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Cultural Competence in Counseling the Muslim Patient: Implications for Mental Health

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A B S T R A C T

Given the rapidly growing population of Muslims in Western societies, it is imperative to develop a better understanding of the mental health needs and concerns of this community. Muslim religious beliefs have an impact on the mental health of individuals, families and communities. The lack of understanding of the interplay between religious influences on health or sickness behaviors can have a significant effect upon the delivery of nursing practice. The Muslim community is experiencing social exclusion (social exclusion correlates with mental health problems) related to their cultural and religious identity. In addition, the emergence of radical extremism and the resulting media coverage have magnified this problem. Misunderstanding the worldview of the patient can lead to ethical dilemmas, practice problems, and problems in communication. Often, Muslim individuals are stigmatized and families are rejected and isolated for their association with mental health problems, addiction and suicide. There are indicators that Muslims experience mental ill health, but that they either are unidentified by mainstream mental health services or present late to the services. The aims of the paper are to examine the religious and cultural influences on mental health beliefs of Muslims, and provide an understanding of mental health problems, and its implications in counseling and spiritual interventions.

Given the rapidly growing population of Muslims in Western societies, it is imperative to develop a better understanding of the mental health needs and concerns of this community. Recently, there has been a growth in the systematic research into religion, spirituality, and mental health. A large volume of research shows, on balance, that there is a strong association between religious belief and decreased depression, as well as reduced anxiety and suicide risk, and to a lesser extent, reduced psychotic disorders (Klocket, Trenetry, & Webstet, 2011). In Islam, the spirit, body and soul have been accorded equal importance. Muslims have a strong belief that there is a balanced connection between one's mental health/spiritual state and one overall health. The religious values and beliefs are intricately linked to cultural norms and practices and shape patients' perception of health and illness, health behaviors and utilization of health services. The lack of understanding of the interplay between religious influences on health or sickness behaviors can have a significant effect upon the delivery of nursing practice and can lead to ethical dilemmas, practice problems, and problems in communication (Catlin & Boffman, 1998). The Muslim community is experiencing Islamophobia, microaggressions, prejudices, hate crimes, and social exclusion (social exclusion correlates with mental health problems), related to their cultural and religious identity. In addition, the emergence of radical extremism among young Muslims and the resulting media coverage has magnified this problem. There is evidence to suggest that the Western media has been playing a considerable role in the social construction of fundamentalism (Ali, 2008). As a consequence of these interrelated factors, there are indicators that Muslims experience both physical and mental health problems (Kira et al., 2010; Sheridan, 2006). The aims of the paper are to examine the religious and cultural influences on mental health beliefs of Muslims, provide an understanding of mental health problems, and its implications for counseling and spiritual interventions.

Muslim and Mental Health Problems

There are no large-scale epidemiological reports on the prevalence and incidence rates of mental health problems amongst Muslims in the 57 Islamic states who are members of the Organization of the Islamic Conference. The rate of schizophrenia in Muslims is similar to that of non-Muslims (Al-Issa, 2000) but high rates of post traumatic syndrome disorder (Abu-Ras & Abu-Bader, 2009); and depression (Sheridan, 2006); and stress (Barkdull et al., 2011). Suicide is strictly forbidden in Islam and international studies in Pakistan, Malaysia and Saudi Arabia, showed low suicide rates prevalence (Al-Khathami, 2001; Murty et al., 2008; Zakiullah et al., 2008). The low prevalence of suicide in countries with a majority population of Muslims may be important due to religious sanctions against suicide in Islam and suicide is illegal in several Islamic countries (Lester, 2006). In addition, many Islamic countries do not collect national suicide statistics or they do not report such statistics to the World Health Organization (WHO) (Pritchard & Amanullah, 2007). However, ideation and attempts are relatively high, particularly

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in young women experiencing intergenerational conflict (Ali, Abu-Ras, & Hamid, 2009). In the UK, it is suggested that hostility, lack of understanding and concerns over the media and politicians' characterization of some Muslims as radicalized are creating increasing anxiety, stress and high levels of depression among Muslims (Dunning, 2011; House of Commons Communities and Local Government Committee, 2010).

