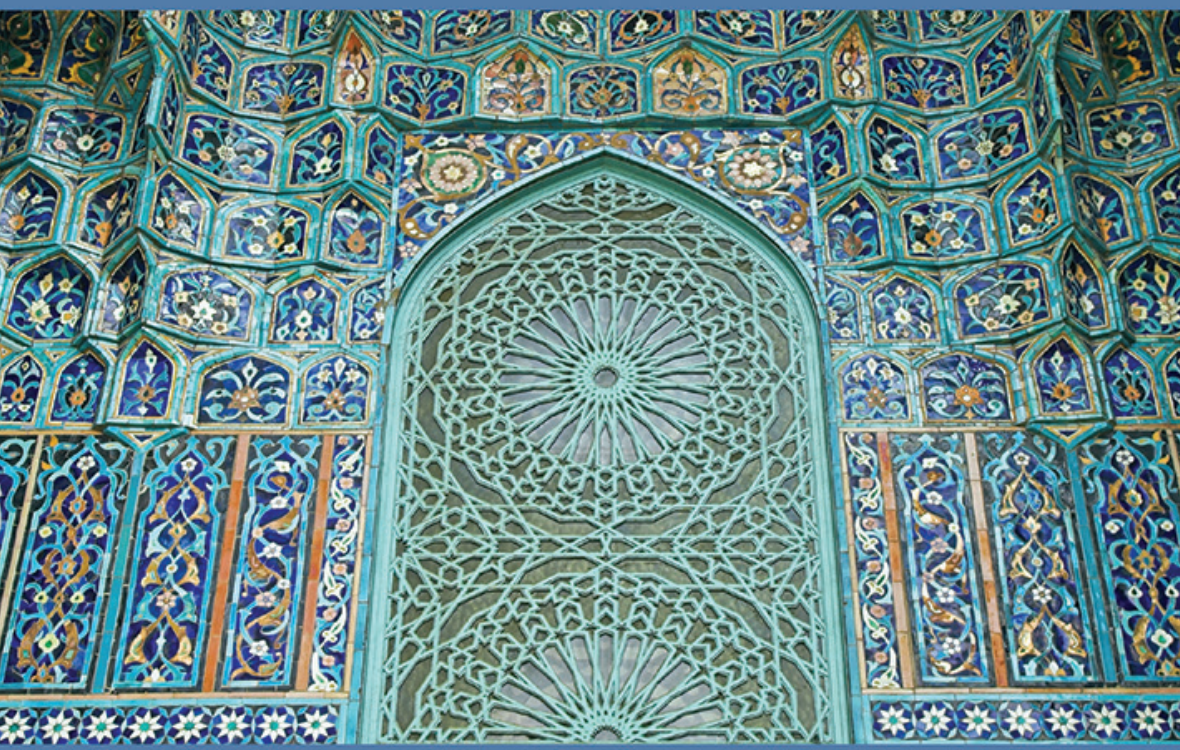
ROUTLEDGE

Islamic Counselling

An introduction to theory and practice



G. HUSSEIN RASSOOL

ISLAMIC COUNSELLING

Islamic counselling is a form of counselling which incorporates spirituality into the therapeutic process. Until now there has been a little material available on the subject with no one agreed definition of Islamic counselling and what it involves. There has also been a rapidly growing population of Muslims in Western societies with a corresponding rise in need of spiritual, psychological and counselling services. *Islamic Counselling: An introduction to theory and practice* presents a basic understanding of Islamic counselling for counsellors and Islamic counsellors, and provides an understanding of counselling approaches congruent with Islamic beliefs and practices from a faith-based perspective.

The book is designed as an introduction for counsellors; its goal is to inform the reader about how the diverse roles of the Islamic counsellor fit together in a comprehensive way and to provide the guidelines that can be potentially integrated into a theoretical framework for use. The book is divided into two parts. Part I: 'Context and background', and Part II: 'Assessment, models and intervention strategies'.

Islamic Counselling encompasses current theory, research and an awareness of the practice implications in delivering appropriate and effective counselling interventions with Muslim clients. It will be essential reading for both professionals and students alike.

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An introduction to theory and practice

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Dedicated to Idrees Khattab, Isra Oya, Asiyah Maryam, Adam Ibn Hussein Ibn Hassim Ibn Sahaduth Ibn Rosool Ibn Olee Al Mauritiusy, Reshad Hassan, Yasmin Soraya, Leyla, Mariam, Safian and Hassim.

- Prophet Muhammad (ﷺ) said: 'If anyone fulfils his brother's needs, Allah will fulfil his needs; if one relieves a Muslim of his troubles, Allah will relieve his troubles on the Day of Resurrection' (Sahih Bukhârî and Muslim).

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PREFACE

The need to develop culturally appropriate counselling intervention strategies in working with Muslim clients, and to understand and accept the legitimacy of alternative worldviews, is beyond dispute. Given the rapidly growing populations of Muslims in Western societies, it is imperative to develop a better understanding of their psychosocial and spiritual needs and concerns. The Muslim community is experiencing Islamophobia, microaggressions, prejudices, hate crimes and social exclusion related to their cultural and religious identity. In addition, as a consequence of these interrelated factors, there are indicators of the corresponding rise of Muslims in need of psychological and counselling services. More counsellors are coming into contact with Muslim clients and it is not unusual to find that counselling professionals find themselves at a loss to intervene effectively with such clients. For the clients this situation is commonly experienced as an inability on the side of counsellors to fully understand their religio-cultural needs. Muslim clients are being offered counselling, primarily with a Eurocentric worldview, which is rooted in the Judaeo-Christian tradition and reflects the dominant values of the larger society.

The book provides a basic understanding of Islamic counselling and fulfils an emerging need in the understanding of counselling approaches congruent with Islamic beliefs and practices. Islamic counselling is a contemporary response that has much in common with other therapeutic modalities, but is based on an Islamic understanding of the nature of human beings. The approaches and strategies of Islamic counselling challenge the existing mainstream models of counselling and suggest that counsellors must accept the notion of 'culture-specific strategies' in delivering appropriate and effective counselling interventions with Muslim clients.

Islamic counselling is a form of counselling that incorporates spirituality into the therapeutic process. The goal of this type of integrative counselling is to address

a variety of underlying psychological needs from a faith-based perspective. Given that the principles and practice of Islamic counselling are not yet in a form where its actual implementation can be monitored, it first requires guidelines that can be integrated into a theoretical framework, a purpose towards which this book is directed. Designed as an introduction for counsellors, its goal is to inform the reader about how the seemingly diverse roles of the Islamic counsellor fit together in a comprehensive manner. The book is seen as a preliminary mapping exercise and as agenda setting to provide a stimulus and encourage further examination and development of the nature, approaches and process of Islamic counselling. Muslims scholars and clinicians should share in this development with non-Muslim counsellors and academics.

The essence of this book is based on the following notions:

- The foundation of Islam as a religion is based on the Oneness of God.
- The source of knowledge is based on the Noble Qur'aan and Hadith (*Ahl as-Sunnah wa'l-Jamā'ah*).
- Muslims believe that cures come solely from Allah (God).
- Seeking treatment for psychological and spiritual health does not conflict with seeking help from Allah.
- Islam takes a holistic approach to health. Physical, emotional and spiritual health cannot be separated.
- There is wide consensus among Muslim scholars that psychiatric or psychological disorders are legitimate medical conditions that are distinct from illnesses of a supernatural nature.
- The family is a partner in the care of the client, and makes decisions about the client's care.
- Counselling, in the Islamic context, is an act of shared spirituality between Islamic counsellor and client, where the nature of the shared spirituality is fluid, depending on the client's psychological and spiritual needs.
- Emerging cultural competence in counselling is aiming to make the services more responsive to the needs of Muslim clients.

It is a sign of respect that Muslims would utter or repeat the words 'Peace and Blessing Be Upon Him' (PBUH) after hearing (or writing) the name of Prophet Muhammad (ﷺ).

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'Bismillah ir Rahman ir Raheem

All Praise is due to Allah, and may the peace and blessings of Allah be upon our Prophet Muhammad (ﷺ), his family and his companions.

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Finally, whatever benefits and correctness you find within this book are out of the Grace of Allah, Alone, and whatever mistakes you find are mine alone. I pray

to Allah to forgive me for any unintentional shortcomings regarding the contents of this book and to make this humble effort helpful and fruitful to any interested parties:

> *Whatever of good befalls you, it is from Allah; and whatever of ill befalls you, it is from yourself.*
>
> *(An-Nisā' (The Women) 4:79)*

PART I

Context and background

1

ISLAM AND MUSLIMS

Introduction

Islam is an Arabic term, which translated literally means 'surrender' or 'submission'. The same Arabic root word gives us '*Salaam alaykum*' ('Peace be with you'), the universal Muslim greeting. Islam is a major world religion with over one billion people from a vast range of races, nationalities and cultures across the globe united by their common Islamic faith. It is considered one of the Abrahamic, monotheistic faiths, along with Judaism and Christianity. Islam is both a religion and a complete way of life based on the guidance of God from the Noble Qur'aan and teachings and practices of the Prophet Muhammad (ﷺ). Islam literally means 'Submission' (to the One True God). Therefore a Muslim is a person who submits to the will of God, or a follower of Islam. Muslims follow a religion of peace, mercy, tolerance and forgiveness and have nothing to do with the myths that are ascribed to the religion and to Muslims, in general, by Eurocentric and orientalists. Within key Western societies, there are genuine negative perceptions, overt or covert hostility, fear, hatred and prejudice towards Islam and Muslims that have given rise to micro-aggressions and Islamophobia. This chapter will enable the reader to have a basic understanding of the principles of the Islamic faith and the Muslim community.

The Muslim world

Nearly a quarter of the world's population today is Muslim and Islam has over 1.62 billion followers worldwide, reaching 2.2 billion in 2030 (Pew Forum on Religion & Public Life, 2011). If current trends continue, 79 countries will have a million or more Muslim inhabitants in 2030, up from 72 countries today. The seven countries projected to rise above 1 million Muslims by 2030 are: Belgium, Canada, Congo,

Djibouti, Guinea Bissau, the Netherlands and Togo (Pew Forum on Religion & Public Life, 2011). Although Islam is often associated with the Arab world and the Middle East, fewer than 18 per cent of Muslims are Arabs. While Asia has the largest number of Muslims among other continents, it is second to Africa in terms of the percentage of Muslims with respect to the total population. The populations of the following countries are almost entirely Muslim (about 99.5 per cent or more of the native populations, and nearly all of the foreign workers, are Muslim): Bahrain, Comoros, Kuwait, Maldives, Mauritania, Mayotte, Morocco, Oman, Qatar, Somalia, Saudi Arabia, Tunisia, United Arab Emirates, Western Sahara and Yemen (Adherents.com, n.d.). Accordingly, the percentage of Muslims in Africa is 43.3, which constitutes 27 per cent of the world's Muslim population. A majority of the world's Muslims (about 60 per cent) continues to live in the Asia-Pacific region, while about 20 per cent will live in the Middle East and North Africa. Indonesia has the largest Muslim population, but Pakistan is expected to surpass Indonesia. The portion of the world's Muslims living in sub-Saharan Africa is projected to rise and in 20 years, for example, more Muslims are likely to live in Nigeria than in Egypt. Although there are Muslim minorities in almost every area, including Latin America and Australia, they are most numerous in the Soviet Union, India and Central Africa (Islamic Affairs Department, 1989). Muslims will remain relatively small but significant minorities in Europe and the Americas, but they are expected to constitute a growing share of the total population in these regions.

Diversity in the ethnic composition of Muslims

There is great diversity in the ethnic composition of Muslim migrant groups in Western and Northern Europe. The presence of different groups in specific countries varies depending on a wide range of factors, including post-decolonisation migration patterns, the history of European labour markets, and refugee flows (Amnesty International, 2012). For example, the biggest groups of Muslims in France are originally from Algeria, Morocco, Tunisia and sub-Saharan Africa, while in Belgium and the Netherlands the majority are of Moroccan and Turkish origin.

The United Kingdom (UK) has a long history of contact with Muslims, with links forged from the Middle Ages onward (Muslim Council of Britain, 2002). In the nineteenth century, Yemeni men came to work on ships, forming one of the country's first Muslim communities. During the 1960s, significant numbers of Muslims from Southeast Asia (Bangladeshi, Pakistani or those of Indian origin and some East African Asians) came to the UK to take up employment. Permanent communities formed and at least 50 per cent of the current population was born in the UK. Significant communities with links to Turkey, Cyprus, Iran, Iraq, Afghanistan, Somalia and the Balkans also exist. However, in the UK, only a small percentage is originally from Northern Africa. A considerable proportion of Muslims living in Switzerland is from former Yugoslavia, whereas the biggest groups of Muslims in Catalonia (Spain) are originally from Algeria, Mali,

Morocco, Pakistan and Senegal. Muslims from Iran and Iraq are relatively numerous in Sweden, Norway and Denmark, if compared with other European countries (Amnesty International, 2012).

The top countries of origin for Muslim immigrants to the United States (US) in 2009 were Pakistan and Bangladesh. About two-thirds of the Muslims in the US today (64.5 per cent) are foreign-born, first-generation immigrants, while slightly more than a third (35.5 per cent) were born in the United States. By 2030, however, more than four in ten of the Muslims in the US (44.9 per cent) are expected to be native born (Pew Forum on Religion & Public Life, 2011). In Canada, Muslims constitute about 3.2 per cent of the population, making them the second largest religion after Christianity and the fastest-growing religion in Canada (National Household Survey, 2011). Immigration has largely fuelled the increase, with the largest share coming from Pakistan. In Australia, 2.2 per cent of the total population are Muslims, making them the third largest religious grouping, after Christianity and Buddhism. The Australian Muslim community is among the most ethnically and racially diverse religious grouping, with members from over 60 different ethnic and racial backgrounds (Australian Bureau of Statistics, 2013).

The fundamentals of Islam as a religion

Islam is not a new religion, but is the continuation of the religion of our patriarch, Abraham, focusing on monotheistic belief. In the traditional sense, Islam connotes the one true divine religion, taught to mankind by a series of Prophets, some of whom brought a revealed book. Such were the Torah, the Psalms and the Gospel, brought by the Prophets Moses (Musa), David (Dawud) and Jesus (Eesa). Prophet Muhammad (ﷺ) was the last and greatest of the Prophets. The Noble book, the Qur'aan, completes and supersedes all previous revelations. Christianity and Judaism, like Islam, believe in the 'oneness' of God and go back to the Patriarch Abraham, and the Prophets are directly descended from his sons (Morgan, 2010). Islam has at its core a simple message that applies to all human beings. Islam tolerates other beliefs as it is one function of Islamic law to protect the privileged status of minorities, and this is why non-Muslim places of worship have flourished all over the Islamic world. History provides many examples of Muslim tolerance towards other faiths. The Constitution of Medina (*Ṣaḥīfat al-Madīnah*) is the earliest known written constitution in the world. To this effect, it instituted a number of rights and responsibilities of the Muslim, Jewish and pagan communities of Medina, bringing them within the fold of one community – the 'Ummah'.

The Qur'aan, the last revealed Word of God, is the prime source of every Muslim's faith and practice. The Qur'aan is a record of the exact words revealed by God through the Angel Gabriel to the Prophet Muhammad (ﷺ). It was memorised by Prophet Muhammad (ﷺ) and then dictated to his companions, and written down by scribes, who cross-checked it during his lifetime. There are 114 chapters in the Qur'aan, which is written in classical Arabic. All the chapters except one begin with the sentence '*Bismillah ir Rahman ir Raheem*', 'In the name

of Allah, the Entirely Merciful, the Especially Merciful.' The longest chapter of the Qur'aan is Surah *Baqarah* (The Cow) with 286 verses and the shortest is Surah *Al-Kawthar* (Abundance), which has three verses. The Qur'aan includes the history of mankind from the creation and addresses rules for everyday social life, such as marriage issues, divorce, personal rights, inheritance, charity to the poor, importance of brotherhood and community, social justice, proper human conduct and an equitable economic system. In addition to the Qur'aan, there are the Sunnah (the practices and examples of the Prophet (ﷺ) and Hadith. A Hadith is a reliably transmitted report of what the Prophet (ﷺ) said, did or approved. Belief in the Sunnah is part of the Islamic faith.

The five pillars of Islam

The obligations of Muslims are known as the five pillars of Islam, which all Muslims around the world will follow in relation to their daily activities, lifestyle and practices. The model framework of Muslims' lifestyle and practices are: *Shahadah*, prayer (*Salah*), self-purification (*Zakat*), fasting (*Sawm*, during *Ramadhan*) and pilgrimage (*Hajj*) to Makkah. The most important fundamental teaching of Islam is belief in the Oneness of God – this is termed *Tawheed*.

- *Shahadah* is the first Article of Faith: 'I bear witness that there is no god but Allah and I bear witness that Muhammad (ﷺ) is his servant and Messenger.' In fact, there is no one worthy of worship except Allah. This simple yet profound statement expresses a Muslim's complete acceptance of, and total commitment to, Islam.
- *Salah*, prayer, is the second pillar. There are obligatory prayers that are performed five times a day at designated times. The Islamic faith is based on the belief that individuals have a direct relationship with God. In addition, a Friday congregational service is also required. Although *Salah* can be performed alone, it is meritorious to perform it with another or with a group. It is permissible to pray at home, at work or even outdoors; however, it is recommended that Muslims perform *Salah* in a mosque.
- *Zakat* means purification and growth. Our wealth, held by human beings in trust, is purified by setting aside a proportion for those in need. *Zakat* is calculated individually and involves the payment each year of a fixed proportion of Muslims' wealth to the needy and poor. This provides guidelines for the provision of social justice, positive human behaviour and an equitable socio-economic system. One of the Hadith (sayings) of Prophet Muhammad (ﷺ) relating to charity is that 'The wealth of a servant is never decreased by paying charity.' The *Zakat* is equal to 2.5 per cent of an individual's total net worth, excluding obligations and family expenses.
- *Sawm*, fasting during the Holy month of *Ramadhan*, is the fourth pillar of Islam. Every year during the month of *Ramadhan*, Muslims fast from first daylight until sunset, abstaining from eating, drinking and sexual relations. Although

the fast is beneficial for health, it is regarded spiritually as a method of self-purification. The spiritual dimension involves reflective practices, increased prayers and having positive thoughts towards other people and remembering Allah in all thoughts and actions. *Ramadhan*, the month during which the *Holy Qur'aan* was revealed to the Prophet Muhammad (ﷺ), begins with the sighting of the new moon, after which abstention from eating, drinking and other sensual pleasures is obligatory from dawn to sunset. The end of *Ramadhan* is observed by three days of celebration called *Eid al-Fitr*, the feast of the breaking of the fast. Customarily, it is a time for a family reunion and the favoured holiday for children who receive new clothing and gifts.

