day, or give up food in order to start preparing for the full fast. Religious Muslims will often adhere to fasting during Ramadan, even though there are religious injunctions freeing a person from this religious obligation if they are pregnant, nursing, menstruating, or ill. A desire to complete the fasts during Ramadan can lead some patients to be non-compliant with medications or timing of medication intake, put off therapy, or risk re-occurrence of symptoms while fasting. This is particularly seen in diabetic patients (Al-Balhan et al., 2018). Understanding the basics of fasting and being knowledgeable about the timing of Ramadan, which changes every year because it is based on the lunar calendar, can help providers discuss the implications of fasting with their clients. Planning treatments around Ramadan, when possible, can make clients feel more in control of their health care planning. Discussions of the

importance of taking medications on time and consistently may be necessary, as well as emphasizing the potential side effects of non-adherence. Recognizing Ramadan and its importance for Muslim clients can further build trust and rapport.

As Islam clashes with many aspects of modernity, the concept of physical and mental illness and intellectual disability as a state that results from a failure to obey God's commandments through indulgence in forbidden practices, or failure to adhere to Islamic norms, continues to dominate the discussion of health in many Muslim religious circles. However, little is understood regarding how these moral and spiritual illnesses translate into physical or psychological symptoms and are then diagnosed and treated. Illness as divine punishment is not usually the interpretation, but rather illness as a test from God, or the will of God (*qadr*), or resulting in straying from God.

Traditional Islamic concepts of health and illness cannot be ignored, as they often serve as important foundations for an individual's understanding of their own health and wellbeing. The influence of the Quran in Muslim understandings of the role of the human soul and body has and continues to serve as the basis for Muslim interpretations of all forms of illness. In addition, external factors such as *jinn* possession, black magic, and the evil eye are acknowledged aspects of Islamic tradition that are clearly identified in the Prophetic literature as legitimate sources of human suffering. These traditional beliefs play a significant role in understanding both attitudes and behaviors related to health and illness among Muslim populations throughout the world.

Contemporary Beliefs of Health and Illness in Muslim Majority Societies

Islamic theological concepts of health and illness do not necessarily correspond with lay conceptions of the general population in traditional Muslim societies. Of particular interest is the attribution of mental illness to spiritual defects, as widely described by Islamic philosophers and Sufi figures (Alawi, 1992; Al-Munajjid, 2003; Ibn Taymiyyah, 1319-1320/2000) or the attribution of mental illness to supernatural causes, such as those described by traditional faith healers and contemporary religious scholars (Ameen, 2005; Bali, 2004).

Little research has been conducted thus far exploring contemporary conceptions of illness, particularly in traditional Muslim societies. Due to core beliefs in pre-destination and the transcendent and omnipotent nature of God, Muslims also tend to view mental illness as a test from God, God's will, and a form of punishment for sins (Husain, 1998). Contemporary Muslims living in Muslim-majority societies tend to make a distinction between the Islamic views of health and illness and the Western concepts of the origin of illness, though they may integrate both views into their beliefs regarding physical and mental health issues. For example, the parents of a child born with a physical or mental disability may accept the biomedical explanation for that disability, while also adhering to the belief that their child's disability is a test from God. How the problem is interpreted can influence willingness to seek out services for the child. Parents who believe that their child's disability is a test from God or the Will of God may use that notion to seek out the best services for their child. Others may view the child's disability as *qadr* (fate or destiny) and view this as a reason not to seek outside help to improve their child's condition. In addition, conceptualizing of illness, such as terminal illness, as God's will can act as a coping mechanism and a source of comfort for patients and their families (Hamdy, 2009).

Contemporary Muslims living in Muslim-majority societies have been shown to hold tightly to many of the traditional conceptions of mental illness, including attributions of psychotic behavior and physical illness to *jinn* possession, and depressive symptoms to the evil eye (Haque, 2004b; Weatherhead &

Daiches, 2010; Kobeisy, 2004). Though not directly referred to as "mental illness," words in Arabic, Persian, and Urdu that refer to madness, insanity, possession, and the evil eye are most often used when referring to these specific illnesses. In South Asia, the word *pagal* is used to refer to a person who talks to themselves, has delusions, or exhibits symptoms of mental retardation. The word *junoon*, on the other hand, might be used to describe a person who is exhibiting obsessive thoughts or behavior, most often over another person (Al-Issa, 2000). These supernatural causes of physical or mental illness put the illness outside of the control of the person, absolving them to a certain extent of the stigma associated with deviant behaviors. As such, some researchers have documented better quality of life and outcomes for patients diagnosed with severe mental illness in Muslim countries (Watters, 2010).

Contemporary views of physical and mental illness and disability in predominately Muslim societies is complex with these conditions often interpreted as a combination of both supernatural and social factors. This has been documented by researchers in Malaysia (Azhar & Varma, 2000), Gulf nations (El-Islam, 2000), North Africa (Endrawes, O'Brien, &Wilkes, 2007; Fadlalla, 2005; Stein, 2000), and Pakistan (Mubbashar, 2000; Saeed, Gater, Hussain, & Mubbashar, 2000). Some of these researchers also note the continued presence of belief in illness as a direct result of the evil eye, God's will, or God's punishment (El-Islam, 1982; Fadlalla, 2005; Haque, 2010; Abu-Rabia, 2005). Abu-Rabia (2005) discusses belief in the evil eye amongst the Bedouin tribes and states: "Belief in the evil eye is constantly present in people's lives, alongside beliefs about spirits, *jinns* and other demons, and it has serious implications for how individuals perceive the world and their place in it" (p. 241). *Nazar,* the term for evil eye in South Asia, can be caused by anyone. Black magic (*jadoo*), on the other hand, can be conducted with the help of *jinn* or certain plants according to some faith healers (Ally & Laher, 2008). These beliefs seem to be moderated by factors such as level of education and exposure to Western psychological and psychiatric ideas.

The findings of contemporary research studies dealing with physical and mental illness in predominant Muslim countries continue to support a multidimensional model of understanding of health and illness as having supernatural, social, and biological causes (Arabiat, Al Jabery, Abdelkader, & Mahadeen, 2013). No one model is accepted within the various populations, and in many cases the supernatural model continues to dominate (Graham & White, 2015). For many individuals, interpretations of the cause or reason for an illness cannot be separated from the role of God as creator and ultimate commander.

Perceptions of Health and Illness Among Muslims Living in Western Societies

Though exploration of contemporary lay conceptions of mental illness in predominately Muslim countries has begun, we know little about the translation of these beliefs to Western contexts. Initial research suggests that, at least in the case of refugees and immigrants, conceptions of illness and trauma are preserved, rather than discarded. Beliefs in fate and God's will inform how many refugees view and process their trauma (Eltaiba, 2014). In a study of older Iranian immigrants, Martin (2009) found divergent conceptions of mental health as originating in the spirit (*ruh*) or the mind. The majority of participants referred to an illness of the *ruh*. They also expressed reluctance to seek mental health care, and a reluctance to use psychotropic medications. Martin (2009) concluded that older Iranian immigrants to the United States possess a holistic approach to health that they perceive as not present in the U.S. health care system. Having knowledge regarding religious views of life, death, health, and illness will therefore help health providers to understand the particular frame of view of these individuals. Other research on Muslim refugees residing in Western countries have found that high religiosity acts as a buffer for the trauma

suffered during war and displacement (Molsa, Kuittinen, Tiiilikinen, Honkasalo, & Punamaki, 2017). Religious appraisals of traumatic situations can be both negative and positive and should be taken into account when engaging in trauma work (Bergenzi, et al., 2017).