In summary, the common mental health problems reported by Muslims working within the Muslim community on issues of mental health in England included: anxiety and depression, ADHD (attention deficit hyperactive disorder), addictions, psychosexual problems, domestic violence, marital problems, and religious delusional behavior (Maynard, 2008). In the US, it is reported that the major issues for Muslims are related to marital problems, and committing sins like drugs, drinking alcohol, sexual activity (Mujahid, 2010; Springer, Abbott, & Reisbig, 2008).

Muslims' Perception of Mental Health Problems

The Islamic perspective of mental health is also dramatically different from the Judeo-Christian nosology of mental health. In Islam, it is believed that good mental health comes from "the unblemished belief in Allah [God] as the Ultimate Maker and Doer, and hence any deviation from the firm acceptance of Allah's ultimate dominance over the lives of his followers leads to disintegration and disruption of inner harmony" (Sayed, 2003). Muslims perceived mental health problems as part of human suffering or as trials and tests from Allah and a positive event that purifies the body (Rassool, 2000). The findings of a survey (Abu-Ras & Abu-Bader, 2009) showed the 98% of the respondents perceived life stressors as a test of one's faith and 84% believed in possession spirit (jinn) possession. It is also perceived that when jinns (spirits mentioned in the Qur'aan and Islamic theology who inhabit an unseen world) possess individuals, hallucinations, delusional beliefs and disorganized behavior may result. Other professed supernatural causes are black magic and the evil eye (Abu-Ras & Abu-Bader, 2009).

The healthcare-seeking patterns or the adoption of alternative healing practices by Muslim patients have an impact on the underutilization of mental health services. These include the mistrust of service providers, fear of treatment, fear of racism and discrimination, language barriers, differences in communication, and issues of culture (Inayat, 2005); the lack of understanding of Islam, the healthcare system's atmosphere as unwelcoming, the provision or absence of cultural accommodation in health care settings (Gender-concordant care, halal food, and prayer space) (Padela, Guntet, & Killawi, 2011). As Muslim communities are based on collectivist family structure, the decision to seek help will be shaped by the attitudes that the family have towards mental health problems.

Possession of the Soul and Evil Eye

The concepts of 'evil eye' and 'spirit possession' are reported in so many cultures that they may be regarded as a universal phenomenon (Spoonet, 2004). Belief in the evil eye is found in the Noble Qur'aan based on the following verse (interpretation of the meaning): "And from the evil of the envied when he envies," [Al-Falaq (The Daybreak), 113:5]. It starts when the person likes a thing, and then his evil feelings affect it, by means of his repeated looking at the object of his jealousy. In most cultures, the primary victims are thought to be babies and young children, because they are so often praised and commented upon by strangest or by childless women. Spirit possession refers to the belief that a spirit can enter a living person, possess them, and control what they say and do. The belief in 'spirit possession' or 'evil eye' is common within the Muslims, particularly for the Western diagnosis of depression and psychological illness. It is common for people to state 'the person's soul has been possessed, by a bad spirit' (Rassool & Gemaey, 2014). According to Islamic writings, jinn live alongside other creatures, but form a world other than that of mankind. It is reported that the most common psychological symptoms caused by the evil eye, magic, or jinn possession include anxiety, insomnia, estrangement, hyperactivity, psychotic disturbances, altered consciousness, abnormal movements, somatic complaints, obsessions, seizures and to speak 'in tongues' (Al-Ashqar, 2003; Al-Habeeb, 2003). Spirit possession is not recognized as a psychiatric or medical diagnosis by the *DSM-V* (American Psychiatric Association, 2013) or the *ICD-10* (World Health Organization, 2001) but possession state as dissociative disorders diagnostic entity and culture-bound syndromes are included in *DSM-V*. It is universally accepted that the majority of Muslims attribute mental health problems as a result of jinn possession or evil eye.