- *Hajj*, the pilgrimage to Makkah, is the fifth pillar and the most significant manifestation of Islamic faith and unity in the world. The annual *Hajj* to Makkah, Kingdom of Saudi Arabia, is an obligation for all Muslims once in a lifetime. However, there are conditions; for example, only those individuals who are physically and financially able are allowed to perform it. The *Hajj* rituals take place in the twelfth month of the Islamic year (based on the Lunar system, Islamic Year 1420 = CE 2000). The pilgrims wear simple garments, which strip away status and distinctions of class, culture and colour, so that all individuals stand equal before Allah.

In a Hadith, the Messenger of Allah (ﷺ) said:

> Islam is to testify that there is no god but Allah and Muhammad is the messenger of Allah, to perform the prayers, to pay the zakat, to fast in Ramadan, and to make the pilgrimage to the House if you are able to do so. He said: 'You have spoken rightly', *Jebreel* (Gabriel).
>
> *(Muslim, cited in Zarabozo, 2008)*

The five pillars of Islam define the basic identity of Muslims, their faith, beliefs and practices, and bind together a worldwide community of believers into a fellowship of shared values and concerns.

Cultural Islam and Islamic culture

Our culture, which is dynamic, shapes our worldview as it influences all of our behaviours and interactions. Culture refers to behaviour, ideals, values, attitudes and traditions shared by a group of people and transmitted from one generation to the next (Brislin, 1993; Cohen, 2009). Muslims from different parts of the world will have varying cultures even though they share the same religious values and practices. Their behaviours are often shaped by cultural practices that may or may not be in concordance with basic religious practices. Some cultural practices (or pre-Islamic practices) performed by Muslims are given an Islamic dimension, although these practices are not considered Islamic practices. According to Saidi (2008), many of the countries that are commonly called 'Islamic countries', which

in reality are merely 'Muslim-majority countries', practise an amalgam of Islamic practices and pre-Islamic/non-Islamic practices, adopted practices and religious innovations and some of those countries have remained patriarchal. According to Philips (2007), 'the Islam being practiced in much of the Muslim world today may be referred to as Cultural Islam. The main feature of this version of Islam is the blind following of local traditions' (p. 33). Generally, religious or Islamic practices include all the practices that have roots in the Qur'aan and Sunnah (traditions). However, there are some cultural practices that are based on authentic Islamic traditions, but the Cultural Muslim is unable to distinguish between the two (Philips, 2007).

Since Islam covers political and economic aspects of human life, it possesses and promotes distinctive cultural characteristics of its own (Saidi, 2008). Islamic culture represents the traditions and customs that evolve from the common features found in all countries and regions. These represent the core of Islamic culture and the variations represent the basic features of Muslim cultures (Philips, 2007, p. 63). The Islamic culture is based on Islamic teachings from the Qur'aan and the Sunnah and is embedded in the common belief that there is no God but Allah and that Muhammad (ﷺ) is His Messenger. Islamic beliefs and practices are based on the following issues:

- *Welfare and society*: The society is responsible for the welfare of an individual, that is, community obligation (*Fard kifaya*).
- *Morals and manners*: Muslims are forbidden from dishonesty, theft, murder, suicide, bribery, forgery, usury, gambling, lottery, consumption of alcohol or pork, backbiting, gossiping, slandering, hoarding, destruction of property, cruelty to animals, adultery, fornication and public nudity.
- *Modesty in dress and behaviour*: Muslims should wear decent and dignified dress. Men should cover their bodies from the navel to the knees, and women should cover their entire bodies except for the face and hands.
- *Care of children and elderly*: Caring for one's children or parents is considered an honour and blessing.
- *Racism and prejudice*: Muslims believe that they should not discriminate against anyone for any reason, being part of a larger brotherhood of humanity. The Prophet (ﷺ) proclaimed, in his last sermon, that no Arab is superior over a non-Arab, and no white person is superior over a black person.
- *Dietary rules*: Islamic dietary laws provide direction on what is to be considered *Halal* (lawful) and *Haram* (unlawful). Food hygiene is part of the Islamic dietary law.
- *Marriage*: Islam is a strong advocate of marriage and considers it a moral safeguard as well as a social building block. Furthermore, marriage is the only valid or *Halal* way to indulge in intimacy between a man and a woman.
- *Relations with non-Muslims*: Our relationships with people of other faiths should only be avoided when they become harmful for Muslims. There is no reason why Muslims should not cooperate with non-Muslims with regard to establishing truth and combating falsehood, or to support the oppressed and ward off

danger from mankind, such as cooperating to fight pollution or to protect the environment, or to combat epidemic diseases and so on (islamqa, n.d.).

Islamic culture is not monolithic and has varieties and a rich diversity. According to Siddiqi (2014), characteristics of Islamic culture include the following:

- *God-centred or theocentric*: Islamic culture is God-centred and strictly *Tawheed* (the concept of monotheism). The fundamental principles include the belief in Allah, and His existence, belief in the angels, belief in the Books, belief in the Messengers, belief in the last Day (Judgement) and belief in the destiny (*Qadar*). The five pillars of Islam are the foundation of Islamic life and the testament of faith, prayer, *Zakat*, fasting and pilgrimage are parameters that essentially define what it means to be Islamic. There is an emphasis on things that are *Halal* (acceptable) and others *Haram* (forbidden).
- *Egalitarian, tolerant and fraternal*: Islamic culture emphasises that all people are equal and reject any ethnic bias or racialism. There is a belief in the worth and value of all human beings as being the creations of God, and a belief in the freedom of religion and accepting no compulsion in matters of religion. Islamic culture is tolerant of people of all faiths, especially the People of the Book (Christians and Jews). There is a sense of brotherhood in faith, regardless of the geographic boundaries or changing political or economic conditions.
- *Dignifying and moralistic*: Islamic culture places great emphasis on the dignity of human beings and their morality. These include truthfulness, honesty, modesty (*Haya'*) and cleanliness, or *Taharah*. Islamic culture teaches self-confidence and self-reliance and places an emphasis upon charity and generosity. The culture is family-oriented with great emphasis on good spouse relations, good care of children, extended families and love and respect for elders. Islamic culture abhors adultery, fornication, homosexuality, gambling or the use of intoxicants.
- *Dynamic, progressive, world affirming and not world-denying or ascetic*: Islamic culture emphasises trials and tribulations, change, social justice, and removal of oppression and evil. It encourages learning, education and the seeking of knowledge. Islamic culture promotes good art and architecture, aesthetics, health, healthy environments and *Halal* entertainment.
- *Non-exclusivist but* Dawah*-oriented and optimistic*: Islamic culture emphasises the promotion of good things with wisdom and patience. There is a belief in inviting or calling all people to Islam without coercion. Islamic culture teaches people to be patient, with a focus on working in a steadfast manner and putting their total trust in our Creator, Allah.

Muslims are constantly engaged in worship, mindful of Allah's laws, orders and guidance. They consider Islam to be a middle road where they strike a balance by fulfilling the obligations of, and enjoyment of, this life, while always mindful of their duties to Allah and to others.

The label 'Cultural Muslim' is used in the literature to describe those Muslims who are religiously unobservant, secular or irreligious individuals who still identify with the Muslim culture due to family background, personal experiences or the socio-cultural environs in which they grew up (Rahman, 2013). Ruthven (2000) defines a Cultural Muslim as a Muslim "who is born to a Muslim father and who takes on his or her parents' confessional identity without necessarily subscribing to the beliefs and practices associated with the faith" (p.8). That is, the label Muslim indicates their ethnicity and group allegiance, but not necessarily their religious beliefs.

In summary, the concept of a Cultural Muslim is 'someone who identifies as a Muslim yet is not religious and is not universally accepted in the Islamic religious community' (Blake, 2003, p. 175). For Cultural Muslims, the declaration of faith is superficial and has no effect on their religious practices. Philips (2007) maintained that these Cultural Muslims have 'fallen prey to the delusion that being born Muslims in a Muslim family and having a "Muslim" name guarantees them paradise, regardless of what they do in this life' (p. 74). This is a false belief as only the true believers would enter paradise (Muslim, n.d.). Many Cultural Muslims treat the five mandatory daily prayers casually and some only pray twice per year during the two annual celebrations (*Eid al-Fitr* and *Eid al-Adha*), and others attend the Friday congregational prayer. During the month of fasting, they flock to the mosque for prayers. Those Cultural Muslims who do not understand the goals of *Zakat* may perform the ritual of giving this charity or may neglect this obligation. Fasting too becomes a ritual during the month of *Ramadhan*, and it is 'a time of celebration instead of religious contemplation and abstinence' (Philips, 2007, p. 88). There is also the belief among Cultural Muslims that it is better to delay the pilgrimage (*Hajj*) until later years (old age).

Cultural Muslims are perceived in the Western world by Eurocentric and orientalists as being 'acculturated' or 'integrated' Muslims. That is, they follow Western-oriented lifestyles and behaviours (emotional, cognitive and behavioral) while maintaining their Muslim identity. This group of people is most welcomed by politicians and non-Muslims, and is popularised by the mass media.

The need for counselling for Muslim clients

The need for counselling has become paramount in order to promote the psychological and physical health of Muslims. With the growth of Islamic populations in Europe and elsewhere, there has been a corresponding rise in the need for psychological and counselling services. The average Muslim today deals with not just the everyday stressors of life, but also the responsibility of defending basic religious rights and values as normal and acceptable (Podikunju-Hussain, 2006). Some of the psychological problems include the lack of family support; the presence of tensions in the family when conflicting core ethnic values between parents and children emerge (for example, relations with the opposite sex, career decisions and other social values); prejudice or discrimination in the workplace or in the society; and racism (Das and Kemp, 1997). There is evidence to suggest that the Imams (Islamic preachers) are asked to address counselling issues in their communities that

reach beyond religious and spiritual concerns and include family problems, social needs and psychiatric symptoms (Ali *et al.*, 2005). In addition, as more counsellors are coming into contact with Muslim patients, it is not unusual to find that non-Muslim counsellors, due to the lack of cultural competence, find themselves at a loss to intervene effectively with Muslim clients.

However, for most Muslims, counselling is taboo. Muslims are reluctant to seek professional counselling because they consider it degrading or inappropriate to speak of one's troubles to others (strangers); they perceive themselves as being stereotyped and misunderstood and encountering insensitivity to cultural and special needs (Moshtagh and Dezhkam, 2004); they want their concerns addressed from a religious viewpoint (Abdullah, 2007; Podikunju-Hussain, 2006); and they express a hesitancy in trusting mental health professionals, fearing that their Islamic values may not be respected (Dwairy, 2006; Hedayat-Diba, 2000; Hodge, 2005; Mohamed, 1996).

Conclusion

This chapter has considered the Islamic way of life, Islam as a religion and Islam as a culture. In the Islamic world, there is an increasing recognition of the need to distinguish between cultural traditions, which may have nothing to do with Islam, and the true teachings of Islam. The cultural fabric of the Islamic community, according to Raza (1991), reveals an intricate web, including areas of social, economic and healthcare. Cultural practices of Islamic communities are strong and very closely linked to their religious beliefs, and separating the two can prove difficult if not impossible. Some Muslims vary a lot in their day-to-day practices and these are often simply local customs taken as Islamic culture. The lack of adherence to Islamic practices arises when people confuse cultural practices with religion. Counsellors need to be aware that not all Muslims are religious, as there is an increasingly recognised body of non-practising Muslims living in the West who are identified (or openly self-identify) as Cultural Muslims. However, most Muslims would not consider themselves as Cultural Muslims as their primary identification is with their religious practices.

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2

COUNSELLING AND ISLAMIC COUNSELLING

An overview

Introduction

> *Help you one another in virtue, righteousness and piety; but do not help one another in sin and transgression.*
>
> *(Al-Mā'idah (The Table Spread) 5:2)*

In the above verse of the Qur'aan (interpretation of the meaning), Allah commands His believing servants to help one another perform righteous, good deeds and to avoid sins. Allah forbids His servants from helping one another in sin and overstepping the limits. That is, one should consult his fellows, advise them and cooperate with them. In addition, you should help and support others, whether they have been unjust towards you or the victims of injustice themselves. So, helping and doing good to others is part of the process. It is narrated that the Messenger of Allah (ﷺ) said that:

> Allah will say on the Day of Judgment, 'O son of Adam, I was sick and you did not visit Me.' He will say, 'O my Lord, how could I visit You, when you are the Lord of the Worlds.' Allah will say, 'Did you not know that My servant so-and-so was sick and you did not visit him? Did you not know that if you had visited him, you would have found Me there?' Allah will say, 'O son of Adam, I asked you for food and you fed Me not.' He shall say, 'O my Lord, how could I feed you and you are the Lord of the Worlds?' And Allah will say, 'Did you not know that My servant so-and-so was in need of food and you did not feed him? Did you not know that if you had fed him, you would have found that to have been for Me?' 'O son of Adam, I asked you for water and you did not give Me to drink.' The man shall say, 'O my Lord, how could I give You water, when You are the Lord of the Worlds?' Allah will say, 'My servant so-and-so asked you for water and you did not give him to drink water. Did you not know that if you had given him to drink, you would have found that to have been for Me.'
>
> *(Bukhârî, cited in OnIslam, n.d.)*

Background

The cultural reality of many countries has changed drastically in the last five decades due to the clustering of visible minorities and newborn Muslims. Social and economic marginalisation and health disparities may compound the burden of mental health problems that indigenous and immigrant Muslims have endured. The emergence of Muslim communities is a reality that challenges counsellors to provide holistic and non-Eurocentric counselling to the clients they are charged with serving. It is argued that mainstream psychology has largely been ethnocentric in its orientation, training and application and has neglected the mental health concerns of other racial groups and the socio-political injustices they endure on a daily basis (Naidoo, 1996). However, as psychology and counselling psychologically have traditionally been Eurocentric and based on the white middle-class value system (Katz, 1985) and Judaeo-Christian tradition, this has resulted in a lack of cross-cultural relevance to Muslim clients. This mono-cultural perspective often operates from the assumption that counselling and psychotherapy, conceptualised in Western, individualistic terms, are applied to meet the needs of Muslim clients.

In a more critical approach to ethnocentric approaches to counselling, Charema and Shizha (2008) observe that Western approaches to counselling demonise and oppress individuals and groups when applied to non-Western cultures. Although there is 'increased attention to diversity and multiculturalism in the counselling profession' (Walden *et al.*, 2003, p. 109), there is still much to be done to move counselling to more openness to diversity and a greater acceptance of other worldviews and culturally different counselling practices. However, overly simplified summaries of Islam, 'laundry lists' of cultural traits and counselling practices risk reinforcing stereotypes and prejudices. A more helpful alternative is to transform the culture of care provision, so that cultural, religious and individual diversity is genuinely accepted, encouraged and accommodated (Betancourt, 2004).

Besides, individuals' perceptions and beliefs regarding health and sickness, especially mental health, are deeply rooted in the spiritual traditions of Muslim communities. It is stated that the 'lack of knowledge about the beliefs and values of a religious group that is under continuous scrutiny can be problematic within a clinical setting, especially in light of the potential importance spirituality may have for a client' (Haque and Kamil, 2012, p. 3). Counsellors should be guarded in the application of counselling models and therapeutic techniques that reflect the religio-cultural heritage that shaped Western society and do not always reflect the religious, socio-cultural traditions of Muslim communities. However, in recent years, factors such as culture, diversity and religion have influenced the counselling process. These factors have challenged the traditional process of counselling and have encouraged counsellors to move beyond traditional counselling paradigms, especially when working in diverse religious and cultural contexts (Abdullah, 2007). A proper understanding of Islamic beliefs and practices, therefore, is crucial for counsellors so that their approaches, free from the cultural conditioning of their personal and professional training, would be operated within a socio-religious context in working with Muslim clients. It is within the context of understanding the

culture, beliefs and traditions that the display of cultural competence in counselling becomes attainable.

What is counselling?

The word 'counsel' originates from the Latin *consilium*, via Old French *counseil* (noun), meaning consultation, advice, judgement or deliberating body (www.OED.com). Counselling is a type of talking therapy that focuses on developmental and psychosocial problems through cognitive, affective and behavioural interventions. It allows a person to talk about his or her problems and feelings in a confidential and trusting environment. The World Health Organization (WHO, 2006, p. 1) states that the practice of counselling entails the application of 'mental health, psychological or human development principles through cognitive, affective, behavioural or systematic intervention strategies'. This implies that counselling is a specialised service that provides clients with a supportive, non-judgemental and confidential environment in which to explore any emotional, psychological or life problems they may be encountering.

According to Feltham and Dryden (2004):

> Counselling is a principled relationship characterised by the application of one or more psychological theories and a recognised set of communication skills, modified by experience, intuition and other interpersonal factors, to clients' intimate concerns, problems or aspirations. Its predominant ethos is one of facilitation rather than of advice-giving or coercion. It may be of very brief or long duration, take place in an organisational or private practice setting and may or may not overlap with practical, medical and other matters of personal welfare. It is a service sought by people in distress or some degree of confusion who wish to discuss and resolve these in a relationship which is more disciplined and confidential than friendship, and perhaps less stigmatising than helping relationships offered in traditional medical or psychiatric settings.
>
> *(p. 53)*

This lengthy definition is based on these essential elements: the application of psychological interventions, the use of interpersonal skills, the confidential nature of the therapeutic relationship, and facilitation rather than advice-giving or coercion. The British Association for Counselling & Psychotherapy (BACP, n.d.) provides the following explanation:

> Counselling and psychotherapy are umbrella terms that cover a range of talking therapies. They are delivered by trained practitioners who work with people over a short or long term to help them bring about effective change or enhance their wellbeing.