Religious identity and practice impact how many Muslims perceive of personal illness, providing meaning, context, and coping mechanisms for diagnosis of illness and injury. Religious identity is rarely acknowledged by health practitioners and most Muslim patients also do not feel comfortable discussing the role of religious belief and practice in how they navigate illness (Mir & Sheikh, 2010). Health care providers may assume a patient is being merely non-compliant when it comes to recommended treatment, if issues like fasting, dietary regulations (i.e. use of gel tablets which may contain gelatin), and modesty are not taken into account. Beliefs about illness or disability as the will of God or predestination have also been shown to be prevalent within Muslims living in Western societies (Al-Khateeb, Al-Hadidi, & Al Khatib), which may impact an individual's motivation to proactively seek out care.

Numerous studies have now been conducted among sub-groups of Muslims living in Western countries, especially the United States, focusing on perceptions of mental illness. These studies have used a variety of methodological approaches and theoretical frameworks. Regardless of the particular racial or ethnic sub-group studied, research repeatedly showed that faith and spirituality informed interpretation of mental illness, understandings of symptoms of mental illness often varied in the United States from symptoms described in country or origin, and mental illness was often stigmatized (Pratt, Fadumo, Hang, Osman & Raymond, 2016). Belief in jinn possession, though not as prevalent as in traditional Muslim societies, has carried over and persists in most Muslim communities, especially communities of recent refugees or immigrants (Cheng, 2017; Bagasra & Mackinem, 2014). Beliefs regarding causation of mental illness in Muslim Americans shows a multidimensional understanding, embracing biomedical, environmental, and psycho-spiritual causes of mental illness and distress. All are viewed as equally legitimate explanations for psychological disruption in an individual's life (Bagasra & Mackinem, 2014).

Help-Seeking Beliefs and Behaviors in Diverse Muslim Populations

Little research has been conducted that refers to Muslim attitudes towards seeking professional psychological help. Studies of help-seeking behaviors of Muslims living in Western countries tend to focus on specific ethnic sub-groups within the population. Previous research has shown that perceptions and attitudes toward seeking psychological help were affected by religious, racial, and cultural identities (Haque-Khan, 1997; Aloud, 2004), and stigma played a major role (Raja, 2005) in willingness to see out help. In addition, knowledge about services and providers, length of time in the country, and previous experience with services influence both help-seeking attitudes and behaviors.

Studies have also found that individuals are more likely to choose family doctors before other resources for help with psychological problems. Attitudes amongst the Muslim community toward counseling and counselors range from positive to neutral or negative and counseling was only used when no other options were available (Kobeisy, 2004). Negative attitudes toward counseling tend to be a result of perceptions that are colored by religious and cultural beliefs. These perceptions include the equation of seeking counseling services with the stigma within Muslim society that is associated with a diagnosis of mental illness. Seeking counseling was also attributed as a sign of lack of internal family support. Negative attitudes can also stem from the view that seeking counseling services is a threat to the authority of the family to resolve internal conflicts. Lack of knowledge regarding the purposes and outcomes associated with therapy are another factor (Kobeisy, 2004; Aloud, 2004).

Muslims living in Western countries may vary in their receptivity to formal services, and often continue to show a preference for informal help that comes from family and friends. Barriers to seeking formal services continue to arise from concerns over stigma, lack of knowledge regarding the purpose and process of services, particularly psychotherapies, and a fear of a lack of cultural understanding on the part of the service provider. These findings suggest that basic education of both practitioners and potential clients may serve to ease the reluctance to seek formal mental health services. Direct outreach to communities by service agencies or individual providers can increase knowledge and provide a connection.

Religious Based Treatments and Interventions

The use of alternative methods of treatment in contemporary Muslim societies continues to be prevalent. These include prayers, herbal remedies, dietary changes, and ritualistic practices including seclusion (Al-Subaie, 1994; Al-Subaie & Alhamad, 2000; Deuraseh, 2009; Mehrabi et al., 2000; Saeed et al., 2000). Traditional healing practices sought by those living in South Asia include homeopathy, naturopathy, traditional faith healing conducted by *pirs* and *hakims*, folk healing at Sufi shrines, and sorcery (Farooqi, 2006). Traditional healing practices in Malaysia include herbal medicine, the use of Quranic verses, talismans, and traditional healers called *bomoh* (Haque, 2008). *Al-Ruqyah* (Quran recitation) is a traditional healing method utilized in many Muslim countries. It has been found to be utilized and viewed as an effective method for the treatment of diseases caused by *jinn* (Deuraseh, 2009). Prayer, *dhikr* (remembrance of God), and Quran recitation, are frequently cited by Muslim physicians and psychotherapists as effective forms of treatment for stress (Athar, 1993; Haque, 2004a) and coping with diagnosis of illness. Dietary laws are also cited as a form of Prophetic medicine (Rahman, 1998). Thus, many common practices found within the Muslim community are associated with therapy and utilized as direct responses to physical and psychological illness.

These traditional treatments have been brought by individuals to many Muslim communities in various Western countries. The extent of their use and their incorporation with biomedical treatments, counseling, or other social services have yet to be fully explored. In addition, religious based coping is common. Using religion to cope with serious physical and mental illness in Muslim clients has been found to have a positive impact on health outcomes or the stresses related to simultaneous treatment (Shaheen Al-Ahwal, Al Zaben, Sehlo, Khalifa, Koenig, 2016)

Attempts have been made to develop forms of religious psychotherapy that seek to address the Islamic worldview (Azhar, Varma, & Dharap, 1994; Razali, Hasanah, Aminah, & Subramaniam, 1998; Hamdan, 2007) and include using cognitive techniques from the Quran, making lifestyle changes according to the *sunnah*, and using repentance if clients have developed a sense of guilt. Individuals with strong inclinations towards psycho-spiritual or supernatural causation of mental illness may be more likely to accept Islamically integrated psychotherapy options (Abu-Raiya, 2015). The practice of counseling continues to increase among Muslims (Ahmed & Amer, 2012), with a growth in the number of Muslim clinical psychologists and counselors over the past few decades. Additionally, Muslim counselors have formed their own clinics and professional organizations in acknowledgement of the increase in the practice of counseling that is designed to meet the needs and worldviews of practitioners of Islam. The intersection of Islam and counseling is widely accepted today (Abdullab, 2007)

Islamic-based counseling and Islamically integrated psychotherapy (York Al-Karam, 2018) reflect the growing revival of the application of Islamic psychology and traditional Islamic concepts of mental illness. Attempts to evaluate the effectiveness of incorporating Islamic forms of worship and religious based

coping into counseling with practitioners of Islam demonstrate the positive impact in many therapeutic settings (Khalid, 2007; Hanin Hamjah et al., 2017; Zakaria & Mat Akhir, 2017). The contemporary use of religiously based therapy for treatment of mental illness for Muslim clients has been documented in Asian, Middle Eastern, and African countries (Ally & Laher, 2008; Al-Issa, 2000; Campion & Bhugra, 1998). Numerous researchers have proposed a method of religiously integrated psychotherapy for use with Muslim clients (Abu Raiya & Pargament, 2010; Abu-Raiya, 2015; Keshavarzi & Haque, 2013). This approach to the treatment of mental illness directly addresses dimensions of Islam that are relevant to the mental health concepts of Muslims, including Islamic methods of coping. Religious psychotherapy has been found to produce significant improvement in patients in Malaysia (Azhar & Varma, 2000) and has been introduced, to varying results, in other Muslim societies (Al-Issa, 2000). There is also ongoing research testing the effectiveness of adaptation of various therapeutic techniques within Muslim populations in both Muslim majority and Muslim minority countries. This includes cognitive behavioral therapy (Naeem et al., 2015).