Guidelines for the Assessment of Muslim Patients

There is a diversity of expressions of symptoms among the different Muslim communities because of the impact of cultural influences on the presentation of symptoms. Conversion and somatisation disorders are common as physical symptoms are more socially acceptable than an expression of psychological distress and the direct verbal expression of emotional distress (Al-Krenawi & Graham, 2000; El-Islam, 2008). Expressions of symptoms may differ from African Muslims from those from South East Asia. For example, clinicians should be aware of the presence of more visual rather than auditory hallucination in persons with schizophrenia (Bhui, 2001). However, culturally shared beliefs can be difficult to distinguish from delusions as jinn possession can be mistaken for first-rank symptoms of thought control or insertion, or passivity delusions (Pasic, Poeschla, Boynton, & Nejad, 2010). The difficulty in recognizing mental health problems from jinn possession is that in jinn possessions individuals present with hallucinations, delusional beliefs and disorganized behavior (Ali et al., 2009; Blom, Eket, Basalan, Aouaj, & Hoek, 2010). In relation to obsessive disorders, obsessive ruminations can be interpreted by patients as satanic temptations and often involve antireligious rather than contamination themes (El-Islam, 2008; Pridmore & Pasha, 2004). It is important to be cautious so as not to judge individual cultural variations as psychopathology. A list of signs and symptoms are presented in Table 1.

When assessing a Muslim patient and constructing a cultural formulation, it is important to examine the patient's cultural and religious identity, patient's explanatory model of their problem or illness, cultural factors related to the psychosocial environment, nurse–patient therapeutic relationship, and treatment interventions (Rassool & Gemaey, 2014). As Muslims patients are not a homogeneous group, it is important to inquire about a patient's individual custom and preferred

Table 1
Signs of Symptoms of Jinn Possession and Evil Eye.

Jinn possession
▪ Turning away and reacting strongly when hearing the adhaan or Qur'aan.
▪ Fainting, seizures and falling when Qur'aan is read over him/her.
▪ A lot of disturbing dreams or nightmares.
▪ Being alone, keeping away from people and behaving strangely.
▪ The devil who is dwelling in him may speak when Qur'aan is read over him.
Evil eye
▪ Headaches that move from one part of the head to another.
▪ Yellow pallor in the face.
▪ Sweating and urinating a great deal.
▪ Weak appetite.
▪ Tingling, heat or cold in the limbs.
▪ Palpitations in the heart.
▪ Pain in the lower back and shoulders.
▪ Sadness and anxiety.
▪ Sleeplessness at night.
▪ Strong reactions due to abnormal fears.
▪ A lot of burping, yawning and sighing.
▪ Withdrawal and love of solitude.
▪ Apathy and laziness;
▪ Health problems with no known medical cause.

Source: Adapted from Fatwa No 125543; Islam Q&A. Evil Eye- Shaykh 'Abd al-'Azeez al-Sadhaan. http://www.islam-qa.com/en/ref/125543, date accessed 5 October 2014.

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practices. This kind of assessment enables patients to understand their "illness" and health related needs (physical/medical, psychosocial and spiritual needs), avoids stereotyping or mislabelling, and provides information on what interventions are required. The following questions have been adapted from the model proposed by Kleinman, Isenberg, and Goode (1978) to be directed to the patient:

- What do you think has caused your current problem?
- Why do you think it started when it did?
- What do you think your illness does to you?
- What do you fear most about your illness?
- What are the main problems that have affected you?
- How severe is your problem?
- What kind of treatment are you receiving from your own culture?
- What kind of treatment do you think you should receive?
- What are your expectations of the treatment?

There are several issues that can complicate the mental health nurse encounters with Muslim patients. Muslims, due to religious expectations, may be accustomed to being examined or receive treatment interventions from a clinician of their own gender. If possible, this should be the norm. In the event of this not being possible, a clinician of the opposite sex can provide mental health treatment but should show sensitivity and understanding. Religious expectations regarding gender can complicate the therapeutic relationship. It is stated that, for example, Arab men may be reluctant to accept a female worker' s directions or guidance and this problem may be due not from the male client, but may arise from a male family member in a position of authority (Al-Krenawi & Graham, 2000). During the initial assessment, the patient and the relatives may be reluctant to disclose information about mental illness, sexual activities, abuse, and unlawful acts within the family because of the stigma and social shame that result. These behaviors might be misinterpreted as being un-cooperative or passive. The issues of suicide may provide some uneasiness as this is taboo in the Muslim community. It is important that sensitivity is applied when providing assessment concerning suicidal thoughts, and may require special phrasing. For example, 'Have you been wishing that God would allow you to die somehow?' (Ali et al., 2009). It is important to examine the family dynamics and the psychosocial stressors emanating from the family. The lack of cultural competence may influence the assessment process and subsequent quality of care and interventions. However, the inherent conflicts arise when the counselor and the patient are different in their religious beliefs and the counselor perceived the inclusion of spiritual narrative in counseling less important than their patients (Betgin & Jensen, 1990).