The traditional counselling paradigms, including psychoanalysis, behaviourism, humanism and existentialism have generally dominated the process of counselling.

In sum, it is apparent that counselling takes place when a counsellor sees a client in a private and confidential setting. It offers the client a feeling of being listened to, valued and accepted in a non-judgemental way. Counselling is an opportunity for clients to explore their emotional difficulties and feelings of inner conflict, resolving specific problems, coping with crisis, developing self-awareness and improving relationships with others. It is an approach of enabling choices with a goal of facilitating positive change. However, mainstream counselling does not involve: giving advice or directing the client to take a particular course of action; being judgemental; exploiting the client in any way; attempting to sort out the problems of the client; getting emotionally involved with the client; and looking at the client's problems from the counsellor's own perspective, based on his or her own value system.

Directive, non-directive, eclectic and integrative counselling

Counselling should be looked upon in terms of the types of facilitation that the counsellor offers to the client. This facilitation ranges from full directions (directive counselling) to no directions (non-directive counselling). Under the process of counsellor-centred counselling, the counsellor listens to a client's problem, plans the counselling process, decides together with the client what should be done and enables the client to make the decision. Although advice-giving is of questionable value, some of the other functions achieved by directive counselling are worthwhile. It is a simple, quick approach to problem solving that provides short-term solutions and is effective for clients with limited problem solving skills who need clear, concise direction. However, this approach may be the only method that can be used when the client cannot make a connection between his or her current behaviour and its consequences. The counselling approach that is aimed at facilitating change may be more directive. For example, cognitive behavioural counselling is concerned with the way people's beliefs about themselves shape how they interpret experiences. In cognitive behavioural counselling, the clients are taught skills that are necessary for them to change and the clients are given tasks or homework to do between sessions. The counsellor plays the role of an adviser and teacher. Other more directive types of counselling are Gestalt counselling, transactional analysis and rational emotive behavioural therapy.

In contrast, non-directive, or client-centred or person-centred counselling, is the process of listening to a client, enabling the client complete freedom to talk about whatever he or she chooses without the interference of the therapist. The person-centred approach to counselling has evolved from the work of Carl Rogers and his colleagues (Rogers, 1961). Rogers initially called this 'non-directive therapy', but later replaced the term 'non-directive' with the term 'client-centred' and then later used the term 'person-centred'. There is an almost total absence of techniques in person-centred counselling and the emphasis is on the engagement of the client, and the quality of the relationship between client and counsellor. The person-centred therapist starts from the assumption that the client has an instinctive movement towards the constructive accomplishment of her or his inherent potential (self-actualisation). In non-directive counselling, the counsellor abstains from

evaluating or making remarks based on a client's attitudes, feelings and behaviours. The non-directive counsellor is more concerned about the client's perceptions of her or his problems, than the problems per se (Rautalinko, 2004). The aim is to enable the client in discovering her or his thoughts and emotions in order to understand the client's worldview or the client's frame of reference. The counsellor must be able to work in accordance with the core conditions: non-directive, non-judgemental, genuine, showing positive regard and having empathy.

An eclectic counselling style of therapy uses a wide range of theories, methods and practices (different schools of thought). Eclectic counselling is defined as:

> the synthesis and combination of directive and non-directive counselling. It represents a middle status between the two extremes represented by the 'non-directive' technique on one hand and the 'directive' technique on the other. In eclectic counselling, the counsellor is neither too active as in the directive counselling nor too passive as in the non-directive counselling.
>
> *(Sharma and Sharma, 2004, p. 210)*

According to McLeod (1993, p. 64), 'An eclectic approach to counselling is one in which the counsellor chooses the best or most appropriate ideas and techniques from a range of theories or models, in order to meet the needs of the client.' It is a more flexible approach that allows the counsellor to adapt to each client's individual psychosocial and spiritual needs. Integrative counselling is a process where the 'counsellor brings together elements from different theories and models into a new theory or model' (McLeod, 1993, p. 64); that is, 'to combine different theories within an integrative framework and then apply the ensuing integrative model in practice' (Lees, 2004, p. 13). In practice, the main approach for achieving integration has been to find a central theoretical concept or framework within which some or all existing approaches can be subsumed (McLeod, 1993).

What is Islamic counselling?

Islamic counselling is a contemporary response, in common with other therapeutic approaches, but is based on an Islamic understanding of the nature of human beings that incorporates spirituality into the therapeutic process. According to Abdullah (2007), Islamic counselling is not a new concept but, when studying its historical location, a distinction may be made between cultural and professional modes. Islamic counselling, according to Al Nasiha Services (n.d.):

> is a consciousness [*sic*] awareness of God in the counselling process. It differs from mainstream counselling as it's based on the implicit understanding of a mutual belief system – Islam – shared by both the client and counsellor. This shared understanding creates a trusting relationship between the client and counsellor – inspiring, uplifting and transforming the client to live a more resourceful life.

In the context of this book, Islamic counselling is a form of counselling that incorporates spirituality into the therapeutic process. The goal of this type of integrative counselling is to address a variety of underlying psychological needs from a faith-based perspective. Islamic counselling emphasises spiritual solutions, based on love and fear of Allah and the duty to fulfil our responsibilities as the servants of Allah (Magid, n.d.). Moreover, the Messenger of Allah (ﷺ) stated that: 'The religion is *Naseehah* (sincerity)' (cited in Zarabozo, 2008, p. 397). Giving *Naseehah* to Muslims in general means giving them advice. The Prophet (ﷺ) said, 'The rights of a believer over a believer are six' and then he mentioned that among them is 'if he asks you for an advice you have to give him advice' (www.40hadithnawawi.com, n.d.). Giving *Naseehah* involves guiding them towards that which will correct their affairs in both this life and the next. It involves protecting Muslims from harm, helping them in times of need, providing what is beneficial for them, encouraging them to do good (*al-Ma'roof*) and forbidding them from evil (*al-Munkar*) with kindness and sincerity, and showing mercy towards them (www.islaam.net, n.d.). And giving *Naseehah* (advice) is a community obligation (*Fard kifaya*). That is, if a sufficient number of people perform it then the obligation is lifted from the community as a whole, and it is obligatory according to the ability of the individual.

In traditional Muslim communities, counselling was given in various forms, the most common of which were giving advice and sharing wisdom. Abdullah (2013) suggested that Islamic counselling is comparable to Western counselling methods and can be located in three sources of Islamic doctrine and practice: Muslim personal law (Muslim family life); Islamic traditional healing based on a model of spirit (*Jinn*) possession; and Sufism. There are divergent views on the validity and acceptability of this model. However, throughout this book the Islamic counselling paradigm is based on the sources of the Qur'aan and Hadith (the teachings, deeds and sayings of the Prophet Muhammad (ﷺ). The differences between counselling and Islamic counselling are presented in Table 2.1. The contrast is made on the basis of religious relationship; the sources of knowledge; what causes illness and maintains sound mental health; responses to illness; and the values, growth and development of both types of counselling. In addition, the focus, purpose, process and intervention strategies of counselling are compared.

Islamic counselling is based on an integrated framework guided by the principles of Islamic belief and practices. However, the application of theories, concepts and intervention strategies from mainstream counselling outside the *Tawheed* paradigm is therefore rejected. Good practice in Islamic counselling will include approaches and techniques of mainstream counselling, acceptable in Islam, and incorporating the Qur'aan, Sunnah, Hadith and Islamic ethics. In Chapter 7 a framework for Islamic counselling is examined. The aims of Islamic counselling include: to address a variety of underlying psychosocial and spiritual needs from a faith-based perspective; to change the negative behaviours of the individual for his or her own benefit and the benefit of the community; to instil Islamic values; to enable the client to reflect on the relationship with the Creator.

TABLE 2.1 Differences between counselling and Islamic counselling

	Counselling (mainstream)	*Islamic counselling*
Orientation	Judaeo-Christian	Islamic
Religious relationship	Oppositional Secular	Integrated
Sources of knowledge	Man-made theories Empirical Parochial	Divine revelation (Qur'aan) and Sunnah
What causes illness?	Bio-psychosocial factors	Bio-psychosocial factors and spiritual factors
Sound mental health	No divine intervention	Submission to God Integration of material and spiritual life
Values	Materialistic Socio-moral value structure Value laden Value dependent	God consciousness Spiritual-divine will Islamic values and morality
Growth and development	Psychosocial development	Spiritual and psychosocial development
Focus	Limited focus on the physical world	Regard for spiritual aspects of human beings. Focus on the seen and unseen world.
Purpose	Promotes personal growth/ self-understanding	Promotes the clear purpose and meaning of life
Process	Individual-based and individual-focused	Mutual responsibility Social obligation Healthy altruism
Responses to illness	Psychological reactions	Spiritual reactions: Patience and prayers
Relationship between mind and body	Mind–body interaction	Mind–body–soul interaction
Personal development	Unlimited freedom	Bonded freedom
Intervention strategies	Based on humanistic, cognitive behavioural and psychoanalytical interventions	Based on humanistic, cognitive behavioural and spiritual interventions
Dream technique	Dream work not emphasised	Use of dreams analysis
Undesired (negative) behaviour	Rationalisation	Therapy of repentance

The Islamic counsellor

To be effective, counsellors should exhibit generic characteristics such as: good psychological health; self-awareness; open-mindedness; having empathy; unconditional positive regard; genuineness and congruence; non-judgementalism; instillation of hope; tolerance for ambiguity; cultural sensitivity and competence. In the

case of an Islamic counsellor, he or she should recognise the value of addressing the spiritual-religious dimension in the helping process.

Central to the counselling relationship is the attitude and skill of empathy. According to Rogers (1957), empathy and unconditional positive regard are the most important personal characteristics for effective counselling. Empathy has been described as seeing the world through another's eyes, hearing as clients might hear, and feeling and experiencing their internal worlds (www.zeepedia.com, n.d.). One core value or characteristic that always stands out in the behaviour of the Prophet (ﷺ) is empathy. The way he carried himself with others was impeccable, and this is why Allah described him as being of an exalted standard of character (interpretation of the meaning):

> *And indeed, you are of a great moral character.*
>
> *(Al-Qalam (The Pen) 68:4)*

The Prophet (ﷺ) was fully conscious of the pivotal role empathy plays in developing astute and diligent human beings and was always keen to educate people from an early age on this important value. In another verse of the Qur'aan, Allah says that (interpretation of the meaning):

> *There has certainly come to you a Messenger from among yourselves. Grievous to him is what you suffer; [he is] concerned over you and to the believers is kind and merciful.*
>
> *(At-Tawbah (The Repentance) 9:128)*

This verse also focuses on the empathetic attitude of the Prophet (ﷺ). In a Hadith, the Prophet (ﷺ) wanted to try to have the believers understand one another and to understand what each other was feeling: 'None of you truly believes until he loves for his brother what he loves for himself' (Bukhârî and Muslim, cited in IslamToday, n.d.). Another characteristic of the effective counsellor is unconditional positive regard, which is Islamically acceptable as a concept. The concept of unconditional positive regard is based on the notion that humans need significant people in their lives to accept and love them for who they are, regardless of the mistakes they make within the Islamic paradigm. There is evidence to suggest that unconditional positive regard may be especially useful in situations where a non-minority psychotherapist is working with a racial/ethnic minority client (Farber and Doolin, 2011). It is stated that as Muslims we understand that positive regard, or *Husn al-Dhan*, is to be optimistic with Allah and with each other as well (Shehadeh, 2012). The story of the Prophet Noah (Hud 11: 25–6) is a good example of giving positive regard to a stubborn and disbelieving people for 950 years. It is narrated by Anas bin Malik that Allah's Messenger (ﷺ) said, 'Help your brother, whether he is an oppressor or is being oppressed.' People asked, 'O Allah's Messenger! We help the one being oppressed, but how do we help an oppressor?' The Prophet (ﷺ) said, 'By seizing his hand (preventing him from oppression)' (Bukhârî, cited in UK Muslimah, n.d.).

Listening is another characteristic of an effective counsellor. It is stated by Ibrahim bin al-Junaid (cited in Bone, 2010) that 'A wise man said to his son: "learn the art of listening as you learn the art of speaking. Listening well means maintaining eye contact, allowing the speaker to finish the speech, and restraining yourself from interrupting his speech."' There is ample evidence to show the effectiveness of therapeutic listening as a treatment tool (Frick and Young, 2009). The Prophet (ﷺ) would listen attentively to the complaints, queries and thoughts of everyone – be it his companions, wives, anyone on the streets or the disbelievers as well. He would also give the person to whom he was listening the feeling that he or she was the most important person. It is stated that the Messenger of Allah (ﷺ) would:

> turn his complete body towards the person making eye contact. His body language would reflect the wants, feelings or thoughts being expressed. He would allow the person to complete his or her thoughts and would paraphrase to let the person know what he understood before responding to the communication.
>
> *(Rahmaa Institute, n.d.)*

Congruence or genuineness refers to the relational quality of counselling. There are two facets of congruence (Kolden *et al.*, 2011): it is both a personal characteristic (intrapersonal) of the therapist, and an experiential quality of the therapeutic relationship (interpersonal). There is evidence to suggest that an effective counsellor models congruence, which may include self-disclosure as well as the sharing of thoughts and feelings, opinions, pointed questions, and feedback regarding client behaviour (Kolden *et al.*, 2011). Prophet Muhammad (ﷺ) was genuine in dealing with people. He is reported to sit anywhere in a gathering, not in the centre; he didn't select a status title; and he refused when people wished to stand up for him. It is stated that He always allowed personal direct contact for both friends and foes. He used to clear a place opposite him for the guest and never pulled away from the conversation first, even when it became aggressive (el-Nadi, 2010). This golden rule is reflected in the behaviour of the Prophet (ﷺ), who taught that a smile is charity, even to strangers, and always used a person's favourite name to address him, even with enemies. The Prophet (ﷺ) respected even the youngest or poorest until each one thought him- or herself the most favoured:

> The Prophet (ﷺ) was offered water, and he drank from it. On his right side there was a boy and on his left side were some old men. He asked the boy, 'Do you mind if I offer the water to them?' The boy said, 'O Allah's Prophet! By Allah! I will not give up my right to drink for anyone (because I am sitting on the right side).' The Prophet (ﷺ) handed the water to the boy.
>
> *(Bukhârî, cited in Zaatari, n.d.)*

One characteristic of an effective counsellor that is neglected in the literature is the instillation of hope. The instillation of hope is an important part of counselling (the

existential psychotherapist). Yalom (2005) cites it as the first of eleven 'primary factors' in the therapeutic experience. The instillation of hope offers a path back to a sense of possibility in our lives when almost all seems lost. For believers, it is asking God, the Almighty, to offer forgiveness, true blessings and hope in trials and tribulations. The Noble Qur'aan informs us that with every difficulty comes ease. Hope is an acknowledgement of that reality that things will get better, and a time of ease will come. According to Imam Tahawiyyah (n.d.), if a man committed a sin, he repents sincerely, and is hopeful of being forgiven.

Conclusion

Based on the increasing recognition of the need for effective counselling with Muslim clients, there is a new development in the nature and scope of Islamic counselling. The way to sum up the nature and process of counselling is that it is spiritual in that it is about the meaning and essence of life. It is about using counselling and interpersonal skills, giving advice (when appropriate), educating the client in the creed (*Aqeedah*) and Islamic jurisprudence (*Fiqh*) and working with people to facilitate their psychological and spiritual growth and development. Given that the principles and practice of Islamic counselling are not yet in a form where its actual implementation can be monitored, it first requires guidelines that can be integrated into a theoretical framework, a purpose to which this book is directed.

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3

SPIRITUALITY AND ISLAMIC COUNSELLING

Introduction

What does spirituality have to do with health and healing? Spirituality has always been linked to health and healing as the body, spirit and soul are intertwined. Despite having lost its importance in modern times due to the technological, cure-oriented model of healthcare, there has been a spiritual renaissance with a growing number of studies revealing that spirituality may play a bigger role in health and in the healing process. Many people have come to realise that modern medicine, with its rejection of the significant contribution of spirituality to health, does not have answers to every question about health and healing. Spirituality is recognised as a factor that contributes to health in many persons (AAMC, 1999). The Islamic notion of health is holistic, which means that physical, social, psychological and spiritual aspects of health are interrelated. All these different dimensions of human health are integrated and unified within the religious worldview of Islam (el Diwani, 2005). The World Health Organization identifies health as 'a state of complete physical, mental, and social well-being', but a proposal was approved to endorse a new definition of health as 'a dynamic state of complete physical, mental, spiritual and social well-being and not merely the absence of disease or infirmity' (WHO, 1998, p. 1).