Traditional Islamic forms of therapy are therefore dynamic and encompass multiple interpretations of the origin of illness and acknowledge the effectiveness of multi-modal approaches to therapy that include assessment, diagnosis, talking therapy, and specific actions . These practices are tied to evidence that is drawn from religious tradition and perceptions of mental illness within unique cultural contexts. The majority of research and testing of Islamic forms of counseling is occuring in the United States, the Middle East, and most prominently in Malaysia. Further research will determine the effectiveness of these varied techniques and their application to different Muslim communities.

The Impact of Stigma and Perceived Bias on Help-Seeking and Service Utilization

Stigma continues to be a significant factor impacting help-seeking and utilization of services among Muslims. This includes stigma associated with a specific problem (such as depression, marital discord, addiction, learning disabilities, etc.) and the stigma of seeking help from sources outside of the family. Stigma and ideas of shame and honor are attached to help-seeking outside of the family for issues such as child sexual abuse (Haboush & Alyan, 2013), intimate partner violence (Eunha & Hogge, 2015), and suicidal ideation (Heredia Montesinos et al., 2019). Stigma related to members of one's community finding out that has a problem or sought help outside of one's family can also decrease intention and actual help-seeking behaviors (Youssef & Deane, 2006). Stigmatizing attitudes toward mental health services and mental health problems within an individual's social network were found to be a deterrent to seeking help (Kapadia, Brooks, Nazroo, Tranmer, 2017).

Therefore, it is important for service providers to emphasize the confidential nature of services and outline ways that they maintain confidentiality (Hamid & Furnham, 2013). Perceived bias and the rise in Islamophobia are compounding the existing stigma. Anti-Muslim actions, particularly verbal and physical attacks on Muslims, have increased significantly in the United States, Europe, and Australia since 9/11. Latham (2016) outlines cases where mandatory reporting among social workers of perceived radicalization in the UK has led to nearly 80% of individuals referred for perceived radicalization not being deemed actual threats in need of intervention. These false accusations result in increased fear of social service providers among the targeted population.

Muslims are now suffering from increased religious and ethnic-based discrimination in many Western nations, further pushing community members to avoid airing issues or problems with those outside of

their community, or a fear of being judged by non-Muslims. In the United States, rising Islamophobia has been connected to poor mental health, health behaviors, and low help-seeking behaviors (Samari, Alcala & Sharif, 2018; Samari, 2016). Studies conducted in Europe, Canada, and the United States indicate an increase in negative attitudes towards Muslims and increased experiences of discrimination by Muslims (Abu-Ras, Suarez, & Abu-Bader, 2018; Wilkins, 2018; Kaya, 2015; Giuliani, Tagliabue, & Regalia, 2018). This can further isolate communities from service providers and from the formation of partnerships between religious organizations and agencies that could improve overall public health.

The Impact of Religiosity on Help-Seeking and Compliance: Assessing Level of Religiosity in Clients

Like members of other religious groups, Muslims vary in their level of adherence to religious practice. Research suggests that level of religiosity may impact willingness to utilize services outside of one's religious tradition. More religious Muslims may rely heavily on Islamic-based treatments or utilize religious coping before considering other available resources. In many cases, they may not have considered outside resources at all and may be suspicious or concerned that non-Muslim service providers will not understand them or would be unwilling to meet their needs.

If a service provider is unsure of how religious a client is, or how much of an impact religiosity plays in their lives, there are a number of brief assessments that can be administered. These resources can help service providers/helping professionals determine whether they need to learn more about the cultural or religious background of clients in order to be effective providers, whether they need to engage in a "clergy consult", or whether it would be in the best interest of clients to refer them out to a same-religion or same-culture provider. One of the most well-known tools is the FICA. It has been utilized to assess spiritual beliefs in a variety of settings, including palliative care, nursing, and counseling. The FICA is recommended as a tool to use at the intake interview with clients (Keshavarzi & Haque, 2013). From a social work perspective, there are a variety of spiritual assessment tools that can be utilized, including spiritual histories, spiritual life maps, spiritual genograms, spiritual ecomaps, and spiritual ecograms (Hodge, 2005). Many of these can be applied to other helping professions.

There have been efforts to define religiosity and religious commitment and to formulate measures specific to the Muslim population (AlMarri, Oei, & Al-Adawi, 2009; Abu Raiya, Pargament, Mahoney, & Stein, 2008; Albelaikhi, 1997; Ji & Ibrahim, 2007a; Krauss, Hamzah, & Idris, 2007; Wilde & Joseph, 1997). Several of these scales have been tested in both Muslim-majority and Muslim-minority countries. Most scales focus on measuring adherence to Islamic beliefs and doctrines, the influence of Islamic doctrine on choices such as what to wear, and frequency of religious behaviors including prayer, reading Quran, attending the mosque, fasting, and giving to charity. Most of these measures are in the early stages of development and testing and may be too lengthy for a helping professional to use in their initial assessment interviews with a new client. However, it should be noted that religiosity scales specific to the Muslim population are available as a potential tool for professionals in addition to the FICA and other spiritual assessment tools. Using some form of cultural and spiritual assessment is viewed as essential to developing an appropriate intervention when working with Muslim clients (Ibrahim & Dykeman, 2011).

If you are working with a client who has been assessed as highly religious, and are having difficulty successfully communicating treatment options or navigating stigma around the situation, a clergy or chaplain consult may be an effective way to build rapport with the client, establish the legitimacy of the services, and obtain religious endorsement for treatments or services that the client views as sus-

pect. An imam is the official title for a religious figure or clergy within the Muslim tradition. This is an individual who is recognized by the community as possessing religious learning, an ability to lead the daily prayers, and apply religious knowledge to addressing community problems. Other names for religious or spiritual leaders in the Muslim community include the title of *sheikh* usually given to a person of high spiritual status or religious learning, and *pir*, a term for a spiritual person that is often used in South Asia and mostly refers to individuals within the Sufi tradition. The role of the *imam*, like that of pastors and other clergy in Western countries, encompasses to some degree counseling, grief and grieving, and family and couples issues (Haddad & Lummus, 1987; Kobeisy, 2004; A.Ali, Milstein, & Marzuk, 2005). Most imams do not have formal training related to counseling or social work but have found themselves called upon to act in this role for community members to address issues mentioned above and increasingly to address the psychological impact of discrimination. Formal relationships with *imams* or chaplains can be established if practicing in an area with a large Muslim population. This type of partnership would encourage imams and Muslim chaplains to make appropriate referrals to service providers and provide a resource regarding religious beliefs and values for helping professionals. Imams can usually be contacted by locating the mosques in the area and calling the direct number for the local mosque or Islamic center. There are also Islamic associations who can help to connect you with a local imam. In addition, many large universities have a designated Muslim chaplain who provides religious knowledge and spiritual leadership to the campus Muslim community. These individuals can be reached through the campus directory.