Counseling and Spiritual Interventions with Muslim Patient

In recent years, there has been a greater focus with the development and implementation of multicultural counseling competencies (Sue & Sue, 2008). Several studies have found that a form of religious psychotherapy may be effective with Muslim clients who suffer from anxiety, depression, and bereavement (Azhar & Varma, 1995a, 1995b; Razali, Hasanah, Aminah, & Subramaniam, 1998). The findings of these studies showed that patients in the religious psychotherapy groups responded significantly faster than those receiving standard treatment. In this approach, unproductive beliefs are identified and modified or replaced with beliefs derived from Islam as a variation of cognitive therapy (Azhar & Varma, 1995a, 1995b). Muslim patients report fear that their values will be undermined by secular counseling (Jafari, 1993). In fact, many Muslim patients who do seek mental health care prefer a counselor with an understanding of Islam (Kelly, Aridi, & Bakhtiar, 1996).

During the last few years there has been an emergence of Islamic counseling as a form of therapy for Muslim patients. Islamic counseling is a contemporary response, in common with other therapeutic approaches, but is based on an Islamic understanding of the nature of human beings which incorporates spirituality into the therapeutic process (Rassool, 2015). In contrast to Western psychotherapy, Islamic counseling use a more direct approach as most Muslims come to clinicians seeking advice or an offering of an approach to deal with their issues (Abdullah, 2007). The counselor in this framework has a dual role of a counselor and spiritual facilitator. Counseling Muslim patients must incorporate "their ideological beliefs, cultural traditions, family support systems, and personal experiences. It must also include the cultural conflict that may not be recognized by the patients themselves" (Kobeisy, 2004). Thus the counselor needs to be aware of the social, political and cultural context of Muslim clients, particularly as they relate to issues surrounding relationship preferences, and practices, extended family history, and modifications of traditional therapy (Ali et al., 2009). An ethical practitioner must also deal with gender-preference, different worldview from the patient, self-disclosure about sensitive issues, expressing negative thoughts or emotions towards one's family, the agreement on protection of information from the family, and inappropriate therapy or psychotherapeutic practices not congruent with Islamic practices. Hamdan (2008) maintained that there are several significant cognitions (the mental process of knowing, including aspects such as awareness, perception, reasoning, and judgment) from the Islamic faith that can be incorporated into the counseling process with Muslim patients: understanding the temporal reality of this world; focusing on the hereafter; awareness of the purpose and effects of distress and afflictions; trusting and relying on Allah; understanding that after hardship there will be ease; focusing on the blessings of Allah; remembering Allah and reading the Qur'aan; and supplications.

The combined usage of counseling and Qur'aanic healing is the preferred method of treatment for Muslims (Abu-Ras & Abu-Bader, 2008). The use of spiritual interventions is part of the treatment journey in supporting someone with mental health problems (Khan, 2006) or during traumatic times (Ali, Milstein, & Marzuk, 2005). The spiritual interventions include prayers, fasting, repentance, supplications and recitation of the Qur'aan. Muslims often seek guidance for mental health problems from the imams (religious leader). In order for Muslim patients to adhere to the prescribed treatment (pharmacological or non-pharmacological), the patient would continue to receive spiritual interventions from an imam or Islamic counselor.