Spirituality can be an important element in the way patients face illness, suffering and loss. In the midst of suffering from chronic physical illness and mental health problems, people are faced with finding meaning and acceptance of their problems and their lifestyles. It is stated that 'while patients struggle with the physical aspects of their disease, they have other pain as well: pain related to mental and spiritual suffering, to an inability to engage the deepest questions of life' (Puchalski, 2001, p. 352). While in severe pain or suffering, people, regardless of their religious affiliations, including atheists or agnostics, may be asking questions such as the following: Why

me? Why is this happening to me now? Why this suffering or loss at this particular time? Is there a God? What will happen to me after I die? Generally, during sickness or calamities, people will go back to spirituality, whether it is God or a 'higher spiritual being'. It is stated that, when in distress or suffering from tribulations, humans are likely to call out to God (Utz, 2011). Numerous verses of the Qur'aan confirm this (interpretation of the meaning):

> *And when the adversity touches man, he calls upon his Lord, turning to Him [alone].*
> *(Az-Zumar (The Troops) 39:8)*

> *And when the adversity touches man, he calls upon Us.*
> *(Az-Zumar (The Troops) 39:49)*

Spirituality and religion

The concept of spirituality for individuals of different cultures, races and communities often carries many interpretations. Spirituality is:

> expressed in an individual's search for ultimate meaning through participation in religion and/or belief in God, family, naturalism, rationalism, humanism, and the arts. All of these factors can influence how patients and health care professionals perceive health and illness and how they interact with one another.
> *(AAMC, 1999, pp. 25–6)*

The definitions of spirituality include:

> a belief in a power operating in the universe that is greater than oneself, a sense of interconnectedness with all living creatures, and an awareness of the purpose and meaning of life and the development of personal, absolute values. It's the way you find meaning, hope, comfort and inner peace in your life.
> *(University of Maryland Medical Center, 2011)*

According to Wright (1999), spirituality can be seen as the summation of our values, which determines the process of how we interact with the world; whereas religion is seen as a pathway to follow the practices and thoughts that are appropriate to God or gods of a particular faith. Spirituality may be further defined as 'an actualizing tendency that directs an individual towards knowledge, love, meaning, hope, transcendence, connectedness, and compassion . . . creativity, growth, and the development of a value system' (Miller, 1999, p. 499). What has been suggested here is that spirituality encompasses all that is spiritual, transpersonal and religious; and also that an individual does not have to be religious in order to be spiritual, and vice versa (Bray, 2011; Rican and Janosova, 2009). It is acknowledged that not

every individual who seeks self-awareness, self-empowerment and self-actualisation pursues a particular religious belief or faith. Furthermore, 'Spirituality in this context, therefore, is not given to mean something religious although it may mean that. Nor does it imply that one focuses on a God or a Supreme being, although for many it may mean that too' (www.thereachapproach.co.uk). In the West, there is an inherent difficulty in the synergy of spirituality and religious beliefs (Rassool, 2000). Religion, as a concept, is perceived by many (in the West) as not being interchangeable with spirituality. In this context, the concept of spirituality has a broader meaning than religion and encompasses philosophical ideas about life, its meaning and purpose (Dyson *et al.*, 1997) and spirituality forms the basis of meaning and purpose for many people (Foglio and Brody, 1988).

Religion and spirituality – an Islamic perspective

In Islam and following the Holy Qur'aan and Hadiths (defined as sayings, deeds or agreements of the Prophet (ﷺ)), there is no distinction between religion and spirituality. The concept of religion is embedded in the umbrella of spirituality. In the Islamic context, there is no spirituality without religious thoughts and practices, and the religion provides the spiritual path for salvation and a way of life (Rassool, 2000). It has been suggested that, for the majority of clients, 'religion and spirituality are important to them and . . . they would like to be able to talk about this area of their lives in therapy' (Eck, 2002, p. 269). Muslims embrace the acceptance of the Divine, and they seek 'meaning, purpose and happiness' in worldly life and the Hereafter. This is achieved through the belief in the 'Oneness of Allah' (*Tawheed*) without any partner, and the understanding and application of Qur'aanic practices and the guidance of the Prophet (ﷺ). *Tawheed* means 'unification' and is used in reference to Allah; it means the realising and maintaining of Allah's unity in all of man's actions that directly and indirectly relate to Him. It is the belief that Allah is one, without partner, one without similitude in His essence and attributes and One without rival in His divinity and in worship. These form the fundamental basis of *Tawheed*. The material realm of this world is given 'in trust' from Allah. *Tawheed* is:

> the very foundation of Islam on which all the other pillars and principles depend. If one's Tawheed is not sound, the rest of one's Islam becomes, in effect, a series of pagan rituals. In this model, Allah's unity must be maintained spiritually, intellectually and practically in all facets of human life.
>
> *(Philips, 1994, p. vii)*

The spiritual discipline that transforms and purifies the inner self of man is the core of the Islamic system. This spiritual discipline frees man from the slavery of the 'self', purges the soul from the lust of materialistic life and instils in humans a passion of love for Allah (Rahman, 1980). It is the process of patience, perseverance and gratitude that opens the door for spiritual and physical well-being. The preservation of human well-being, worldly and spiritual, personal and public, is

the basis and aim of Divine Revelation and Guidance. Counselling is a means of preserving such well-being, and is a communal obligation (*Fard kifaya*). It needs, however, 'to be rooted in a sound worldview; a sound understanding of the reality of the individual, their faculties, and the reality of the heart (qalb)' (Rabbani, n.d.).

Evidence of religion and spirituality in health

Research is now pointing to the relevance of religiosity and spirituality in the lives of individuals. Basically, empirical evidence based on over 300 studies has demonstrated in many, but not all, cases that a positive relationship exists between spiritual or religious factors and health (Thoresen, 1999). There is evidence to suggest that those persons who are more spiritually or religiously involved have higher rates of overall well-being and life satisfaction; lower rates of depressive symptoms and suicide; lower rates of divorce and higher rates of marital satisfaction; and lower rates of alcohol and other drug abuse, including cigarette smoking and recreational drug use (Larson *et al.*, 1998; Worthington *et al.*, 1996).

Research shows that religious and spiritual beliefs and practices are beneficial for improving and maintaining good mental and physical health (Larimore *et al.*, 2002), and are beneficial for people with mental health problems. Such benefits include greater strength in coping and decision making, enhanced social support and personal coherence or wholeness (Fallot, 2001). Cotton *et al.* (2007) reviewed the literature on the effects of religious and spiritual beliefs and practices on mental, emotional and physical well-being in the lives of American youth (12 to 20 years). The authors found that, in general, adolescents who have higher religiosity and/or spirituality fare better than their less religious or spiritual peers, having lower rates of risky health behaviours and fewer mental health problems. There seemed to be a link between spirituality and morbidity. It has been suggested that unmet spiritual needs can adversely affect health and may increase mortality independent of mental, physical or social health (Pargament *et al.*, 2001). Some studies suggest that people who have regular spiritual practices tend to live longer (Strawbridge *et al.*, 1997). Another study indicates the association between increased levels of IL-6 (Interleukin 6 is secreted by T cells and macrophages to stimulate an immune response) with an increased incidence of disease. In effect, the literature supports a relationship between various measures of religiousness (for example, church attendance) and disease indicators, including mortality. A study (Koenig *et al.*, 1997) involving 1,700 older adults showed that those who attended church were half as likely to have elevated levels of IL-6. The authors postulated that religious commitment may offer better coping mechanisms, richer social support and the strength of personal values and worldviews to control stress.

There is evidence to suggest that religion and spirituality contribute to increased rates of well-being and life satisfaction and decreased rates of 'suicide, substance abuse, and antisocial behaviour' (Brawer *et al.*, 2002, p. 204). In contrast, rigid religious beliefs based on sin and guilt may deepen mental illness such as depression, and delusions and hallucinations may be accentuated by religious content (Fallot,

2001). A growing body of literature suggests that people often turn to religion when coping with stressful events. Religious coping means dealing with stress through prayer, collective support and religious faith. Religious or spiritual factors have been found to influence patients' ability to cope with illness, with 90 per cent of hospitalised patients using religion to enable them to cope with their illnesses and over 40 per cent indicating that it is their primary coping behaviour (Koenig, 1998). A meta-analysis of 49 relevant studies on religious coping and psychological adjustment to stress supported the hypotheses that positive and negative forms of religious coping are related to positive and negative psychological adjustment to stress, respectively (Ano and Vasconcelles, 2005).

The findings of a study showed that, when coping with a terminal illness such as gynaecological cancer, and when asked what helped them cope with their cancer, 93 per cent of 108 women cited spiritual beliefs (Roberts *et al.*, 1997). In addition, 75 per cent of these patients stated that religion had a significant place in their lives, and 49 per cent said they had become more spiritual after their diagnosis. Parents also find comfort in their religious beliefs when dealing with children who have died of cancer (Cook and Wimberly, 1983). Spiritual commitment has also been found to enhance recovery from illness and surgery. A study of heart transplant patients showed that those who participated in religious activities complied better with follow-up treatment, had improved physical functioning, had higher levels of self-esteem, and had less anxiety and fewer health concerns (Harris *et al.*, 1995).

Some studies indicate that those who are spiritual tend to have a more positive outlook and a better quality of life, and are better at coping with pain (Brady *et al.*, 1999; Yates *et al.*, 1981). There is evidence to suggest that personal prayer was the most commonly used non-drug method of controlling pain: 76 per cent of the hospitalised patients studied made use of it (McNeill *et al.*, 1998). According to one study (Johnstone *et al.*, 2012), spirituality has been found to improve the health of most people, both of seemingly healthy individuals and of those with conditions and illnesses. Furthermore, better mental health is significantly related to increased spirituality, increased positive personality traits (for example, extraversion) and decreased negative personality traits (for example, neuroticism). The only spiritual trait predictive of mental health after personality variables were considered was forgiveness.

Emergence of spiritual dimension in counselling

There is a host of critical analysis of the concept of spirituality in the counselling literature. Historically, as European counselling emerged in the last century, it purposefully distanced itself from established religions and spiritual beliefs, allying itself with scientific and secular values and constructions of knowledge (Nelson, 2009). However, with increasing multicultural and diversity practice in counselling, there was a need to incorporate the spiritual dimension in the counselling process in order to effect changes in clients. Subsequently, there is the emergence of spiritually oriented therapies and practices that focus more on the non-expert,

personal qualities of therapists and therapeutic relationships as healing (Nelson, 2009; Richards and Worthington, 2010). Increasingly, schools of thought such as psychosynthesis, transpersonal psychology and 'fringe' approaches to therapy are rapidly emerging to make the concept of spirituality a more acceptable phenomenon. It is not surprising that Carl Rogers (1995) stated 'I am compelled to believe that I, like many others, have underestimated the importance of this mystical, spiritual dimension' (p. 130).

It has been suggested that 'spirituality is at the centre of Rogers' conceptualisation of the empathic relationship between counsellor and client, and he regarded its spiritual characteristics as outcomes of the universe's actualizing tendency' (Bray, 2011, p. 83) Spirituality in counselling is a pivotal component of the therapeutic process. Spiritual or religious-based counselling, meditation and forgiveness protocols may improve spirituality-based beliefs, practices and coping strategies in positive ways (Johnstone *et al.*, 2012); 'the concept of spirituality in counselling really refers to the discovery or the recovery of peace of mind, stability and happiness' (Reach, n.d.). Spiritual counselling:

> involves the use of interpersonal skills, like those of counselling, to help an individual (generally) to explore their own responses to physical, emotional and spiritual issues that are affecting them, and to redefine those responses that are no longer helpful to them by reference to their higher self.
>
> *(Wilson, 2008, p. 1)*

From a counsellor's standpoint, understanding clients' spirituality is quite significant as it is integral to the clients. Clients want to talk about their spiritual lives and expect counsellors to treat them using a holistic approach with bio-psychosocial, emotional and spiritual needs.

Spirituality may be a dynamic in the client's understanding and perception of the problem. Questions about meaning and existence commonly occur in the counselling process. In their therapeutic exploration it is useful to understand what degree religious and spiritual beliefs, values and practices impact upon these questions and influence clients (Bray, 2011). In addition, in order to clarify and assist the therapeutic process and reveal potential sources of support for the client, it is important to assess the influence of the spiritual domain in a client's life by discussing the client's history of religious and spiritual participation and experiences; reviewing the client's current practices, rituals, and community involvement; and discussing his or her beliefs (Bray, 2011).

The worldview of Muslim patients regarding health and illness incorporates the notion of receiving illness and death with patience, meditation and prayers (Rassool, 2000). Muslim clients understand that illness, suffering and dying are part of life and a test from Allah. It is stated in the Qur'aan that (interpretation of the meaning):

> *Be sure we shall test you with something of fear, hunger, some loss in wealth, lives or the produce (of your toil), but give glad tidings to those who patiently persevere.*
>
> *(Al-Baqarah (The Cow) 2:155)*

Muslims consider an illness as atonement for their sins, and death as part of a journey to meet their God (Athar, 1998). Health and illness become part of the continuum of being, and religious beliefs remain the salvation in both health and in sickness. The religious beliefs may lead to positive coping, where clients seek control through a partnership with God, ask God's forgiveness and try to forgive others, draw strength and comfort from their spiritual beliefs, and find support from a spiritual or religious community. These actions lead to less psychological distress (Pargament *et al.*, 1998). Muslims typically find comfort in their religious or spiritual beliefs and practices during times of uncertainty or crisis. It is important that counsellors, when building therapeutic alliances with clients, encourage spiritual expression. Therapists should facilitate this by creating a setting of openness, trust and respect for their clients' spiritual expression.

Conclusion

Spirituality is recognised as a factor that contributes to the maintenance of psychological health. The Islamic notions of health, holistic in nature, are integrated and unified within the religious worldview of Islam. Jung (1933) stated that 'Among my patients in the second half of life, that is over 35 years of age, there has not been a single one whose problem has not been in the last resort that of finding a religious outlook on life' (p. 164). Both the spiritual dimensions of health and counselling share the common aim of being a response to trials and tribulations and human suffering. For most Muslims religion is a salvation and an important part of the coping process.

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4

UNDERSTANDING HUMAN NATURE AND PERSONALITY DEVELOPMENT IN THE ISLAMIC CONTEXT

Islam and human nature

It is appropriate here to examine human nature and personality development from an Islamic perspective in order to understand the worldview of Muslim clients. According to the Qur'aan, Allah says (interpretation of the meaning):

- *Recite in the name of your Lord who created*
- *Created man from a clinging substance.*
- *Recite, and your Lord is the most Generous*
- *Who taught by the pen*
- *Taught man that which he knew not.*

(Al-'Alaq (The Clot) 96:2–6)

These verses, according to Ibn Kathir (n.d.), are to:

> inform the beginning of man's creation from a dangling clot, and that out of Allah's generosity He taught man that which he did not know. Thus Allah exalted him and honored him by giving him knowledge, and it is the dignity that the Father of Humanity, Adam, was distinguished with over the angels. Knowledge is sometimes in the mind, sometimes on the tongue, and sometimes in writing with the fingers. Thus, it may be intellectual, spoken and written. And while the last (written) necessitates the first two (intellectual and spoken), the reverse is not true.

It has been suggested that 'when the Qur'aan talks about the story of Adam and Eve it does not present only as the story of the first man and woman but rather it depicts the ethical experience of Adam and Eve as well as every other human

being' (Badawi, 2010). In the Qur'aanic version of the Adam and Eve story, they both begged God's forgiveness (Qur'aan 7:23) and he punished them with a mortal life on earth. In addition, when the Qur'aan speaks about the story of Adam and Eve it addresses the fact that they committed their mistake, realising their mistake, repenting and praying sincerely to God who forgave both of them. Allah says in the Qur'aan (interpretation of the meaning):

> *Then Adam received from his Lord [some] words, and He accepted his repentance. Indeed, it is He who is the Accepting of repentance, the Most Merciful.*
>
> *(Al-Baqarah (The Cow) 2:37)*

The Qur'aan does not conclude from this the doctrine of original sin as some Christian theologians have. According to Badawi (2010), 'the Qur'aan is very clear that sin cannot be inherited and no soul can carry the burden of another soul or passed on to a future generation'. Human beings are believed to be innately good and born with an inclination towards goodness, a natural state that has been implanted in every soul by God. Humans are separated from the rest of creation by being created with intelligence and free will for the purpose of obeying and serving God. As Badawi (2010) stated, 'The secret for the honouring of mankind is that only the human being has to integrate and harmonise the various components of his existence by utilising his physical body, intellect and soul.' He went on to suggest that the 'reason why human beings are dignified is that they have free choice, and the potential for good and evil. The Qur'aan states clearly that God has "shown him the two highways" [Al-Balad (The City) 90:10] of truth and falsehood' (Badawi, 2010) – or 'the good and the evil'.

In summary, from an Islamic perspective the essence of human nature is regarded as the trustee of God (*Khalifah*) on earth. The blessings bestowed on humans are the utilisation of the physical body, intellect and soul. The rationale for why humans are dignified is that they have intellect and free choice, and the potential for good and evil. Furthermore, every person has within them the ability to distinguish between right and wrong. Prophet Muhammad (ﷺ) said:

> Consult your heart. Righteousness is that which makes the heart and the soul feel tranquil, wrongdoing is that which wavers in the soul, and moves to and fro in the chest even though a legal opinion may have been given in its favour.
>
> *(Ahmad and al-Darimi, cited in LNM, 2010)*

This means there is an awareness when something is right, wrong or morally unacceptable. With freedom of choice comes responsibility and accountability for our deeds till the last day (Day of Judgement) and whether we follow our innate goodness or choose to live outside the legal wish of God.

The innate instinct: the *fitrah*

Belief in God begins with belief in His existence and is part of human nature. The innate instinct is termed '*fitrah*'. Utz (2011) defined *fitrah* as 'the pristine nature within humans that leads them to acknowledge the truth of God's existence and to follow His guidance' (p. 47) – that is, a natural state of submission to Allah. According to Ibn Taymiyah [a] (n.d.), 'Every human being is born in the nature of Islam. If this nature is not subsequently corrupted by the erroneous beliefs of the family and society, everyone will be able to see the truth of Islam and embrace it' (p. 3). Allah says in the Qur'aan (interpretation of the meaning):

> *So direct your face toward the religion, inclining to truth. [Adhere to] the fitrah of Allah upon which He has created [all] people. No change should there be in the creation of Allah. That is the correct religion, but most of the people do not know.*
>
> *(Ar-Rūm (The Romans) 30:30)*

This means that humans should adhere to the religion that Allah has prescribed and to worship of Allah alone without partners. The verse describes a *fitrah* of primordial faith that Allah Himself implanted in human nature. It also implies Islam's essential message of submission to the will of Allah as taught and practised by the Prophets (Mohamed, 1996).