The Impact of Acculturation on Health Outcomes and Help-Seeking

Many studies have been conducted linking acculturation to health outcomes in minority populations. Many of these studies have focused on the poor mental health of recent immigrants due to the stresses associated with the process of acculturation (Berry & Kim, 1988). Both low assimilation as well as high assimilation have alternately been linked to poor health (Padilla et al., 1985; Oh, Koeske, & Sales, 2002). Strong family ties and social support networks appear to act as a buffer, lowering the risk of mental and behavioral health problems (Eschbach, Pstir, Patel, Markides, & Goodwin, 2004), while lack of acceptance from the dominant or host society can lead to poorer health outcomes, especially for immigrants (Organista et al., 2003; Thomas, 2006). Acculturative stress experienced by Muslim populations has been linked to anxiety, depression, and overall well-being (Amer, 2005; Timazi, 2008; Khuwaja et al., 2007; M. Ali, 2007). Acculturation is often measured by the length of time the individual has lived in the country, and language use. These measures may not be very effective within Muslim populations, as they fail to take into account acculturation experienced by native-born Muslims, converts, and first-generation Muslims, who are often perceived by the society as foreign or other. Measures that look at level of conformity to local norms may be a more accurate measure of acculturation than language usage, length of time, and social interaction (Bagasra & Mackinem, 2019).

The degree of acculturation and assimilation of an individual can have an effect on his or her attitude toward health services and actual behavior in seeking help (Pilkington, Msetfi, & Watson, 2012). This may be influenced by a number of factors including education, rather than length of time within a country, and previous experiences with helping professions may be a larger determinant of help-seeking behaviors. A service provider may want to ask basic questions about length of time in the country if it is apparent that the individual is not native-born. They may also want to know if the individual is a refugee or asylum seeker, as this can impact the level of acculturative stress experienced with the process of

trying to adapt to a new culture. Depending upon the type of service, other questions may be appropriate. For example, within the education system, a school counselor may need to know more about the family background of a child they have been assigned to work with. A child may quickly assimilate, or want to assimilate to the host culture, but may experience resistance or resentment from parents who are holding on to the culture of origin. This can create family conflicts that may be central to behavioral or mental health needs of a child. A child may also be serving as translator or taking on significant roles due to their acculturation status and language ability. Ability to navigate a new culture can be beneficial and burdensome. Similarly, adolescents trying to establish a personal identity may choose to strengthen their religious identity by wearing hijab or increasing participation in religious activities. This can create distress if family conflict arises, or an adolescent loses social support from family or friends. The bi-directional nature of acculturation, especially for children and adolescents trying to establish personal identity, can result in psychological, social, and physical distress. It is important for a provider to take into account the "story" of each individual client, which may include their journey towards a fuller embrace of the local cultural and social norms, or a careful examination of these norms in the face of their religious values or values of a culture of origin. For Muslim converts, they may choose a specific type of Islam to follow, or to adopt the cultural background of a specific Muslim country, such as wearing the traditional clothing of Pakistan or Morocco. The intersection of culture, religion, self-identity, and societal labeling creates a complex web of factors that a service provider may be able to acknowledge but not address, especially if interaction with a client is short-term.

The Impact of Gender and Family Dynamics on Help-Seeking and Service Utilization

Some Muslims, especially the highly religious or individuals coming from societies where strict gender segregation has been in practice, adhere to gender norms that may prevent a person from seeking health or social services from service providers of the opposite gender. Beliefs regarding being alone in a room with a member of the opposite gender can restrict access to some services, unless accommodation is made that allows a family member to be present during service rendering, or a door left open during the session. In some countries like Saudi Arabia, there are guardianship laws that require women to have permission from a *mahram* (this would be a biological male relative such as a father, brother, uncle, or son) to travel, work, go to school, or go to the doctor; access to services would only come through explicit permission from the male relative. Even though this is not law in many other Muslim countries, variations are in place informally. Though men are not restricted in the same way socially, it is considered inappropriate for men to also be alone with a woman who is not their biological relative or spouse. The presence of a relative during services may be an option but can be especially difficult for social workers and counselors, as confidentiality is a key aspect of their work. Gender segregation and family dynamics that restrict a woman's movement can have significant implications on help-seeking, especially for refugees and recent migrants who have not assimilated to gender mixing and freedom of movement found in most Western countries (Weatherhead & Daiches, 2015).

Modesty in dress for both men and women is an important belief for practitioners of Islam. Some Muslim women engage in various forms of *hijab*, which can range from wearing modest clothing and a head scarf, to wearing free flowing robes called an *abaya* or *jilbab*, to wearing a piece of cloth that covers the face called a *niqab*. Wearing of the hijab may reflect cultural or family norms, a desire to assert one's Islamic identity, strong beliefs in religious injunctions regarding modesty, or a combina-

tion of these factors. Many religious Muslim women wear hijab, and many other women who consider themselves religious do not regularly wear the hijab. All Muslim women cover the body and head when engaged in formal daily prayer (*salat)*. Men are expected to be covered from the navel to the knee under all circumstances and to dress modestly. Clothing that features human figures are not to be worn when performing the daily prayers, and a Muslim should not face a human figure or pictures of human figures while in prayer. This can be important if providing a space for meditation or prayer in a practice or clinic.

Muslims will attempt to maintain modesty even in medical situations where it may be difficult such as labor and delivery, physical exams, and surgery. Muslim women consider the gender and cultural background of a health care provider as important, especially for reproductive healthcare (George, Terrion, &Ahmed, 2014). Differences in beliefs about modesty can be a barrier to seeking out health services (Yosef, 2008). Nurses and doctors working with Muslim patients can acknowledge norms of modesty and ask patients to communicate any discomfort. Efforts can be made to keep the patient covered as much as possible during a physical exam. When it comes to labor and delivery, women can bring modest gowns and robes to use to maintain as much sense of modesty throughout the process. Modesty norms and availability of same-gender care providers have been found to influence health behaviors, including mammography (Padela et al., 2016).

Making direct eye contact is also viewed as displaying lack of modesty, as men are admonished to lower their gaze in the Quran. Both men and women may avoid direct eye contact with a member of the opposite gender. Refusing eye contact is therefore not a sign of depression, dishonesty, or lack of respect for the service provider by Muslim clients. In the presence of a same gender service provider, lack of eye contact could indicate respect for an authority figure or alternately indicate a sense of shame or distress regarding the situation at hand. Cultural background can result in varied non-verbal behaviors in a clinical setting.

In addition to these norms, an individual may feel uncomfortable sharing their problems with a member of the opposite gender and a person outside of their family, as it would deviate from standard conduct. If a same gender professional is not available, and the individual is not comfortable disclosing information, considerations for referring out to a same-gender provider should be considered. If a referral is not possible, directly addressing discomfort and ways to address that discomfort in sessions may be useful.