The mode of therapy most frequently prescribed by faith healers to patients with evil eyes, jinn possession, and magic are: ruqyah. Ruqyah in Islam is the recitation of the Qur'aan, seeking of refuge in Allah, remembrance and supplications that are used as a means of treating sicknesses and other problems as the Quran is a source of healing (Sheikh Assim Al-Hakeem). The main purpose of ruqyah is to treat and cure evil eye, possession of jinn, envy and black magic. The essence behind this is to be sincere and placed one full trust, reliance and dependence only on Allah, the source of all healing and cure (Rassool, 2015). In any case of alleged jinn possession, underlying organic disorders should be excluded by physical examination and by such investigations as are necessary. Any underlying mental health problem should be treated by usual psychiatric methods, but the clinician should respect the cultural issues and avoid directly contradicting statements from the patient or relatives about the reality of possession (Rassool & Gemaey, 2014). For those with jinn possession there may be a strong case for involving an Imam in the management of these cases (Khalifa & Hardie, 2005). The management of evil eye and jinn possession is presented in Table 2.

Case Study

Mr Amin, 49-year old unemployed Somali was admitted to a local hospital following episodes of severe neglect, apathy, and abnormal, disinhibited behavior, low mood and delusional ideas. He has previously been given a diagnosis of schizophrenia, but had not taken any of his regular neuroleptic medications for over a few weeks. During his brief admission, he repeatedly expressed the belief that being possessed by a Jinn, having thought insertion and claimed to have supernatural

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Table 2
Management of Evil Eye and Jinn Possession.

	Nursing interventions
Attitude	Be non-judgmental and non-punitive. No condemnation of their cultural and spiritual beliefs.
Communication	Examine and listen to the patient, recognize their way of being, be culturally sensitive.
Assessment	Questionnaire: age, gender, marital status, employment, country of birth, language. Results are a condensate sample.
Expectations	Patients will expect medications for pain relief. Family involvement in care.
Religious leaders	Health care professionals should work with religious leaders in supporting the patient.

power to heal. His extended family, however, was convinced that he was possessed by jinn and discharged him from the psychiatric unit, against medical advice. He was taken to a local faith healer, who reinforced their views and treated him in the traditional African way. However, his condition deteriorated over the next few weeks and he was referred to an Imam. The Imam recognized that it was not jinn possession, but suffered from mental health problems. The Imam referred the patient to the local psychiatric unit and he was thus readmitted.

Comments

It is debatable whether this unemployed gentleman did in fact have jinn possession or whether a highly suggestible person with a possible dissociative state. However, it is clear that his lapse and relapse are due to him not adhering to his course of psychotropic therapy. The complaint of hearing voices or thought insertion did not disappear after having traditional healing treatment from the faith healer. In fact, his conditions became unmanageable after seeing the traditional faith healer. There is concern that in desperation, some families may turn to exorcists who inflict physical harm in an attempt to free the individual from possession—sometimes with catastrophic consequences (Rassool & Gemaey, 2014). In this case, it was the Imam who managed to convince the families that the behavior of Mr Amin was not due to jinn possession but mental health problems. Imams nationwide, report that their congregants come to them for a full range of emotional problems, marital and family problems, and psychological and social concerns (Ali et al., 2005). However, a major barrier for the preference for Imams is that they are not trained to act as agents of referral to mental health professionals (Ali et al., 2009). However, working in close liaison with the Imam or Islam counselor has the potential to facilitate appropriate referrals and improve access to culturally appropriate psychosocial therapies.

CONCLUSION

The above case illustrates the difficult interactions between cultural and religious beliefs and conventional medicine. Any underlying mental health problems should be treated by usual psychiatric methods, but the mental health nurse should respect the religious and cultural issues and avoid directly contradicting statements from the patient or relatives about the reality of possession. "When medicine invites conflict with culture and religion, the therapeutic alliance suffers" (Khalifa & Hardie, 2005). Islamic institutions can play a most effective and vital role in the promotion of mental health and the prevention of chronic mental health problems. Hospital-based psychiatric mental health nurses and community psychiatric mental health nurses could collaborate with Imams through outreach services to help fulfil a potentially vital role in improving access to appropriate mental health and social services for minority Muslim communities while there currently appears to be unmet psychosocial needs. Above all, there is a need to foster communication and trust between Muslim religious leaders and mental health professionals to improve access to culturally appropriate psychiatric services.

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