Fitrah is the common denominator among people of different educational and social backgrounds, walks of life and orientations. It was only in the twentieth century that whole societies were established based on the denial of God's existence (Philips, 2007, p. 96). Evidence for the innate instinct in the belief in God (*fitrah*) is indicated by the majority of people in the world who believe in God or a 'higher being' in one form or another. It was estimated in 2005 that 33 per cent of the world's inhabitants, some 2.2 billion people, considered themselves Christian, about 21 per cent were followers of Islam (1.5 billion) and Hindus made up 14 per cent. Only 16 per cent of people are considered to be agnostics, atheists, theists and new secular humanists (www.adherents.com, n.d.). According to Gallup (2011), approximately 91 per cent of Americans say they believe in the existence of God or a higher power. A survey by Larson and Whitham (1997), reported in the journal *Nature*, showed that 40 per cent of biologists, physicists and mathematicians said they believed in God, and not just a non-specific transcendental presence, but, as the survey put it, a God to whom one may pray 'in expectation of receiving an answer'.

Since the essential component of the *fitrah* is *Tawheed*, belief in the Oneness of Allah with no partners, the Prophets, peace be upon them, were sent to guide man to that which is integral to his original nature. The concept of *Tawheed* was examined in Chapter 3. Since Allah's *fitrah* is engraved upon the human soul, mankind is born in a state in which *Tawheed* is integral (Mohamed, 1996). Islam is also called '*Dîn al-fitrah*', the religion of human nature. As Utz (2011) points out, 'Islam is the religion of *fitrah* because it is the religion that guides humanity to true faith in Allah' (p. 47). It seems that:

> fitrah is the original nature of man, uncorrupted by subsequent beliefs and practices, ready to accept the true ideas of Islam. Islam is nothing but submitting to Allāh and to none else; this is the meaning of the words, 'there is no god except Allāh'.
>
> *(Ibn Taymiyah [a], n.d., p. 3)*

According to Islamic theology, mankind's chief failing is pride and rebellion. In their pride, humans attempt to partner themselves with God and thereby damage the unity of God. The cardinal virtue, then, is submission, or *Islam* (www.religion-facts.com, n.d.).

However, due to socialisation and parental attitudes and beliefs, humans are led astray from their true human nature. The Prophet Muhammad (ﷺ) said that 'All human beings are born with fiṭrah, the nature (of Islam). It is their parents who make them a Jew, a Christian or a Zoroastrian' (Muslim, n.d.). According to Ibn Taymiyah [a] (n.d.), 'God endowed mankind with this essential nature the day He addressed them, saying, "Am I not your Lord?" and they said, "Yes, You are" (Qur'aan 7:172)' (p. 3) That every child is born in this pure state of *fitrah* is also supported by the following Hadith. The Prophet (ﷺ) said that, 'Man is born with a perfectly sound nature (fiṭrah), just as a baby animal is born to its parents, fully formed without any defect to its ears, eyes or any other organ' (Bukhârî and Muslim, cited in Ibn Taymiyah [a], n.d.). However, all children will have their own unique personality characteristics and their socialisation and experiences will often shape their responses to situations. That is, circumstantial (for example, parental, familial and other social) influences cause people to change and become alienated from their *fitrah* with deviating beliefs and practices.

The Prophet (ﷺ) emphasised that a sound heart is like a sound body, and a defect is something alien that intervenes. He also quoted God's words, stating that 'I created my people faithful to none but Me; afterwards the devils came upon them and misled them. They forbade them what I had permitted, and commanded them to associate with Me ones I had never authorized' (Muslim, n.d.). However, according to Ibn Taymiyah [a] (n.d.), the fact that the people are born with *fiṭrah* does not mean that a human body is actually born with Islamic beliefs. He adds that 'we are only born with an uncorrupted heart, which is able to see the truth of Islam and submit to it. If nothing happens which corrupts the heart we would eventually become Muslims' (p. 4). In the Qur'aan, Allah appeals to the human intellect and rationality, saying (interpretation of the meaning):

> *Or were they created by nothing, or were they the creators [of themselves]? Or did they create the heavens and the earth? Rather, they are not certain.*
>
> *(Aṭ-ṭūr (The Mount) 52:35–6)*

There is no dispute that the universe had a beginning. Thus, 'every action requires a doer, and thus the existence of creation necessarily indicates the existence of the Creator' (www.islamweb.net [a], n.d., p. 34). Evidence of the predisposition of

humans to believe in gods and the afterlife is confirmed in multiple site research studies representing a diverse range of cultures. The studies (both analytical and empirical) conclude that humans are predisposed to believe in God and an afterlife, and that both theology and atheism are reasoned responses to what is a basic impulse of the human mind (Barrett and Trigg, 2011). In addition, it has been suggested that 'to suppress religion [is] likely to be short-lived as human thought seems to be rooted to religious concepts, such as the existence of supernatural agents or gods, and the possibility of an afterlife or pre-life' (Trigg, 2011).

Fitrah is further evidenced by the fact that, when exposed to trials and tribulations, and when in physical or psychological distress, humans are likely to remember and call out to God. In several verses of the Qur'aan, Allah says (interpretation of the meaning):

> *And when adversity touches man, he calls upon his Lord, turning to Him [alone]; then when He bestows on him a favour from Himself, he forgets Him whom he called upon before, and he attributes to Allah equals to mislead [people] from His way.*
>
> *(Az-Zumar (The Troops) 39:8)*

> *And when adversity touches man, he calls upon Us; then when We bestow on him a favour from Us, he says, 'I have only been given it because of [my] knowledge.' Rather, it is a trial, but most of them do not know.*
>
> *(Az-Zumar (The Troops) 39:49)*

In summary, humans have an inherent and inborn recognition of their Creator. According to Nabulsi (2012):

> God created mankind and installed in their nature the belief in Him. If they follow this belief, they will be composed, assured, calm, and happy; whereas, if they fail to do so, they will suffer hardships and sickness, developing the symptoms of the soul disease, such as arrogance, cruelty, haughtiness, selfishness, and pompousness.

Despite the abundance of proof, there are those who simply refuse to believe. Allah says in the Qur'aan (interpretation of the meaning):

> *Indeed, those upon whom the word of your Lord has come into effect will not believe, even if every sign should come to them, until they see the painful punishment.*
>
> *(Yūnus (Jonah) 10:96–7)*

Human nature: covenant and purpose

The theological framework for linking human beings with God and each other is the covenant (*mithaq*). The Islamic view of human nature as expressed by the notion of *fitrah* is closely linked with the covenant, which is integral in understanding

the place of man and his role in this universe (Ibn 'Ashur, 2009). The Qur'aan emphatically testifies that all the created souls made a covenant to worship and obey God before the creation of the universe. This occupies a fundamental place in the Muslims' creed (*Aqeedah*). Allah says in the Qur'aan (interpretation of the meaning):

> *'Am I not your Lord?' They said, 'Yes, we have testified.' [This] – lest you should say on the day of Resurrection, 'Indeed, we were of this unaware.'*
>
> *(Al-'A'rāf (The Heights) 7:172)*

According to Ibn Kathir (n.d.):

> Allah stated that He brought the descendants of Adam out of their fathers' loins, and they testified against themselves (by circumstance and words) that Allah is their Lord and King and that there is no deity worthy of worship except Him. Allah created them on this *fitrah*.

This ontological covenant points to man's essential nature and the purpose of human beings' worldly existence, both as God's servants and viceregents on earth (Ibn 'Ashur, 2009). This covenant is not only a testament that God is their Lord, but also says not to direct any form of worship to others besides Him. According to Philips (2014):

> This is the essential meaning of the declaration of faith (*Shahadah*) which everyone must make in order to become a bona fide Muslim; (There is no god worthy of worship but Allah) also known as '*Kalimah at-Tawheed*', the statement of Allah's Unity.

This notion of covenant binds Muslims to God because man has declared God's unity and is indebted to worship only one God without any partners. Humans serve God by doing good deeds, telling the truth and obeying righteous deeds defined by Allah and His Prophet (ﷺ).

The fulfilment of the covenant with Allah can only be made 'by a Muslim by choice, regardless of whether his parents were Muslims or not, and the application of the covenant is, in fact, the implementation of the principles of Islam itself' (Philips, 2014). In addition, Philips (2014) maintains that:

> Man's fitrah is the basis of Islam, so when he practices Islam in its totality, his outer actions and deeds come into harmony with the very nature in which Allaah created man's inner being. When this takes place, man unites his inner being with his outer being which is a key aspect of *Tawheed*.

In conclusion, the Islamic conception of human nature and the fundamental idea of the original covenant is the core of human beings' roles and responsibilities.

Thus, man's ultimate life objective is to worship the creator (God) by abiding by the Divine guidelines revealed in the Qur'aan and the tradition of the Prophet (ﷺ).

Personality development

Personality is defined as enduring characteristics and patterns of thoughts, feelings and behaviours that make a person unique. According to Kasule (2000, p. 1), 'personality is the totality of behavior of an individual with a given tendency system. Tendency means there is consistency.' That is, generally, the individual remains fairly consistent throughout life. A number of different theories and models have emerged to explain different aspects of personality. Some theories focus on explaining how personality develops, while others are concerned with individual differences in personality. The biological perspective suggests that much of one's personality is a result of genetic inheritance. The trait theories focus on identifying core traits that can be used to describe the personality. According to behaviourists, human personality is composed of traits. All behaviours are learned, and learning can be effective in changing maladaptive behaviour. The social-cognitive theory has added the notion that we acquire personality by observing others (imitation, role models) and building a sense of self-efficacy.

The theory of cognitive development of Jean Piaget in relation to how children think differently compared to adults is an important contribution to our understanding of personality development. In psychoanalytic theory, the focus is on Sigmund Freud's psychosexual stages of development: oral stage, anal stage, phallic stage, latency period and genital stage. Failure to successfully complete these stages, he suggested, would lead to personality problems in adulthood. Erik Erikson's eight-stage theory of human development is built on Freud's stages of psychosexual development. The focus of Erikson's theory is on how social relationships impact personality development across the entire lifespan. Lawrence Kohlberg developed a theory of personality development that focused on the growth of moral thought. The humanistic personality theories stress the inherent basic goodness of human beings and the need to achieve one's full potential (self-actualisation).

Personality development in the Islamic context

Islamic personality is directly linked to the practice of Islam, as Islam teaches its adherents to acquire good moral behaviour. Moral character is not simply a goal within the life of a Muslim, but the end goal of the Islamic faith itself (Ricardo, 2012). Islam has emphatically called upon people to adopt good moral character and the following Hadiths reinforce this characteristic:

> The Prophet (ﷺ) was asked, 'Which Muslim has the perfect faith?' He answered: 'He who has the best moral character' (Tibrani). Another tradition has it, 'They asked [the Prophet (ﷺ)] what is the best thing given to

> man?' He replied, 'Best moral character' (Tirmidhî). Abdullah bin' Amar has reported: 'I have heard the Prophet (ﷺ) as saying: "Should I not tell you who amongst you is the most likeable person to me? And who will be the nearest to me on the Day of the Judgment?" He repeated this question twice or thrice. The people requested him to tell them about such a person. He said "He who amongst you has the best moral character"' (Ahmed).
>
> *(Cited in www.islambasics.com [a], n.d.)*

That is, every Muslim, in essence, should demonstrate good interpersonal behaviour and conduct, character and morality. It is worth noting that personality is an aspect of spiritual development. There is evidence to suggest that spirituality functions as a personality trait (Johnstone *et al*., 2012). The authors suggested that, with increased spirituality, people reduce their sense of self and feel a greater sense of oneness and connectedness with the rest of the universe. All psychological phenomena, according to Islamic tradition, originate in the *Nafs*. The concept of *Nafs* appears in the Qur'aan and means the self, soul, ego and psyche.

The self from an Islamic perspective

In traditional psychology, the self takes many forms in personality theories: transpersonal knowledge, and readiness for psychological development and interpersonal relationships. From an Islamic perspective, the self is represented in several forms: the heart (*Qalb*), the soul or spirit (*Ruh*), and the *Nafs*. According to Inayat (2005), the spiritual heart (*Qalb*) is the most important, containing the deepest spiritual wisdom of the individual; the soul or spirit (*Ruh*) refers to a connection with the divine; and the *Nafs* is the most superficial level of the Islamic self.

*The heart (*Qalb*)*

In the Qur'aan, *Qalb* is the general word used for the heart and the root word means something that turns around, something that changes easily. From an Islamic perspective, the heart is connected to the soul as an integral component and is mentioned in the Qur'aan no less than 137 times. It is also the seat of intellectual, cognitive and emotional faculties, volition and intention (*Niyyah*) (Haque, 2004, p. 48). The Prophet (ﷺ) is reported to have said: 'It is only called the *qalb* (heart) because of how it can change. The similitude of the heart is like a leaf hanging from the trunk of a tree that is being blown upside down by the wind and it is only called the heart (*al-qalb*) because it changes so rapidly (*Yataqallib*)' (Ahmad, n.d.). Ibn Taymiyah [b] (n.d.) stated that many doctors and philosophers have said that the mind is in the brain, so we think and understand with our brains and not with our hearts. He then said that the centre is actually the heart. Ibn Kathir said: 'The arrogant philosophers say that the mind is in the brain ' (cited in understandquran.com, n.d.). The heart is not only considered to be the centre of emotions but is also capable of thought and understanding. Scientists are discovering that our hearts

may actually be the 'intelligent force' behind the intuitive thoughts and feelings we all experience (Armour, 1991; Frampton, 1991; Ghilan, 2012; Pearsall *et al.*, 2002). In addition, it is not just a piece of flesh in your body, but it is the centre of all feelings, emotions, motives, drives, aspirations, remembrance and attention (Murad, 1985).

The heart's capacity to be involved in cognitive, emotional and behavioural responses is expressed in several Qur'aanic verses. It is the heart which softens (Qur'aan 39:23), or hardens (2:74). It is the heart that goes blind and refuses to recognise the truth (22:46), and it is the heart that inspires the function to reason and understand (7:179; 22:46; 50:37). In the heart, lies the root of all outward diseases (5:52); it is the seat of all inner ills (2:10). The heart is the abode of faith (5:41) and hypocrisy (9:77). It is the heart that is the centre of all that is good and bad, whether it be contentment and peace (13:28), the strength to face afflictions (64:11), mercy (57:27), brotherly love (8:63) and God-consciousness (49:3; 22:32), or doubt and hesitation (9:45), regrets (3:156) and anger (9:15). The Prophet (ﷺ) said about the heart: 'Truly in the body there is a morsel of flesh which, if it be sound, all the body is sound and which, if it be diseased, all of it is diseased. Truly it is the heart' (Bukhârî and Muslim, cited in understandquran.com, n.d.). In this context, the statement suggests that 'If the heart is good, then it makes use of the knowledge and it avoids what is prohibited. If the heart is corrupted, then the knowledge is of no benefit to it and it will indulge in what is prohibited' (www.islamweb.net [b], n.d.). Thus, the heart plays a significant role in human behaviour and experience, and it is not merely a physical organ but has prominent emotional, cognitive and spiritual roles.

There are three different types of heart: healthy heart, dead heart and sick heart. The characteristics of the three types of heart are presented in Table 4.1. The healthy heart is free from all the temptations, desires and needs that are in contradiction with the command of Allah and His prohibitions. On the Day of Judgement, only those who come to Allah with a healthy heart will be saved (Qur'aan 26:88–9). The dead heart is the opposite of the healthy heart. It seeks immediate gratifications based on desires and temptations. It is devoid of the love of God, neither knowing His Lord nor worshipping Him. This type of heart has an aversion to God (39:45); such people have a seal on their hearts (2:7); or their hearts are hardened like stones (2:74). The sick heart, the third type, is a heart with both life and disease.

Ibn al-Qayyim al-Jawziyyah (2006) describes the three types of heart. The first one is devoid of faith and devoid of all good. The second type is the heart that is illuminated by faith and the third type is brimming with faith. From a psychological perspective, it is valuable to identify the signs of a diseased heart. According to Zarabozo (1999, pp. 472–3), the signs of a disease heart include:

- Lack of affect: not feeling hurt or pain when committing sins.
- Showing concern about less important matters while neglecting more important ones.

TABLE 4.1 Characteristics of healthy, dead and sick heart

Healthy heart	*Dead heart*	*Sick heart*
• A heart free from all the temptations, desires and needs that oppose command of Allah. • Secure from every doubt and uncertainty that contradicts what He reveals. • Secure from displaying servitude to any other than Allah. • Becomes sound by loving Allah. • Seeks and follows rulings of His Messenger (ﷺ). • Has fear, hope, trust and reliance, penitence and humility only for Allah. • Prefers what pleases Allah in every circumstance. • Distances itself from what displeases Allah. • Loves and hates for the sake of Allah. • Gives and withholds for the sake of Allah. • Will have positive personality characteristics.	• A heart that contains no life. • Seeks immediate gratifications based on desires and temptations. • Is immersed in its concern with worldly objectives. • Is devoid of the love of God, neither knowing His Lord nor worshipping Him. • Does not accept the truth nor submit. • Worships other than Allah. • Directs love, fear, hope, glorification and submits to other than Allah. • Knowledge: person's knowledge of the truth while he refuses it. • Has covering upon heart, seals for ears and blindness for eyes. • Allah places a seal on the heart – unable to perceive guidance.	• A heart with both life and disease. • Contains love of Allah and faith. • Also has a craving for lust and pleasure. • Is full of self-admiration, which can lead to its own destruction. • Wavers between two conditions. • One calling to Allah, His Messenger (ﷺ) and Hereafter. • Other calling to temporal worldly matters. • Responds to one that is most influential at the time. • When disease is predominant, it joins ranks of dead and harsh hearts. • If soundness is predominant, it joins ranks truthful and sound hearts.

Source: Adapted from 'Purification of the soul: The types of heart', compiled from the works of Ibn Rajab al-Hanbali, Ibn al-Qayyim al-Jawziyyah and Abu Hamid al-Ghazali, www.missionislam.com/health/types_of_hearts.htm; and from *Psychology of Personality* (PSY202), Faculty of Psychology, Islamic Online University.

- Disliking the truth and having difficulty accepting or submitting to it.
- Feeling discomfort among righteous believers, but contentment among misguided people, sinners or even evil doers.
- Not being affected by admonition.