Family dynamics, the presence of intergenerational conflict, and the impact of collectivist and patriarchal structures can all contribute to distress, social and psychological issues, and willingness to seek help for Muslim clients (Graham, Bradshaw, & Trew, 2010). The concepts of honor and shame have been noted as particularly salient for Muslim women who adhere to a collectivist framework (Helms, 2015). Both women and men who are afraid of being viewed as dishonoring or shaming their family by seeking out help for personal and interpersonal problems may be more reluctant to utilize available services, both from Muslim and non-Muslim providers. This is particularly true for domestic violence, victims of sexual assault, psychological distress, and behaviors viewed as socially deviant, including addiction and sexual behavior. (Helms, 2015; Oyewuwo-Gassikia, 2016; Cowburn, Gill & Harrison, 2015; Hamid & Furnham, 2013).

Family dynamics may result in an individual turning to family members for help first, before considering using a professional such as a doctor, counselor, or social worker. Advice from family members may be utilized as a first defense against problems. Once this resource has been exhausted, an individual may consider seeking outside help. Sometimes this is a matter of cost of services, stigma associated with exposing a problem to those outside of the family, and fear of how the problem will look to others (fear of being judged as well as fear of upsetting the image of a model minority).

CONCLUSION

Islamic beliefs and behaviors, mediated by levels of religiosity and acculturation, and impacted by external factors such as culture, status, experiences with discrimination, and previous experiences with services, all play a role in how Muslim clients view health, illness, interpersonal problems and trauma. In turn, perceptions of problems often dictate attitudes towards available care options and help-seeking behaviors. None of these factors exist independent of each other and represent an ongoing and ever-changing dynamic.

This leaves the helping professional in the position of 1) showing dedication to learning the basic values and beliefs of a client in order to engage in culturally-informed care, 2) willingness to engage in communication with individuals who can assist them in gaining religious or cultural information that can inform their care plan and interventions, 3) assessing various aspects of the client including religiosity, acculturation status, and social and cultural norms that may prevent care or adherence to a care plan, and 4) addressing any pre-conceived biases or perceptions that the provider may unknowingly or knowingly harbor as it relates to Muslims. Islamophobia, as well as negative, stereotypical, or inaccurate media coverage of Muslims can contribute to implicit bias of service providers towards Muslim clients. Previous research by the author found some Muslim Americans who had experiences with mental health services reported bias, perceived discrimination, or offensive questions from professionals. These included suggesting that Islam was a source of stress for the individual, viewing the hijab as a sign that a woman is oppressed, and other forms of stereotyping (Bagasra, 2011). Muslims in North America, Europe, and Australia often view helping professions either through the lens of previous experiences with similar services in Muslim-majority countries, which may or may not accurately reflect the nature of the services offered in Western societies, or through the lens of previous experiences by themselves or other community members with such services. Negative experiences or the perception that they will be treated negatively by service providers, have a significant impact on willingness to seek out, utilize, or continue usage of available services.

In sum, culturally competent care requires understanding, willingness to learn and view individuals as distinct from prevailing stereotypes, and open communication. Education and partnerships with religious organizations in the local Muslim community, and communication with and endorsement from Muslim community leaders can help a provider establish a strong relationship built on mutual respect and understanding.

REFERENCES

Abdullab, S. (2007). Islam and Counseling: Models of Practice in Muslim Communal Life. *Journal of Pastoral Counseling*, *42*, 42–55.

Abu-Rabia, A. (2005). The evil eye and cultural beliefs among the Bedouin tribes of the Negev, Middle East. *Folklore*, *116*(3), 241–254. doi:10.1080/00155870500282677

Abu-Raiya, H. (2015). Working with Muslim clients: A dynamic Qura'nic-based model of psychotherapy. *Spirituality in Clinical Practice*, *2*(2), 120–133. doi:10.1037cp0000068

Abu-Raiya, H., & Pargament, K. (2010). Religiously integrated psychotherapy with Muslim clients: From research to practice. *Professional Psychology, Research and Practice*, *41*(2), 181–188. doi:10.1037/a0017988

Abu-Raiya, H., Pargament, K., Mahoney, A., & Stein, C. (2008). A psychological measure of Islamic religiousness: Development and evidence for reliability and validity. *The International Journal for the Psychology of Religion*, *18*(4), 291–315. doi:10.1080/10508610802229270

Abu-Ras, W., Suárez, Z. E., & Abu-Bader, S. (2018). Muslim Americans' safety and well-being in the wake of Trump: A public health and social justice crisis. *The American Journal of Orthopsychiatry*, *88*(5), 503–515. doi:10.1037/ort0000321 PMID:29629779

Ahmed, S., & Amer, M. (2012). *Counseling Muslims: Handbook of Mental Health Issues and Interventions*. New York: Routledge.

Al-Adawi, S., Dorvlo, A. S. S., Al-Ismaily, S. S., Al-Ghafry, D. A., Al-Noobi, B. Z., Al-Salmi, A., ... Chand, S. P. (2002). Perception of and attitude toward mental illness in Oman. *The International Journal of Social Psychiatry*, *48*(4), 305–317. doi:10.1177/002076402128783334 PMID:12553410

Al-Balhan, E., Khabbache, H., Laaziz, A., Watfa, A., Mhamdi, A., Del Puente, G., & Bragazzi, N. L. (2018). To fast or not to fast during the month of Ramadan? A comprehensive survey on religious beliefs and practices among Moroccan diabetic patients. *Diabetes, Metabolic Syndrome and Obesity*, *11*, 633–640. doi:10.2147/DMSO.S171990 PMID:30410375

Al-Issa, I. (2000). *Al-Junun: Mental illness in the Islamic world*. Madison, CT: International Universities Press.

Al Khateeb, J. M., Al Hadidi, M. S., & Al Khatib, A. J. (2014). Arab Americans With Disabilities and Their Families: A Culturally Appropriate Approach for Counselors. *Journal of Multicultural Counseling and Development*, *42*(4), 232–247. doi:10.1002/j.2161-1912.2014.00057.x

Al-Munajjid, M. (2003). Dealing with worries and stress. Birmingham, UK: Daar -us-Sunnah Publishers.

Al-Subaie, A. (1994). Traditional healing experiences in patients attending a university outpatient clinic. *Arab Journal of Psychiatry*, *5*, 83–91.

Al-Subaie, A., & Alhamad, A. (2000). Psychiatry in Saudi Arabia. In I. Al-Issa (Ed.), *Al-Jun-un: Mental illness in the Islamic world* (pp. 205–233). Madison, CT: International Universities Press.

Alawi, A. (1992). The Qur'anic concept of mental health. In Z. Ansari (Ed.), *Qur'anic concept of human psyche* (pp. 87–97). Islamabad, Pakistan: The International Institute of Islamic Thought and Institute of Islamic Culture.

Ali, M. (2007). *Impact of acculturation, ethnic identity, religiosity, and individual difference variables on the subjective well-being of Pakistani Muslims in the United States* (Doctoral dissertation). Retrieved from ProQuest Dissertations and Theses database. (AAT 3229824)

Ali, O., Milstein, G., & Marzuk, P. (2005). The Imam's role in meeting the counseling needs of Muslim communities in the United States. *Psychiatric Services (Washington, D.C.)*, *56*(2), 202–205. doi:10.1176/appi.ps.56.2.202 PMID:15703349

Ally, Y., & Laher, S. (2008). South African Muslim faith healers' perceptions of mental illness: Understanding, Aetiology and Treatment. *Journal of Religion and Health*, *47*(1), 45–56. doi:10.100710943-007-9133-2 PMID:19105000

AlMarri, T., Oei, T., & Al-Adawi, S. (2009). The development of the short Muslim practice and belief scale. *Mental Health, Religion & Culture*, *12*(5), 415–426. doi:10.1080/13674670802637643

Aloud, N. (2004). *Factors affecting attitudes toward seeking and using formal mental health and psychological services among Arab-Muslim population* (Doctoral dissertation). Retrieved from ProQuest Dissertations and Theses database. (AAT 3124971)

Alsolamy, S. (2014). Islamic Views on Artificial Nutrition and Hydration in Terminally Ill Patients. *Bioethics*, *28*(2), 96–99. doi:10.1111/j.1467-8519.2012.01996.x PMID:22845721

Ameen, A. (2005). The jinn and human sickness: Remedies in the light of the Qur'aan and Sunnah. Riyadh, Saudi Arabia: Darussalam.

Amer, M. (2005). *Arab American mental health in the post September 11 era: Acculturation, stress, and coping* (Doctoral dissertation). Retrieved from ProQuest Dissertations and Theses database. (AAT 3171022)

Arabiat, D. H., Al Jabery, M., Abdelkader, R. H., & Mahadeen, A. (2013). Jordanian Mothers' Beliefs About the Causes of Cancer in Their Children and Their Impact on the Maternal Role. *Journal of Transcultural Nursing*, *24*(3), 246–253. doi:10.1177/1043659613481808 PMID:23545695

Athar, S. (Ed.). (1993). *Islamic perspectives in medicine: A survey of Islamic medicine: Achievements & contemporary issues*. Indianapolis, IN: American Trust.

Azhar, M. Z., & Varma, S. L. (2000). Mental illness and its treatment in Malaysia. In I. Al-Issa (Ed.), *Al-Jun-un: Mental illness in the Islamic world* (pp. 163–186). Madison, CT: International Universities Press.

Azhar, M. Z., Varma, S. L., & Dharap, A. S. (1994). Religious psychotherapy in anxiety disorder patients. *Acta Psychiatrica Scandinavica*, *90*(1), 1–2. doi:10.1111/j.1600-0447.1994.tb01545.x PMID:7976440

Bali, W. (2004). *Sword against black magic and evil magicians* (C. Abdelghani, Trans.). London, UK: Al-Firdous.

Berry, J. W., & Kim, U. (1988). Acculturation and mental health. In P. Dasen, J. W. Berry, & N. Sartorius (Eds.), *Health and cross-cultural psychology* (pp. 207–236). London, UK: Sage.

Cheng, K. (n.d.). "My husband is possessed by a jinn": A case study in transcultural mental health. *Australasian Psychiatry, 25*(5), 471–473.

Cowburn, M., Gill, A. K., & Harrison, K. (2015). Speaking about sexual abuse in British South Asian communities: Offenders, victims and the challenges of shame and reintegration. *Journal of Sexual Aggression*, *21*(1), 4–15. doi:10.1080/13552600.2014.929188

Deuraseh, N. (2009). Using the verses of the Holy Qur'an as ruqyah (Incantation): The perception of Malay-Muslim society in Kelantan and Terengganu on ruqyah as an alternative way of healing in Malaysia. *European Journal of Soil Science*, *9*(3), 448–456.

El-Islam, M. F. (2000). Mental illness in Kuwait and Qatar. In I. Al-Issa (Ed.), *Al-Junun: Mental illness in the Islamic world* (pp. 121–137). Madison, CT: International Universities Press.

Eltaiba, N. (2014). Counseling with Muslim Refugees: Building Rapport. *Journal of Social Work Practice*, *28*(4), 397–403. doi:10.1080/02650533.2013.875523

Endrawes, G., O'Brien, L., & Wilkes, L. (2007). Mental illness and Egyptian families. *International Journal of Mental Health Nursing*, *16*(7), 178–187. doi:10.1111/j.1447-0349.2007.00465.x PMID:17535163

Fadlalla, A. H. (2005). Modest women, deceptive jinn: Identity, alterity, and disease in Eastern Sudan. *Identities (Yverdon)*, *12*(2), 143–174. doi:10.1080/10702890490950556

Farooqi, Y. (2006). Traditional healing practices sought by Muslim psychiatric patients in Lahore, Pakistan. *International Journal of Disability Development and Education*, *53*(4), 401–415. doi:10.1080/10349120601008530

George, P., Terrion, J. L., & Ahmed, R. (2014). Reproductive health behaviour of Muslim immigrant women in Canada. *International Journal of Migration, Health and Social Care*, *10*(2), 88–101. doi:10.1108/IJMHSC-09-2013-0032

Giuliani, C., Tagliabue, S., & Regalia, C. (2018). Psychological Well-Being, Multiple Identities, and Discrimination Among First and Second Generation Immigrant Muslims. *Europe's Journal of Psychology*, *14*(1), 66–87. doi:10.5964/ejop.v14i1.1434 PMID:29899799

Graham, J. M., & White, D. (2015). Muslim Nursing Student Beliefs about Possession States: An Exploratory Survey of Beliefs and Causal Attributions. *The Journal of Educational Thought (JET). Revue de La Pensée Éducative*, *48*(1/2), 43.

Graham, J. R., Bradshaw, C., & Trew, J. L. (2010). Cultural considerations for social service agencies working with Muslim clients. *Social Work*, *55*(4), 337–346. doi:10.1093w/55.4.337 PMID:20977057

Haboush, K. L., & Alyan, H. (2013). "Who Can You Tell?" Features of Arab Culture That Influence Conceptualization and Treatment of Childhood Sexual Abuse. *Journal of Child Sexual Abuse*, *22*(5), 499–518. doi:10.1080/10538712.2013.800935 PMID:23829830

Haddad, Y., & Lummis, A. (1987). *Islamic values in the United States: A comparative study*. New York, NY: Oxford University Press.

Hamdan, A. (2007). A case study of a Muslim client: Incorporating religious beliefs and practices. *Journal of Multicultural Counseling and Development*, *35*(2), 92–100. doi:10.1002/j.2161-1912.2007.tb00052.x

Hamdy, S. F. (2009). Islam, Fatalism, and Medical Intervention: Lessons from Egypt on the Cultivation of Forbearance (Sabr) and Reliance on God (Tawakkul). *Anthropological Quarterly*, *82*(1), 173–196. doi:10.1353/anq.0.0053

Hamid, A., & Furnham, A. (2013). Factors affecting attitude towards seeking professional help for mental illness: A UK Arab perspective. *Mental Health, Religion & Culture*, *16*(7), 741–758. doi:10.1080/13674676.2012.718753

Hanin Hamjah, S., Mat Akhir, N. S., Ismail, Z., Ismail, A., & Mohd Arib, N. (2017). The Application of Ibadah (Worship) in Counseling: Its Importance and Implications to Muslim Clients. *Journal of Religion and Health*, *56*(4), 1302–1310. doi:10.100710943-015-0122-6 PMID:26359049

Haque, A. (2004a). Psychology from Islamic perspective: Contributions of early Muslim scholars and challenges to contemporary Muslim psychologists. *Journal of Religion and Health*, *43*(4), 357–377. doi:10.100710943-004-4302-z

Haque, A. (2004b). Religion and mental health: The case of American Muslims. *Journal of Religion and Health*, *43*(1), 45–58. doi:10.1023/B:JORH.0000009755.25256.71

Haque, A. (2008). Culture-bound syndromes and healing practices in Malaysia. *Mental Health, Religion & Culture*, *11*(7), 685–696. doi:10.1080/13674670801958867

Haque, A. (2010). Mental health concepts in Southeast Asia: Diagnostic considerations and treatment implications. *Psychology Health and Medicine*, *15*(2), 127–134. doi:10.1080/13548501003615266 PMID:20391230

Haque-Khan, A. (1997). *Muslim women's voices: Generation, acculturation, and faith in the perceptions of mental health and psychological help* (Doctoral dissertation). ProQuest Dissertations and Theses database. (AAT 9733466)

Helms, B. L. (2015). Honour and Shame in the Canadian Muslim Community: Developing Culturally Sensitive Counselling Interventions/Honneur et honte dans la communaute musulmane au Canada : Elaborer des modes d'intervention et de counseling tenant compte des cultures. *Canadian Journal of Counselling and Psychotherapy*, (2), 163.