There are many diseases of the heart, such as acts of disobedience, jealousy, envy, greed, lust, harmful speech and showing off. According to Farid (1993), the acts of disobedience that poison the heart and cause disease include unnecessary talking, unrestrained glances, too much food and keeping bad company. In essence, Muslims should aim to strive to purify their hearts and turn back to Allah with sound hearts. In Islam, there is a science called *at-Tassawuf*, to purify

our hearts, which is related to the purification of the soul (*Tazikiyyah al-Nafs*) or excellence in faith. The Prophet (ﷺ) said: 'These hearts become rusty just as iron does when water affects it.' On being asked what could clear them, he replied, 'A great amount of remembrance of death and recitation of the Qur'aan' (Bayhaqi, cited in The Khilafah, n.d.). The Prophet (ﷺ) used to say often: 'O changer of the hearts, make my heart firm upon your religion (*Deen*).' The companions said, 'O Messenger of Allah, we believed in you and what you have brought. Do you fear for us?' He answered, 'Yes, verily, the hearts are between Allah's fingers and he turns them any way he wills' (Tirmidhî, n.d.).

Nafs: the essence of personality

The *Nafs* (pl. *Anfus* or *Nufus*) lexically means soul, the psyche, the ego, self, life, person, heart or mind (Afifi al-'Akiti, 1997). In Islamic terminology, the *Nafs* is the essence of an individual and the sum of desires, wishes, experiences, tendencies and temperament. It has been suggested that the majority of Muslim scholars maintains that the terms *Nafs* and *Ruh* (spirit, soul or breath of life) are interchangeable. According to Utz (2011, p. 66), the main distinction is that the *Nafs* refers to the soul when inside the body, whereas *Ruh* is used for when the soul is separated or apart from the body. The *Nafs* is perceived as a human's personality, which distinguishes one person from another. The *Nafs*, according to Karzoom (2012) is:

> something internal in the entity of a human whose exact nature is not perceived. It is ready to accept direction towards good or evil. It combines together a number of human attributes and characteristics that have a clear effect on human behaviour.
>
> *(Cited in Zarabozo, 2011, p. 30)*

Some scholars have classified the *Nafs* up to seven stages of development. However, there is a consensus among the scholars that, in the Qur'aan, God has described at least three main types of the *Nafs*: *Nafs al-Ammara Bissu'* (the *Nafs* that urges evil), *Nafs al-Lawwammah* (the *Nafs* that blames) and *Nafs al-Mutma'innah* (the *Nafs* at peace) (al-Tabari, 1406/1906). They are stages in the process of development, refinement and mastery of the *Nafs* (Deuraseh and Abu Talib, 2005). A summary of these states of the *Nafs* is given by al-Tabari (1406/1906).

Nafs al-Ammara Bissu' *(the* Nafs *that urges evil)*

This is the *Nafs* that urges us to commit evil as stated in the following Qur'aanic verse (interpretation of the meaning):

> *Indeed, the soul is a persistent enjoiner of evil.*
>
> *(Yūsuf (Joseph) 12:53)*

The *Nafs* is dominated by earthly desires (*Shahwat*) and passions. This is the impulsive behaviour of humankind being subjected to the demands of their desires and

compulsions for which there is no limit. This *Nafs* is equivalent to the Id from the psychodynamic approach (Freudian) to personality development. This is the *Nafs* that brings punishment itself and, by its very nature, it directs its own towards every wrong action (al-Tabari, 1406/1906). The Qur'aan enjoins the faithful '*to hinder the Nafs from lower desires*' (79:40).

Nafs al-Lawwammah *(the* Nafs *that blames)*

This word is derived from '*Lom*' which means to 'reproach'. This is the stage of the awakening of the conscience or morality when a sin or evil is committed. In the Qur'aan, Allah mentions 'the *Nafs* that blames' (interpretation of the meaning):

> *And I swear by the reproaching soul.*
>
> *(Al-Qiyāmah (The Resurrection) 75:2)*

Hasan al-Basri said, 'You always see the believer blaming himself and saying things like "Did I want this? Why did I do that? Was this better than that?"' (cited in Afifi al-'Akiti, 1997). The Freudian concept of the superego can be related to the *Nafs al-Lawwammah*.

Nafs al-Mutma'innah *(the* Nafs *at peace)*

This is the stage at which the *Nafs* reaches reassurance and is at peace. It is certainty of 'its evolutionary cycle and its meeting with the Lord. It can commit a fault or sin, but it is so ahead that it is certain it will never backslide' (www.ezsoftech.com, n.d.). Allah says in the Qur'aan (interpretation of the meaning):

> *[To the righteous it will be said], 'O reassured soul. Return to your Lord, well-pleased and pleasing [to Him]. And enter among My [righteous] servants.'*
>
> *(Al-Fajr (The Dawn) 89:27–30)*

This is the stage that is the goal of this life and the *Nafs* is at peace as to the certitude of Allah. The *Nafs* that has achieved perfection is one that has rid itself of all negative attributes and has acquired all the positive ones (Kasule, 2001). Various scholars have commented on the state of the *Nafs al-Mutma'innah*. Ibn Abbas said, 'It is the tranquil and believing soul' (cited in Afifi al-'Akiti, 1997). Al-Qatadah said:

> It is the soul of the believer, made calm by what Allah has promised. Its owner is at rest and content with his knowledge of Allah's Names and Attributes, and with what He has said about Himself and His Messenger, and with what He has said about what awaits the soul after death: about the departure of the soul, the life in the Barzakh (Barrier between the physical and spiritual worlds, in which the soul awaits after death and before resurrection the Day of Judgement), and the events of the Day of Judgement (*Qiyamah*) which will follow. So much so

> that a believer such as this can almost see them with his own eyes. So he submits to the will of Allah and surrenders to Him contentedly, never dissatisfied or complaining, and with his faith never wavering. He does not rejoice at his gains, nor do his afflictions make him despair, for he knows that they were decreed long before they happened to him, even before he was created.
>
> *(Cited in Afifi al-'Akiti, 1997)*

According to Imam Baghawi:

> The *Nafs al-Mutma'innah* has an angel to help it, who assists and guides it. The angel casts good into the *Nafs* so that it desires what is good and is aware of the excellence of good actions. The angel also keeps the self away from wrong action and shows it the ugliness of bad deeds. All in all, whatever is for Allah and by Him, always comes from the Soul which is at Peace.
>
> *(Cited in Afifi al-'Akiti, 1997)*

Nafs and the psychodynamic approach

The *Nafs al-Ammara Bissu'*, *Nafs al-Lawwammah* and *Nafs al-Mutma'innah* have limited equivalence with Freud's psychoanalytic theory of personality: the id, the ego and the superego. The *Nafs al-Ammara Bissu'* can be expressed as the id. This stage of the *Nafs*, driven by the pleasure principle, strives for immediate gratification. In addition, it does not consider right or wrong and only takes into account the satisfaction of desires and wants. *Nafs al-Lawwammah* is the second stage of the *Nafs* and has some equivalence with the Freudian concepts of ego and superego. The ego operates on the reality principle, which strives to satisfy the id's desires in realistic and socially acceptable ways. This is when the individual assesses the costs and benefits of an action (good or bad deeds) before deciding to act upon or abandon it. Here the *Nafs al-Lawwammah* will allow the behaviour or action, demanded by the *Nafs al-Ammara Bissu'*, but only in the appropriate context and time. According to Naaz (2013), *Nafs al-Lawwammah* is the stage of conflict and the stage of decisions in which good actions win a majority of the time. In this stage, the *Nafs* is also referred to as the soul that blames, as is mentioned in the Qur'aan (75:2). Hawwa (cited in Afifi al-'Akiti, 1997) stated that, if the *Nafs* does not attain peace with itself, rather being exposed to desires, this soul reproaches its owner due to the owner's carelessness in fulfilling God's wishes.

According to Naaz (2013), *Nafs al-Mutma'innah* is the highest and purest stage of *Nafs*, which perhaps Freud never dealt with. According to Freud, the key to a healthy personality is a balance between the id, the ego and the superego. In this stage the *Nafs* is tranquil and there is no conflict of interest in performing righteous deeds or actions. The focus here is not on material life, but towards a better Hereafter. Ibn al-Qayyim al-Jawziyyah discussed the states of *Nafs*:

> The *Nafs* is a single entity, although its state may change: from the *Nafs al-Ammara Bissu'*, to the *Nafs al-Lawwammah*, to the *Nafs al-Mutma'innah*, which is the final aim of perfection . . . It has been said that the *Nafs al-Lawwammah*

> is the one, which cannot rest in any one state. It often changes, remembers and forgets, submits and evades, loves and hates, rejoices and become sad, accepts and rejects, obeys and rebels. *Nafs al-Lawwammah* is also the *Nafs* of the believer . . . It has also been mentioned that the *Nafs* blames itself on the Day of Judgement, for every one blames himself for his actions, either his bad deeds, if he was one who had many wrong actions, or for his shortcomings, if he was one who did good deeds. All of this is accurate.
>
> *(Cited in Afifi al-'Akiti, 1997)*

Personality: development of character from an Islamic perspective

The ideal Muslim character embodies a particular way of thinking, feeling and behaving based on the teachings of the Qur'aan and the 'Sunnah' (sayings, actions and the approvals of the Prophet Muhammad (ﷺ) in all aspects of his lifestyle and behaviour). The Prophet Muhammad (ﷺ) epitomised virtuous and righteous character traits and is a living example for all humans to follow as a role model for personality development. Islamic personality, according to Siddiqi (2012) is not rigid, parochial, racial or nationalistic but is universal, wholesome, dynamic and balanced. According to al-Banna:

> A Muslim should strive to attain a strong body, good character, cultured thought. He should be able to earn a living, have pure belief, and correct worship. He should be able to control his desires, be careful about his time, organized in his affairs, and beneficial to those around him. These comprise the duties of every Muslim as an individual.
>
> *(Cited in Diwan, 2012)*

In other words, physical, intellectual, social and spiritual aspects are important in the development of the ideal Muslim personality.

The Prophet Muhammad (ﷺ) used to emphasise Muslim personality with examples and parables: 'By Him in whose hand is Muhammad's soul, the example of a believer is like that of a piece of gold. The goldsmith puts it under the heat, but it does not change and does not lose itself' (Jami' al-Masanid Suyuti, 24576, cited in Siddiqi, 2012). That is, 'A true believer is like gold, pure, precious and good. If he/she goes through trials and difficulties, they make him even better. He comes out stronger and shines more' (Siddiqi, 2012). It is stated that the Prophet Muhammad (ﷺ) once summarised his code to be:

> mindfulness of God privately and publicly, fairness in anger or satisfaction, moderation in poverty or wealth, connecting with those who avoided him, giving to those who deprived him, forgiving those who wronged him, speaking out for what is good, and making his silence a meditation, his speech a recital of the name of God, and what he saw a lesson.
>
> *(www.muslimsofcalgary.ca, n.d.)*

The ideal personality characteristics that believers strive to develop reflect the basic values of Islam: faith, kindness, mercy, humility, truthfulness, honesty, sincerity, chastity, generosity, courage, sacrifice, patience and justice. According to al-Hahimi (1997), ideal Muslims are of the highest moral character in their relation with their Lord, themselves, family, parents, relatives, friends and the community at large. They strive to improve their characters daily by the teachings of Islam. For more comprehensive, authentic sayings of the Prophet Muhammad (ﷺ) for guidance on the cultivation of souls, purification of hearts and refinement of character, see *40 Hadith on the Islamic Personality* (www.islambasics.com [b], n.d.). Allah says in the Qur'aan (interpretation of the meaning):

> *O mankind!*
> *There has come to you an instruction from your Lord,*
> *a cure for whatever (disease) is in your hearts,*
> *a guidance and a blessing for the true believers.*
> *(Yūnus (Jonah) 10:57)*

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5

PSYCHOLOGICAL HEALTH

Cultural and religious influences

Introduction

Traditionally, psychologists and mental health professionals have underemphasised religious issues in their work. In Western societies, religion has often been seen by mental health professionals as irrational, outdated and dependency forming, and has been believed to result in emotional instability (Crossley, 1995; Dein, 2010). Religion, in the context of mental health, has been perceived as being a 'universal obsessional neurosis' (Freud, 1907, p. 25) and as 'psychiatry's last taboo' (Kung, 1986). It was only in the past two decades that 'religious or spiritual problems' was introduced into the *Diagnostic and Statistical Manual of Mental Disorders, 4th Edition* (*DSM-IV*) as a new diagnostic category that invites professionals to respect patients' beliefs and rituals. Recently, there has been a growth in systematic research into religion, spirituality and mental health. A large volume of research shows, on balance, that religious involvement is generally conducive to better mental health, and people who are more religious/spiritual have better mental health and adapt more quickly to health problems compared to those who are less religious/ spiritual (Klocker *et al.*, 2011; Koenig, 2012). In addition, the findings show that the strongest association is the link between religious belief and decreased depression, as well as reduced anxiety and suicide risk and, to a lesser extent, reduced psychotic disorders (Klocker *et al.*, 2011).

Counsellors should be aware of religious and personal cultural beliefs and consider how these factors influence their interactions with clients from differing ethno-cultural groups. The lack of understanding of the interplay between religious influences and health or sickness behaviours can have a significant effect on the counselling process. Cultural and religious differences that may have an impact include: the client's expectations of the counsellor; the expression of symptoms; family roles and relationships; gender roles; and attitudes to sex and marriage. In addition, counsellors

have a lack of awareness of cultural issues, may be biased, or may be unable to speak the client's language. Misunderstandings can develop easily and can lead to ethical dilemmas, practice problems and problems in communication, and their effects on the individual are often misunderstood and negatively construed.

Muslim religious beliefs have an impact on the mental health of individuals, families and communities, and are considered a central component of identity (Nassar-McMillan and Hakim-Larson, 2003). The Muslim community is experiencing social exclusion (social exclusion correlates with mental health problems) related to their cultural and religious identity. Often, Muslim individuals are stigmatised and families are rejected and isolated for their association with mental health problems, addiction and suicide (Pridmore and Pasha, 2004). There are indicators that Muslims experience mental ill health, but that they either remain unidentified by mainstream mental health services or present late to the services (Ali *et al.*, 2005).

Muslims and mental health problems

Muslims in the United States and in European countries form a minority group that faces increasing religious, cultural and ethnic discrimination. There are no large-scale epidemiological reports on the prevalence and incidence rates of mental health problems among Muslims in the 57 Islamic states who are members of the Organization of the Islamic Conference. In fact, there is no satisfactory single description of mental health services possible and limited English language information is available (Pridmore and Pasha, 2004). The rate of schizophrenia in Muslims is similar to that of non-Muslims (al-Issa, 2000), but there are high rates of post-traumatic stress disorder (PTSD) (Abu-Ras and Abu-Bader, 2008), depression (Sheridan, 2006) and stress (Barkdull *et al.*, 2011). Prevalence studies showed that women had a higher rate of depression than men (Douki *et al.*, 2007; Ghubash *et al.*, 2001; Mirza and Jenkins, 2004). Suicide is strictly forbidden in Islam and international studies in Pakistan, Malaysia and Saudi Arabia showed low suicide rates (al-Khathami, 2001; Murty *et al.*, 2008, Zakiullah *et al.*, 2008). However, ideation and attempts are relatively high, particularly in young women experiencing intergenerational conflict (Ali *et al.*, 2009). However, the epidemiological data reported from most predominantly Muslim countries suffer from lack of adequate reporting facilities and methodology (al-Issa, 2000). This is more so in the case of suicide, as this may not be reported due to fear of stigmatisation. In summary, the common mental health problems reported by respondents in England included: anxiety and depression, ADHD (attention deficit hyperactivity disorder) and other apparent conduct disorders, substance misuse, alcoholism and gambling, issues regarding identity, relationships and psychosexual problems, domestic violence (both perpetration of and experience of) and religious delusional behaviour (Maynard, 2008). In the United States, the reported problems are related to feelings of anxiety and fear of hate crimes, stigmatisation and high rates of PTSD post-9/11 (Abu-Ras and Abu-Bader, 2008).

Culture-bound syndromes are amalgamations of psychiatric and somatic (bodily) symptoms identified only within a specific society or culture. In theory, culture-bound syndromes are those folk illnesses in which alterations of behaviour and experience figure prominently. In actuality, however, many are not syndromes at all. Instead, they are local ways of explaining any of a wide assortment of misfortunes (Simons, 2001). The concept of the culture-bound syndrome was included in the *DSM-IV* (APA, 2000), and *DSM-V* updates criteria to reflect cross-cultural variations in presentation, gives more detailed and structured information about cultural concepts of distress, and includes a clinical interview tool to facilitate comprehensive, person-centred assessments (APA, 2013). Some of the common culture-bound syndromes include: the evil eye and Zār or Zaars (Middle-Eastern and African societies); Dhat syndrome and possession syndrome (Indian subcontinent); and amok, koro and lattah (Malaysia, Philippines). Possession is regarded by some commentators as a culture-bound syndrome, but others argue that, although the manifestations may differ according to culture, the underlying theme is always the same (Pereira *et al.*, 1995).

Stigma of mental health in the Muslim community

The stigma of mental health problems continues to be a major barrier for individuals and families in seeking help. The literature distinguishes two types of stigma: label avoidance and public stigma. Label avoidance refers to instances in which individuals choose to not seek help for mental health problems in order to avoid negative labels (Ben-Zeev *et al.*, 2010; Corrigan *et al.*, 2011). Public stigma is the prejudice and discrimination that occurs when members of the community endorse stereotypes about mental health problems. In order to avoid psychiatric labels, individuals may choose to not associate themselves with mental health clinics or professionals – avoiding diagnosis by avoiding mental healthcare (Ciftci *et al.*, 2012).