Heredia Montesinos, A., Aichberger, M. C., Temur-Erman, S., Bromand, Z., Heinz, A., & Schouler-Ocak, M. (2019). Explanatory models of suicidality among women of Turkish descent in Germany: A focus group study. *Transcultural Psychiatry*, *56*(1), 48–75. doi:10.1177/1363461518792432 PMID:30131021

Husain, A. (2006). *Islamic psychology: Emergence of a new field*. New Delhi, India: Global Vision Publishing House.

Husain, S. A. (1998). Religion and mental health from the Muslim perspective. In H. Koenig (Ed.), *Handbook of religion and mental health* (pp. 279–291). San Diego, CA: Academic Press. doi:10.1016/B978-012417645-4/50087-0

Ibn Taymiyyah, S.-I., & Al-Haazimee, I. (Eds.). (2000). The disease of the heart & their cures (A. Rumaysah, Trans.). Birmingham, UK: Daar us-Sunnah Publications. (Original work published ca. 1319-1320)

Ibrahim, F. A., & Dykeman, C. (2011). Counseling Muslim Americans: Cultural and Spiritual Assessments. *Journal of Counseling and Development*, *89*(4), 387–396. doi:10.1002/j.1556-6676.2011.tb02835.x

Ji, C.-H. C., & Ibrahim, Y. (2007a). Islamic doctrinal orthodoxy and religious orientations: Scale development and validation. *The International Journal for the Psychology of Religion*, *17*(3), 189–208. doi:10.1080/10508610701402192

Kapadia, D., Brooks, H. L., Nazroo, J., & Tranmer, M. (2017). Pakistani women's use of mental health services and the role of social networks: A systematic review of quantitative and qualitative research. *Health & Social Care in the Community*, *25*(4), 1304–1317. doi:10.1111/hsc.12305 PMID:26592487

Kaya, S. (2015). Islamophobia in Western Europe: A Comparative, Multilevel Study. *Journal of Muslim Minority Affairs*, *35*(3), 450–465. doi:10.1080/13602004.2015.1080952

Keshavarzi, H., & Haque, A. (2013). Outlining a Psychotherapy Model for Enhancing Muslim Mental Health within an Islamic Context. *The International Journal for the Psychology of Religion*, *23*(3), 230–249. doi:10.1080/10508619.2012.712000

Khalid, S. (2007). Counselling from an Islamic perspective. *Therapy Today*, *18*(2), 34–37.

Khuwaja, S., Selwyn, B., Kapadia, A., McCurdy, A., & Khuwaja, A. (2007). Pakistani Ismaili adolescent females living in the United States of America: Stresses associated with the process of adaptation to U.S. culture. *Journal of Immigrant Health*, *9*(1), 35–42. doi:10.100710903-006-9013-y PMID:17103322

Kim, E., & Hogge, I. (2015). Intimate Partner Violence among Asian Indian Women in the United States: Recognition of Abuse and Help-Seeking Attitudes. *International Journal of Mental Health*, *44*(3), 200–214. doi:10.1080/00207411.2015.1035073

Kobeisy, A. H. (2004). *Counseling American Muslims: Understanding the faith and helping the people*. Westport, CT: Praeger.

Krauss, S., Hamzah, A., & Idris, D. (2007). Adaptation of a Muslim religiosity scale for use with four different faith communities in Malaysia. *Review of Religious Research*, *49*(2), 147–164.

Latham, S. (2016). The Global Rise of Islamophobia: Whose side is social work on? *Social Alternatives*, *35*(4), 80.

Martin, S. (2009). Illness of the mind or illness of the spirit? Mental health-related conceptualization and practices of older Iranian immigrants. *Health & Social Work*, *34*(2), 117–125. doi:10.1093/hsw/34.2.117 PMID:19425341

Mehrabi, F., Bayanzadeh, S., Atef-Vahid, M., Bolhari, J., Shahmohammadi, D., & Vaezi, S. (2000). Mental health in Iran. In I. Al-Issa (Ed.), *Al-Junun: Mental illness in the Islamic world* (pp. 139–163). Madison, CT: International Universities Press.

Mir, G., & Sheikh, A. (2010). "Fasting and prayer don't concern the doctors ... they don't even know what it is": Communication, decision-making and perceived social relations of Pakistani Muslim patients with long-term illnesses. *Ethnicity & Health*, *15*(4), 327–342. doi:10.1080/13557851003624273 PMID:20544446

Mölsä, M., Kuittinen, S., Tiilikainen, M., Honkasalo, M.-L., & Punamäki, R.-L. (2017). Mental health among older refugees: The role of trauma, discrimination, and religiousness. *Aging & Mental Health*, *21*(8), 829–837. doi:10.1080/13607863.2016.1165183 PMID:27080403

Mubbashar, M. H. (2000). Mental illness in Pakistan. In I. Al-Issa (Ed.), *Al-Junun: Mental illness in the Islamic world* (pp. 187–203). Madison, CT: International Universities Press.

Mullick, M. S. I., Khalifa, N., Nahar, J. S., & Walker, D.-M. (2013). Beliefs about Jinn, black magic and evil eye in Bangladesh: The effects of gender and level of education. *Mental Health, Religion & Culture*, *16*(7), 719–729. doi:10.1080/13674676.2012.717918

Naeem, F., Phiri, P., Munshi, T., Rathod, S., Ayub, M., Gobbi, M., & Kingdon, D. (2015). Using cognitive behaviour therapy with South Asian Muslims: Findings from the culturally sensitive CBT project. *International Review of Psychiatry (Abingdon, England)*, *27*(3), 233–246. PMID:26211879

Nurbakhsh, J. (1992). *The psychology of Sufism*. London, UK: Khaniqahi-Nimatullahi Publications.

Oyewuwo-Gassikia, O. B. (2016). American Muslim Women and Domestic Violence Service Seeking. *Affilia*, *31*(4), 450–462. doi:10.1177/0886109916654731

Padela, A. I., Vu, M., Muhammad, H., Marfani, F., Mallick, S., Peek, M., & Quinn, M. T. (2016). Religious beliefs and mammography intention: Findings from a qualitative study of a diverse group of American Muslim women. *Psycho-Oncology*, *25*(10), 1175–1182. doi:10.1002/pon.4216 PMID:27424488

Padilla, A. M., Wagatsuma, Y., & Lindholm, K. J. (1985). Acculturation and personality as predictors of stress in Japanese and Japanese Americans. *The Journal of Social Psychology*, *125*(3), 295–305. doi:10.1080/00224545.1985.9922890 PMID:4079350

Pilkington, A., Msetfi, R. M., & Watson, R. (2012). Factors affecting intention to access psychological services amongst British Muslims of South Asian origin. *Mental Health, Religion & Culture*, *15*(1), 1–22. doi:10.1080/13674676.2010.545947 PMID:24348087

Pratt, R., Fadumo, A., Hang, M., Osman, S., & Raymond, N. (2016). Perceptions of mental illness in the Somali community in Minnesota. *International Journal of Migration, Health and Social Care*, *12*(1), 16–25. doi:10.1108/IJMHSC-04-2014-0011

Rahman, F. (1998). *Health and medicine in the Islamic tradition*. Chicago, IL: ABC International Group.

Raja, R. A. (2005). *Attitude of Pakistani American Muslim men towards seeking psychotherapy* (Doctoral dissertation). Retrieved from ProQuest Dissertations and Theses database. (AAT 3177435)

Rassool, G. H. (2015). Cultural competence in counseling the Muslim patient: Implications for mental health. *Archives of Psychiatric Nursing*, *29*(5), 321–325. doi:10.1016/j.apnu.2015.05.009 PMID:26397436

Razali, S. M., Hasanah, C. I., Aminah, K., & Subramaniam, M. (1998). Religious-sociocultural psychotherapy in patients with anxiety and depression. *The Australian and New Zealand Journal of Psychiatry*, *32*(6), 867–872. doi:10.3109/00048679809073877 PMID:10084352

Saeed, K., Gater, R., Hussain, A., & Mubbashar, M. (2000). The prevalence, classification and treatment of mental disorders among attenders of native faith healers in rural Pakistan. *Social Psychiatry and Psychiatric Epidemiology*, *35*(10), 480–485. doi:10.1007001270050267 PMID:11127723

Samari, G. (2016). Islamophobia and Public Health in the United States. *American Journal of Public Health*, *106*(11), 1920–1925. doi:10.2105/AJPH.2016.303374 PMID:27631738

Samari, G., Alcalá, H. E., & Sharif, M. Z. (2018). Islamophobia, Health, and Public Health: A Systematic Literature Review. *American Journal of Public Health*, *108*(6), e1–e9. doi:10.2105/AJPH.2018.304402 PMID:29672152

Shafi, S. (1998). A study of Muslim Asian women's experiences of counselling and the necessity for a racially similar counsellor. *Counselling Psychology Quarterly*, *11*(3), 301–314. doi:10.1080/09515079808254062

Shafii, M. (1988). *Freedom from the self: Sufism, meditation and psychotherapy*. New York, NY: Human Sciences Press.

Speziale, F. (2003). Tradition & modernization of Islamic psychiatric care in the subcontinent. *IIAS Newsletter*, *30*, 11.

Stein, D. (2000). Views of mental illness in Morocco: Western medicine meets the traditional symbolic. *JAMC*, *163*(11), 1468–1470. doi:10.1891/1559-4343.11.2.120 PMID:11192655

Thomas, N. K. (2006). Efforts to prevent terrorism: Impact on immigrant groups. In P. Kimmel & C. Stout (Eds.), *Collateral damage: The Psychological consequences of America's war on terrorism* (pp. 131–144). Westport, CT: Praeger.

Timazi, M. (2008). *The impact of acculturation on psychosocial well-being among immigrant Muslim youth* (Doctoral dissertation). Retrieved from ProQuest Dissertation and Theses database. (AAT 3307125)

Vu, M., Azmat, A., Radejko, T., & Padela, A. I. (2016). Predictors of Delayed Healthcare Seeking Among American Muslim Women. *Journal of Women's Health, 25*(6), 586–593.

Walton, L. M., Akram, F., & Hossain, F. (2014). Health Beliefs of Muslim Women and Implications for Health Care Providers: Exploratory Study on the Health Beliefs of Muslim Women. *Online Journal of Health Ethics / the University of Mississippi Medical Center*, *10*(2), e1–E36.

Watters, E. (2010). *Crazy like us: The globalization of the American psyche*. New York, NY: Free Press.

Weatherhead, S., & Daiches, A. (2010). Muslim views on mental health and psychotherapy. *Psychology and Psychotherapy: Theory, Research and Practice*, *83*(1), 75–89. doi:10.1348/147608309X467807 PMID:19735608

Weatherhead, S., & Daiches, A. (2015). Key Issues to Consider in Therapy with Muslim Families. *Journal of Religion and Health*, *54*(6), 2398–2411. doi:10.100710943-015-0023-8 PMID:25801751

Wilkins, L. S. (2018). Islamophobia in Canada: Measuring the Realities of Negative Attitudes Toward Muslims and Religious Discrimination. *Canadian Review of Sociology*, *55*(1), 86–110. doi:10.1111/cars.12180 PMID:29446538

York Al-Karam, C. (Ed.). (2018). *Islamically Integrated Psychotherapy: Uniting Faith and Professional Practice*. Templeton Press.

Yosef, A. R. O. (2008). Health beliefs, practice, and priorities for health care of Arab Muslims in the United States: Implications for nursing care. *Journal of Transcultural Nursing*, *19*(3), 284–291. doi:10.1177/1043659608317450 PMID:18445762

Youssef, J., & Deane, F. P. (2006). Factors influencing mental-health help-seeking in Arabic- speaking communities in Sydney, Australia. *Mental Health, Religion & Culture*, *9*(1), 43–66. doi:10.1080/13674670512331335686

Zakaria, N., & Mat Akhir, N. S. (2017). Theories and modules applied in Islamic counseling practices in Malaysia. *Journal of Religion and Health*, *56*(2), 507–520. doi:10.100710943-016-0246-3 PMID:27145944

KEY TERMS AND DEFINITIONS

Acculturation: Acculturation is a process that can occur for any individual or group trying to adjust or adapt to the dominant or host culture as a result of contact between cultures.

Evil Eye: Within the Islamic tradition, the evil eye is the belief that a person can cause misfortune, physical or mental illness, by placing a curse on another person as a result of envy. Often referred to as Nazar.

Jinn: Beings within Islamic theology made from "Smokeless fire" and distinct from humans and angels. Jinns can be bad and good and belong to different religions. Traditionally, it is believed that jinn can possess humans and cause symptoms of physical and psychological illness.

Qadr: Often translated as pre-destination or fate, it indicates Divine Will for followers of Islam. Allah (God) is unrestricted by time and knows the final outcome for each individual. The concept does not fully discount the idea of free will.

Religiosity Measures: Psychometric instruments that measure some aspect of religiosity or religious commitment either within a specific religion or measuring religiosity in general.

Religious Identity: The role of religion in personal identity, and the importance of religion in the person's group membership and overall self-concept.

Shame: Shame, honor, or izzat originates in the collectivist notion that an individual's actions reflect in their reputation and the reputation of their family and even larger community. Sinful behaviors, either committed by an individual or against an individual (such as rape, sexual abuse, or domestic violence) may all be viewed as bringing shame on an individual and household.

Spiritual Assessment: Oral or written questions designed to assess a client's spirituality or religiosity, to strengthen communication between a provider and a client, and elicit a better understanding of the role of spiritual or religious belief in the individual's life and decision making.