However, cultural differences also have significant implications with respect to stigmatisation. Families may also keep a member's mental health problems a secret in order to save face, preserve family honour and avoid shame, prejudice and discrimination (Aloud and Rathur, 2009; Amer, 2006; Ciftci, 1999; Marrow and Luhrmann, 2012). There is evidence to suggest that Muslims in Oman hold common stereotypes about people with mental health problems and affirm that psychiatric facilities should be segregated from the community (al-Adawi *et al.*, 2002). Muslim women may avoid sharing personal distress and seeking help from counsellors due to fear of negative consequences with respect to marital prospects or their current marriages (Ciftci *et al.*, 2012). In a study of Pakistani families in the UK, none of the participants reported that they would consider marriage with a person with mental health problems, only half expressed a willingness to socialise with such a person, and less than a quarter reported they would consider a close relationship (Tabassum *et al.*, 2000). Stigmatisation was found to be the most significant barrier to accessing mental health services due to the shame of disclosing personal and family issues to outsiders (Aloud and Rathur, 2009; Youssef and

Deane, 2006). This kind of public shame and label avoidance is perhaps the most significant way in which stigmatisation impedes care seeking.

Muslims' understanding of mental health problems

The Islamic perspective of mental health is also dramatically different from the Judaeo-Christian nosology of mental health. Muslims have a broad range of beliefs about the cause of mental health problems. They primarily attribute mental health problems to different phenomena, including the evil eye (*Hasad*), possession by supernatural entities such as demons (*Jinn*) and magic (*Sihr*). Mental health problems are part of human suffering and often regarded as a way of atoning for sins or as trials and tests from Allah (Abu-Ras *et al.*, 2008; Rassool, 2000). Believing illness is a punishment from God for some wrongdoing influences some Muslims to take a passive attitude towards dealing with afflictions (Ali *et al.*, 2009). For this reason, many Muslims do not seek help, as they believe illness can and will purify the body (Rassool, 2000). The reward may be greater if suffering is endured with patience and prayer. However, Muslims believe an illness is not something viewed in the negative sense, but rather as a positive event that purifies the body. So, when any disease befalls a Muslim, it can be expiation for his or her sins (Rassool, 2000). There is a narration from the Prophet Muhammad (ﷺ) stating that: 'No affliction befalls a Muslim, but Allah forgives his wrong actions because of it, even if it to be no more than a thorn' (Bukhârî, n.d.).

Traditionally, it is important to note that supernatural causes of illnesses are widely acknowledged and are considered very real within Islam, but not all mental health problems are associated with supernatural causes. One of the early Muslim scholars in psychiatric healthcare, Ibn Sina, rejected the popular notion that mental health problems originated from evil spirits (Pridmore and Pasha, 2004). Islamic teachings also explain mental health problems as a result of God's will. In Islamic culture, belief in *Qadar* (predestination) or destiny is strong. The strong belief in *Qadar* (one of the six pillars of *Iman* (belief, faith)) also suggests positive acceptance of Allah's will and higher levels of optimism with respect to healing (Nabolsi and Carson, 2011). In a study about perceptions of mental illness, Abu-Ras and Abu-Bader (2008), 98 per cent of survey respondents agreed that life stressors are a test of one's faith. Eighty four percent (84 per cent) of respondents believed in devil possession of mentally ill persons such as *Jinn* possessing individuals, hallucinations, delusional beliefs and disorganised behaviour. Other purported supernatural causes such as black magic, the evil eye and envy (intentional or not) can invoke negative consequences, and charms, markings, jewellery, prayers or rituals are used to distract jealousy and envy.

There is also the perception among Muslims that mental health problems stem from straying away from God and Islamic principles. According to el Azayem and Hedayat-Diba (1994), mental health is perceived not as the absence of psychological abnormalities, but as the successful blending of the issues of everyday life with the requirements of Islam. Research has identified that religion and religious belief

are absolutely central to the way Muslims interpret the cause and development of their mental health problems (Nada, 2007). Thus, mental illness stems from doubt or uncertainty about the basic teachings of Islam, as well as being a direct result of acting in a manner that is in direct opposition to the teachings of Islam (Farooqi, 2006). This is consistent with the findings that there is a tendency to believe that depression is caused by spiritual weakness and an inability to believe in God (al-Mateen and Afzal, 2004), or a failure to live in harmony with the universality of God (Ali *et al.*, 2004).

Muslim clerics also endorsed the religious causes for mental illness, such as spiritual poverty, as being more important than did Christian clerics (Youssef and Deane, 2013). Smither and Khorsandi (2009) suggest that psychological distress in some ways resembles the loss of contact with the collective unconscious that causes mental illness in analytical psychology (Jung, 1933), or in terms of psychosocial theory (Erikson, 1968). The crisis comes from feeling estranged from the culture with which a person identifies. Thus, mental health problems may be seen as an opportunity to remedy disconnection from Allah or a lack of faith through regular prayer and a sense of self-responsibility (Padela *et al.*, 2012; Youssef and Deane, 2006).

Good mental health comes from 'the unblemished belief in Allah 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, pp. 449–50). Haque (2004) indicated that the Qur'aan explicitly states that certain virtues will preserve good mental health. These virtues include: acts of worship, enjoining what is good, avoiding what is forbidden, doing good to others and following Islamic rules of attire, eating, cleanliness, relationships, good intentions and a desire to seek knowledge of self and knowledge of God. In fact, adhering to the principles and practice of the Islamic faith would result in better psychological adjustment and mental health. In fact, studying the Qur'aan and performing the five daily prayers can be seen as a medium for meditation, a prophylactic against stress and a way of promoting psychological and spiritual maturity (el Azayem and Hedayat-Diba, 1994; el-Islam, 2004). It is important to note that Qur'aanic verses summarised Islam's attitudes towards those with mental health problems, who were considered unfit to manage property but must be treated humanely and be kept under care by a guardian, according to Islamic law.

Possession of the soul and the evil eye

In the Noble Qur'aan, Allah informs us that certain types of physical and psychological problems are caused by the influence of the *Jinn*, the spiritual creatures who live in the unseen world (*al-ghayb*). As *Jinn* are mentioned several times in the Qur'aan and in the Sunnah, it becomes obligatory upon Muslims to believe in their existence. The word '*al-Jinn*' (plural: *al-Jaan*) in Arabic refers to something that is covered or concealed. Hence, the word '*Jinn*' itself implies the existence of

something that cannot be seen. However, according to the Qur'aan the origin of the *Jinn* is different from that of man (interpretation of the meaning):

> *And indeed, We created man from sounding clay of altered black smooth mud. And the Jinn, We created aforetime from the smokeless flame of fire.*
>
> *(Al-Hijr (Al-Hijr) 15:26–7)*

According to Islamic writings, *Jinn* live alongside other creatures, but form a world other than that of mankind. In Islam, the *Jinn* share a very distinctive characteristic with human beings: free will. The Qur'aan says (interpretation of the meaning):

> *We (Allah) have not created the Jinn or humans, but to worship Us.*
>
> *(Adh-Dhāriyāt (The Winnowing Winds) 51:56)*

In addition, they are accountable for their actions in the same way as humans, as they have the freedom to choose between right and wrong and between good and bad. Among the *Jinn*, there are those who are obedient to God and others who are not, entirely analogous to humans (Qur'aan 72:14–15). Like human beings, the *Jinn* must nourish their bodies with food and have the capacity to breed (Qur'aan 18:50). Nonetheless, the belief in *Jinn* possessing some divine qualities (for example, all-knowing, all-seeing) is categorically in opposition to the Islamic creed (*Aqeedah*) (Philips, 2002). Moreover, scholars agree that supplications to *Jinn* (for example, in the form of prayers, or carrying amulets), or to anything or anybody else but Allah, for that matter, are considered 'shirk' (the worship of anything but Allah), the greatest sin in Islam if done intentionally (Younis, 2013). In Islamic writings true *Jinn* possession can cause a person to have seizures and to speak in an incomprehensible language (al-Ashqar, 2003). Those with *Jinn* possession appear to suffer from intense fear, psychological disorders (for example, depression, anxiety), physical sickness, hallucinations, creating animosity between individuals (couples, friends, etc.), sexual problems and causing damage to material possessions (with fire, for example) (Ameen, 2005). These behaviours may be interpreted as symptoms of various mental disorders.

The concepts of 'evil eye' and 'spirit possession' are reported in so many cultures that they may be regarded as universal phenomena (Spooner, 2004). Spirit possession refers to the belief that a spirit can enter a living person, possess that person and control what he or she says and does. The evil eye represents a fear of evil influence through other people. It is defined as 'a set of beliefs that the envy elicited by the good luck of fortunate people may result in their misfortune' (*Webster's Online Dictionary*). In most cultures, the primary victims are thought to be babies and young children, because they are so often praised and commented upon by strangers or by childless women. Belief in the evil eye started in antiquity. Nowadays, this phenomenon is strongest in the Middle East, East and West Africa, South Asia, Central Asia and Europe, especially the Mediterranean region. The Asian term for evil eye is '*Nazar*'. 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 envier when he envies.*
>
> *(Al-Falaq (Daybreak) 113:5)*

The Messenger of Allah (ﷺ) stated that:

> The influence of an evil eye is a fact: if anything would precede the destiny it would be the influence of an evil eye, and when you are asked to take a bath (as a cure) from the influence of an evil eye, you should take a bath.
>
> *(Muslim, cited in SahihMuslim.com, n.d.)*

Magic and sorcery, resulting from the contact with the *Jinn*, are recognised as real in Islam. Renowned Islamic scholar of the twentieth century, Sheikh Ibn Baz, said:

> *Sihr* (sorcery) is a word referring to something hidden. It is real and there are kinds of witchcraft that may affect people psychologically and physically, so that they become sick and die, or husbands and wives are separated. It is a devilish action, most of which is only achieved by means of associating others with God and drawing close to the minions of Satan.
>
> *(Cited in Stacey, 2012)*

The Prophet Muhammad (ﷺ) counselled to avoid one of the seven destructive sins: the practice of sorcery (Bukhârî and Muslim, cited in www.islamreligion.com, n.d.). Traditionally, one of the most popular forms of sorcery was to tie knots in a rope and then recite incantations over the knots, thus bewitching or harming another person. This is mentioned in the second to last chapter of the Qur'aan, where we are encouraged to seek refuge from this evil. Allah says (interpretation of the meaning):

> *And from the evil of those who practise witchcraft when they blow on knots.*
>
> *(Al-Falaq (Daybreak) 113:4)*

The explanation of 'And from the evil of the blowers in knots' refers to the witches when they perform their spells and blow into the knots (Ibn Kathir, n.d.). Al-Qayyim said: 'The witchcraft which can cause sickness, lethargy, mental sickness, love, hatred and delusions is something that does exist and is known by the masses. Many people know it from experience' (cited in islamqa, n.d.).

The belief in 'spirit possession' or the 'evil eye' is common within Muslim and Asian communities, particularly when considering the Western diagnosis of depression and psychological illness. These two concepts of 'soul possession' and 'witchcraft' should be considered when understanding the influence of culture on health, as many ethnic minorities from the Indian subcontinent, Africa and the Middle East, living in the UK and elsewhere, strongly believe that this affects their health. In their study of beliefs about *Jinn*, black magic and the evil eye among Muslims in the UK, Khalifa *et al.* (2011) found that almost 80 per cent of the

participants believed in *Jinn* and almost half of them believed that *Jinn* could cause physical and mental health problems in humans. This finding in a Muslim UK population has been endorsed by Dein *et al.* (2008) in their study of notions of *Jinn* and misfortune among the Bangladeshi community in East London. With regard to gender, there is evidence to suggest that females are more likely than males to believe in the existence of *Jinn* (Khalifa *et al.*, 2011, 2012).

Differential diagnosis: *Jinn* or mental health problems?

Spirit possession is not recognised as a psychiatric or medical diagnosis by the *DSM-V* (APA, 2013) or the *International Classification of Diseases* (*ICD-10*) (WHO, 2015), but possession disorders, dissociative disorders and culture-bound syndromes are included in *DSM-V*. In *ICD-10*, trance or possession disorders are classified under dissociative (conversion) disorders, disorders in which there is a temporary loss of the sense of personal identity and full awareness of the surroundings. Possession or trance has to be involuntary and to occur outside religious or culturally accepted situations. This classification excludes states associated with psychotic disorders, affective disorders, organic personality disorder, post-concussion syndrome and psychoactive substance intoxication. 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 and fear of developing disease (al-Habeeb, 2003).

Cultural beliefs in possession and the impact of sorcery or the evil eye affect interpretation of mental symptoms. Muslims (especially those from more traditional cultures) can be quick to attribute mental illness to *Jinn* possession as there are fewer stigmas associated with *Jinn* possession than with mental health problems. In many cases, the symptoms are related to mental health problems and are not the result of *Jinn*. It is reported that clients who attribute symptoms of mental health problems to possession by *Jinn* have low educational attainment (Dein *et al.*, 2008; Mullick *et al.*, 2012), are from low socio-economic backgrounds, or have underlying physical or mental health problems (Bayer and Shunaigat, 2002).

In clinical reality, both mental health problems and *Jinn* possession have slightly different symptoms and widely differing causes. However, in some cases, it is valuable to note that the symptoms of *Jinn* possession overlap quite a bit with symptoms of mental health problems and can, therefore, be seen as one and the same thing in certain instances. It is common for people to confuse dissociative disorders, schizophrenia and *Jinn* possession. According to Hussain (2013), the difference in classification is the result of the subtle differences between symptoms, the causes and the relationship to 'supernatural activity'. For example, dissociative disorder is confused with schizophrenia, because of its delusional aspects, which are interpreted as dissociation; and schizophrenia can be confused with *Jinn* possession, mainly due to occasional references, although there is no evidence for 'supernatural' activity in the experiences of patients with schizophrenia. The difference here is clear since,

in the case of *Jinn* possession, there is often clear physical evidence, unlike schizophrenia (Hussain, 2013).

Delusions, hallucinations, obsessions, compulsions, anxiety, fear, anger outbursts, multiple personalities, dissociation, prolonged malaise, erratic behaviour, hysterical behaviour, changing emotions, confusion and memory problems may be the symptoms of both mental health problems and *Jinn* possession. However, symptoms common to *Jinn* possession are turning away from Islam (such as not praying, feeling unease at the sound of Qur'aan recitation), thinking badly about Allah or Islam, extremely distressing sleep problems such as very bad nightmares, or physical changes with no medical cause (such as problems moving or inexplicable bruises or marks appearing (Muslim Mind, 2013).

Conclusion

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 and health or sickness behaviours can have a significant effect upon delivery of counselling practice. Misunderstanding the worldviews of patients can lead to ethical dilemmas, practice problems and difficulties in communication. Often, Muslim individuals are stigmatised 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 remain unidentified by mainstream mental health services or present late to the services.

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6

UNDERSTANDING THE MUSLIM CLIENT

Introduction

Given the diversity and heterogeneity of Muslim clients, it is becoming increasingly important to have a basic understanding of the common religious and cultural practices of Muslims. Despite the core commonalities in terms of religious beliefs and practices, there are variations in the degree to which one identifies with being Muslim in faith, function or culture (Ali *et al.*, 2009). This may have an impact on the counselling process. Counsellors should be aware not to develop stereotypical assumptions about beliefs and practices, but be familiar with the health beliefs and health-seeking behaviours of Muslims. There are a number of Islamic religious beliefs that will affect the attitudes and behaviours of Muslim clients seeking psychological help. It is important that counsellors have some understanding of these attitudes and beliefs so that more culturally appropriate or congruent interventions may be provided. In this chapter, the focus will be on understanding Muslim clients in relation to their beliefs, value systems and help-seeking behaviours.

Understanding the health beliefs of the Muslim client

It is increasingly clear that specific attributions or causal explanations of health and illness can be fully understood only by taking into account the wider beliefs and value system of the individual. People from different cultures often make very different attributions, make attributions in different ways or approach the entire task of social explanations in different ways (Triandis, 1976). All cultures have systems of health beliefs to explain what causes illness (aetiology), how it can be cured or treated (treatment) and who should be involved in the process (healthcare providers). Health beliefs can be influenced by cultural beliefs and identity, psychosocial factors, mass media and our level of knowledge. The beliefs that influence health behaviours in most people are often carried in their lay beliefs or culture's folk tales.

In addition, health beliefs have significant influence on client roles and expectations, gender and family roles, the desired information about the condition and any intervention strategies, and the processes for decision making.

Muslims' health beliefs include religious and cultural beliefs to explain what causes illness, how it can be cured or treated (medical or religious therapies), and who should be involved in the process. Health beliefs are especially important in the area of mental health and counselling, in which there is often an aversion to seeking help, especially outside the lay system and the family. A client whose health belief is that his psychological or marital problem is due to sins or *Jinn* possession will believe that recovery will only be obtained when atonement for his sins is made or the *Jinn* possession is removed. In addition, clients' health beliefs may affect their healthcare decisions and their ability to follow treatment recommendations. From a religious perspective, Muslims understand recovery from any condition or deterioration as being only in the hands of their God, because God meant it to be that way. The Prophet (ﷺ) said that: 'No fatigue, nor disease, nor sorrow, nor sadness, nor hurt, nor distress befalls a Muslim, even if it were the prick he receives from a thorn, but that Allah expiates some of his sins for that' (Bukhârî [a], n.d.). For this reason many Muslims discard 'depression' as an illness, as it is seen to be related to a lack of faith (Fonte and Horton-Deutsch, 2005).

Tests and suffering

Part of the journey of Muslims and non-Muslims is the tests and suffering that may be endured throughout life. For a believer, suffering from sickness is not just a reality, but also a philosophy that comes with blessings. Trials and tribulations are a system of tests that determine our spiritual perfection or lack of it or show gratitude to our Lord. Allah said in the Qur'aan (interpretation of the meaning):

> *And We will surely test you with something of fear and hunger and a loss of wealth and lives and fruits, but give good tidings to the patient.*
>
> *(Al-Baqarah (The Cow) 2:155)*

> *Indeed, We created man from a sperm-drop mixture that We may try him; and We made him hearing and seeing. Indeed, We guided him to the way, be he grateful or be he ungrateful.*
>
> *(Al-'Insān (The Man) 76:2–3)*

The Prophet (ﷺ) said: 'If Allah wants to do good to somebody, He afflicts him with trials' (Bukhârî [b], n.d.). True beliefs are tested by sufferings, patience and steadfastness. But suffering also reveals the hidden self to God. It is stated that 'suffering is built into the fabric of existence, so that God may see who is truly righteous and God uses suffering to look within humans and test their characters, and correct the unbelievers' (Davies-Stofka, n.d.). Furthermore, the trials of life

are a means to test an individual's gratitude to God, to show patience in the face of adversity and worship God in times of both ease and difficulty. When Muslims encounter suffering, they often question their degree of commitment to the faith or feel that they have broken God's law, leading to a period of testing, punishment and suffering. However, the purpose of testing and suffering is not necessarily for revenge, punishment or humiliation. Allah has said in the Qur'aan (interpretation of the meaning):

> *But when He tries him and restricts his provision, he says, 'My Lord has humiliated me.'*
> *(Al-Fajr (The Dawn) 89:16)*

Trials and tribulations are part of the test that humans undergo within the context of God's justice, power and mercy. According to Sheikh Abdullah Hasan (2013), calamities and misfortunes are often tests from Allah when people deny the proof of Allah after it has been made clear to them. In addition, trials and tribulations unveil the true nature of people by sieving out the good from the bad, the righteous from the wicked and the believer from the hypocrite (Hasan, 2013). It is a Muslim's belief that sufferings, including pain, hunger and tragic accidents, are due to one's sins, for Allah wants this suffering to erase these sins (al-Munajjid, n.d.). Allah may decide to punish a person for sin in this world rather than in the Hereafter (Qur'aan 68:33) or expiates the sins of people through inflicting them with some misfortune or calamity. The Messenger of Allah (ﷺ) said: 'Trials will continue to befall the believing man or woman in himself, his child and his wealth until he meets Allah with no sin on him' (Tirmidhî, n.d.).

In another statement, the Messenger of Allah (ﷺ) stated that 'When Allah desires for His servant some good, He hastens his punishment in this life, and when Allah intends some depraved for His servant, He will postpone His punishment until he will be recompensed on the day of judgment' (Abdul Malik Muwatta, cited in al-'Uthaymin, n.d.). According to Sheikh Muhammad al-'Uthaymin:

> Allah wants good for His servant. He hastens for him punishment in the worldly life, either in his wealth or family or in his self or someone whom he has ties with; the crucial point is the punishment is hastened for him, because punishments expiate bad deeds.

He added:

> So if punishment is hastened and Allah expiates by way of that the servant's bad deeds, then certainly he will meet Allah free of any sin, for indeed the calamities and tribulations (he endured) purified him. It may even be the case that an individual's death would be difficult (for him) due to a remaining sin or two in order for the servant to leave this world (*dunyah*) pure from sin. (And) This is a blessing due to the fact that punishment in the *dunyah* is lighter than the punishment in the Hereafter.

There are many Hadiths showing that Allah expiates sins of people through inflicting them with some misfortune or calamity. They include the statements of the Prophet (ﷺ), who stated that: 'No calamity befalls a Muslim but that Allah expiates some of his sins because of it, even though it was the prick he receives from a thorn' (Bukhârî [c], n.d.). Trials and tribulations also elevate the rank or raise the status of the afflicted believer because of his or her patience and forbearance, faith and trust in Allah, and humility. Trials and tribulations also provide an opportunity for individuals to have self-awareness about their faults and shortcomings and past mistakes and make repentance. Allah says in the Qur'aan (interpretation of the meaning):

> *What comes to you of good is from Allah, but what comes to you of evil, [O man], is from yourself. And We have sent you, [O Muhammad (ﷺ)], to the people as a messenger, and sufficient is Allah as Witness.*
>
> *(An-Nisā' (The Women) 4:79)*

Tribulations are also important signs that there are some shortcomings or negligence in the individual. It has been suggested that, if the individual takes heed, he or she will be successful but otherwise will deserve the punishment (Khan, n.d). The evidence for this is found in the Qur'aan. Allah says (interpretation of the meaning):

> *And We have already sent [messengers] to nations before you, [O Muhammad]; then We seized them with poverty and hardship that perhaps they might humble themselves [to Us]. Then why, when Our punishment came to them, did they not humble themselves? But their hearts became hardened, and Satan made attractive to them that which they were doing.*
>
> *(Al-An'ām (The Cattle) 6:42–3)*

Sheikh Muhammad Salih al-Munajjid (n.d.) stated that the wisdom behind trials and calamities includes the following:

- Calamities drive out self-admiration from our hearts and bring them closer to Allah, to demonstrate the true nature of people, for there are people whose virtue is unknown until calamity strikes.
- Calamities strengthen people's resolve.
- A person becomes able to distinguish between true friends and friends who only have their own interests at heart.
- Calamities remind you of your sins so that you can repent from them.
- Calamities show you the true nature of this world and its transience, and that they are temporary inconveniences, and shows us that true life is that which is beyond this world, in a life in which there is no sickness or exhaustion.
- Calamities remind you of the great blessings of good health and ease.

Finally, Ibn al-Qayyim al-Jawziyyah (n.d.) stated that:

> Were it not that Allah treats His slaves with the remedy of trials and calamities, they would transgress and overstep the mark. When Allah wills good for His slaves, He gives him the medicine of calamities and trials according to his situation, so as to cure him from all fatal illnesses and diseases, until He purifies and cleanses him, and then makes him qualified for the most honourable position in this world, which is that of being a true slave of Allah (*'Uboodiyyah*), and for the greatest reward in the Hereafter, which is that of seeing Him and being close to Him.

Ill-health and disease, disability, grief and bereavement, loss of wealth, oppression and injustice and many other calamities play a causative role in human suffering. Suffering develops our awareness, refines our spiritual and emotional responses, teaches us humility, and prepares humans to be able to turn to God in repentance and maintain their trust that God only can relieve their hardship. Allah says in the Qur'aan (interpretation of the meaning):

> *For indeed, with hardship [will be] ease. Indeed, with hardship [will be] ease.*
> *(Ash-Sharĥ (The Relief) 94:5–6)*

Patience in times of trial and tribulation

Patience in times of trial and tribulation is an important virtue in Islam. The word *sabr* (from *sabara* in the Arabic language) means to be patient and to persevere. It is an indication of having self-control. In the *Shari'ah*, patience implies: restraining the soul from being agitated; restraining the tongue from complaining; and restraining the hands from slapping the cheeks, tearing the clothes and doing other similar actions (Ibn al-Qayyim al-Jawziyyah, n.d.). There are three kinds of patience in the Islamic context: patience while (fulfilling) the orders of Allah; patience while abandoning, and keeping away from, the prohibitions of Allah; and patience with the Decree of Allah with respect to afflictions and difficulties (Imam 'Abdur-Rahmaan Ibn Hasan aalush-Shaykh, n.d.). There are many Hadiths regarding the virtues of patience, including 'Patience is light' (Muslim, cited in Hadith Garden, n.d.) and 'No one has been given anything more excellent and more comprehensive than patience' (Bukhârî and Muslim, cited in pearlsofislam.tumblr.com, n.d.). Impatience varies in degree among individuals. Some people, who are impatient in overcoming difficult situations, may react through negative coping strategies. Impatient behaviours may also have an impact on one's relationship with God, on interpersonal relationships and on our psychological health. For some individuals, reactions to sickness and pain may lead to anger and antipathy towards themselves or directed towards God. This is the 'why me!' situation. This impatience with their afflictions may lead to reverting back to weakened faith or disbelief. Allah says in the Qur'aan (interpretation of the meaning):

> *And of the people is he who worships Allah on an edge. If he is touched by good, he is reassured by it; but if he is struck by trial, he turns on his face [to the other direction]. He has lost [this] world and the Hereafter. That is what is the manifest loss.*
>
> *(Al-Hajj (The Pilgrimage) 22:11)*

When one suffers through a serious disease that brings prolonged physical pain and discomfort, or even the prospect of death, only he or she can feel the full extent of the pain and distress. That is where we must be reminded that patience is a virtue in Islam. The Prophet (ﷺ) stated that 'The real patience is at the first stroke of a calamity' (Bukhârî [d], n.d.). It is stated that:

> No one else can possibly come close to appreciating what he goes through physically and mentally. Yet, let him be reminded that it is perhaps through this sickness and suffering that Allah intends to bless him with Paradise. There cannot be any reward or success greater than that.
>
> *(Rahman, 2004)*

Patience is a noble attribute with good consequences Those who are patient will have an unlimited reward, as Allah says (interpretation of the meaning):

> *Indeed, the patient will be given their reward without account.*
>
> *(Az-Zumar (The Troops) 39:10)*

It was reported that the Prophet (ﷺ) stated: 'Anyone who strives to be patient, Allah will grant him patience. No one is given a better or a larger gift than patience' (Bukhârî and Muslim, cited in QSEP, n.d.). The Prophet (ﷺ) also stated:

> Wonderful are the affairs of a believer; for there is good in every affair of his; this is not the case with anyone else except a believer. If he has an occasion to feel delight, he thanks (Allah), thus there is good for him in it; and if he suffers affliction, he endures patiently, which is good for him.
>
> *(Muslim [b], cited in KSA, n.d.)*

The reward for patience is Paradise, as Allah says (interpretation of the meaning):

> *And will reward them for what they patiently endured [with] a garden [in Paradise] and silk [garments].*
>
> *(Al-'Insān (The Man) 76:12)*

However, patience in times of trial and tribulation involves the seeking of help through patience and prayer. Allah says in the Qur'aan (interpretation of the meaning):

> *And seek help through patience and prayer, and indeed, it is difficult except for the humbly submissive [to Allah].*
>
> *(Al-Baqarah (The Cow) 2:45)*

For Muslims, there is the submission to the decree of Allah (predestination), and bearing with patience when trials and tribulations have befallen. It is stated that 'patience is obligatory, and belief in the divine decree is obligatory' (islamqa [a], n.d.).

Fear and hope

The personal trait of hope can be viewed as an important core factor that can affect various components of the spiritual framework of coping (Snyder *et al.*, 2002). Hope is a cognitive construct that consists of both the person's sense of motivation or goal-directed purpose (agency) and his or her perception of the ability to initiate and maintain goal-directed behaviours (pathways) (Snyder *et al.*, 2003). Hope has implications for one's emotional well-being as well as the process of cognitive appraisal (Snyder *et al.*, 2002) and coping behaviour. Research in the area of psychosomatic medicine has long demonstrated that hope has an ameliorative effect on healing (Swanston *et al.*, 1999) and that it is linked to aspects of physical and mental well-being (Chang and De Simone, 2001; Nekolaichuk *et al.*, 1999). Researchers have also found that individuals with high levels of hope tend to find meaning or benefit in the context of difficult and traumatic events (Nolen-Hoeksema and Davis, 2002). In the context of serious illness, a person's focus shifts from hope to fear or vice versa. Before obtaining a firm diagnosis, one has the hope that the medical problem is less significant. However, after the diagnosis, there is hope for a remedy. But as time progresses, and if a cure appears unlikely, the nature of one's hopes will continue to change. This may lead to feelings of hopelessness, helplessness and despair.

From an Islamic perspective, it is necessary that we should have fear of Allah and, at the same time, must have hope in His Mercy and Rewards. But it is important for us to navigate a course between hope and fear. However, it should not get to the point where the fear overwhelms us. That would lead us to hopelessness and despair. Despair is a negative feeling. It makes us abandon our good deeds. When we succumb to despair and lose hope, we stop trying and we simply give up trying. When we give up trying, this is when we start losing our spiritual health. 'We should also not allow fear to overwhelm us, but need to be aware emotionally and spiritually that Allah, our Lord, is Entirely Merciful, the Especially Merciful (*Rahman and Raheem*)' (Rassool, 2014). Allah's mercy is always closer than His wrath. He forgives our sins, no matter how numerous those sins may be. All we have to do is turn to Him in sincere repentance. The road to damnation is when our feelings of hope are getting the better of our good judgement and making us feel complacent; then we need to cultivate our fear. When we start feeling that our deeds are so very good, we should remind ourselves that Allah may not accept our deeds from us. We should have the fear that we would be called to account when we are being neglectful and that He is indeed severe in punishment.

Allah says in the Qur'aan (interpretation of the meaning):

> *O you who have believed, if you fear Allah, He will grant you a criterion (to judge between right and wrong), and will remove from you your misdeeds and forgive you. And Allah is the possessor of great bounty.*
>
> *(Al-Anfal (The Spoils of War) 8:29)*

Our journey between hope and fear must focus on the remembrance of Allah often, by carrying out all of our religious obligations with sincerity. Imam Abu Ja'far Salamah al Azadi, al Tahawi stated that:

> A slave should remain between fear and hope. For the right and approved kind of fear is that which acts as a barrier between the slave and the things forbidden by Allah. But if the fear is excessive, then the possibility is that the man will fall into despair and pessimism.
>
> *(Cited in Ali ibn Abi al-'izz al-Adhru'I, n.d.)*

In sickness, if there is more fear than hope, there is a tendency for the individual to fall into despair. In addition, the individual may also lose hope in the Mercy of God. It has been suggested that 'Fear and hope are like the two wings of a bird. If they are well balanced, the flight will be well balanced. But, if one is stunted, the flight would also be stunted. And, to be sure, if the two are lost, the bird will soon be in the throes of death' (Ali ibn Abi al-'izz al-Adhur'I, n.d.). So, fear and hope should be in equal balance. Al-Fudayl ibn 'Iyyaad (n.d.) said that, when one is healthy and well, then fear should predominate, but when terminally ill then hope should predominate. So that one should strive to do good when well and not despair of Allah's Mercy when terminally ill. So both fear and hope should be present in our hearts in equal proportions.

Dealing with grief and loss

Different kinds of loss, such as the loss of a child or spouse, sudden infant death, miscarriage, stillbirth, abortion or suicide, lead to different kinds of grief and mourning and require different responses. All kinds of difficult emotions are expressed but these are normal reactions to a significant loss. However, these are healthy coping mechanisms. Grief is a natural response to loss and, the more significant the loss, the more intense the grief will be. Grieving is a personal and highly individual experience. The response to grief depends on many factors, including personality and coping style, life experience, faith and the nature of the loss. The experience of losing a child is devastating, but for Muslims there are special rewards from Allah for parents who lose their children. The Prophet (ﷺ) always insisted that children who died before their parents went as forerunners for their parents in the life Hereafter, and would serve as 'protection' against Hell-fire (Maqsood, 2002). It is stated that:

> In the case of sudden infant death, parents should be allowed full opportunity of grieving over the death, and be assured that their innocent soul is safe with Allah. The grieving over a miscarriage or a stillbirth baby should not be minimised. In fact, it is important to recognise that the parents have sustained a real death.
>
> *(Mehraby, 2003)*

However, Islam allows women to prevent pregnancy but forbids them to terminate it.

Muslims believe that all suffering, life, death, joy and happiness are derived from Allah and that Allah is the one who gives us strength to survive. These beliefs are usually sources of comfort and aid the healing process. For example, in accepting grief and loss, the relatives of the deceased person are urged to be patient (*sabr*) and accept Allah's decree. The Prophet Muhammad (ﷺ) said: 'Allah, the Exalted and Glorious Says: "I have no better reward than Paradise for a believing servant of Mine who is patient and resigned when I take away one of his beloved one, among those he most cherishes in the world"' (Bukhârî, cited Sabiq, 1991).

The question of mourning for the deceased is an interesting one in Islam, and it is clear from the tradition that the Prophet (ﷺ) forbade it. Grief at the death of a friend or relative is normal and weeping is allowed. Nonetheless, in Arab and Muslim cultures grieving normally does take the form of clear outward lamenting, sometimes loud and prolonged wailing (Abu Aisha, 2010). Condolences may be offered in any words so long as they lighten the distress, induce patience and bring solace to the bereaved. Muslims are encouraged to show empathy to the bereaved, but it should be done without exaggeration, comforting and supporting the bereaved as long as it remains necessary. Thus, the bereaved should be visited from time to time. Traditionally, the family, especially the widow, stays indoors for the first three days and in some cases for the *Idaah* (four months and ten days) after the funeral. No loss, however great, should be permitted to sour one's outlook. Endurance should be shown by the bereaved, who are recommended to praise God and say, 'We belong to him, and to him we return.'

Religio-cultural considerations in counselling

Counsellors need to be aware of, and cognisant of, some of the religio-cultural factors that may impinge on the counselling relationship and process. Basic knowledge of these factors can enable counsellors to make decisions about relationship building, assessment, communication strategies and counselling interventions. It has been suggested that the more the counsellor is knowledgeable about the religio-cultural practices of Muslims, the more the counsellor is able to differentiate his or her own biases and to become more sensitive to the diversity of the needs that exist within the Muslim community (Altareb, 1996). Cultural sensitivity remains one of the important characteristics of effective counselling (Sumari and Jalal, 2008). Some of the significant religio-cultural issues faced by counsellors include greeting, modesty and eye contact.

The Islamic greeting for Muslims universally is '*Assalamu Alaykum Wa Rahmatullaahi wa barakatu*' (peace, mercy and blessings of God be upon you). In short, most Muslims say '*Assalamu Alaykum*' (peace and blessing be upon you), then the reply is '*wa alaykum assalam*' (and peace be upon you too). At the first encounter you need to be aware of the etiquette that you do not shake hands with, or embrace, a client of the opposite gender. Though the shaking of hands

is a friendly gesture, it is taboo for Muslims. Physical contact is not permissible between opposite genders unless a blood relationship exists. In fact, it has been suggested that:

> The established etiquette when men and women meet (regardless of whether they're Muslim or not) is that it is up to the woman to initiate physical contact, including the shaking of hands. If the woman extends her hand, then the man can shake it, but the man is not supposed to initiate the process.
>
> *(Khan, 2010)*

Shaking hands or touching is acceptable among members of the same gender. The counsellor needs to take the cue from the client. Some 'Westernised' Muslim clients of the opposite gender may offer to shake hands, but this is cultural and not an acceptable religious practice. Islamic culture has strict rules regarding eye contact between the sexes; these rules are connected to religious laws. Allah says in the Qur'aan (interpretation of the meaning) that '*believing men should lower their gaze and guard their modesty*' and to the '*believing women that they should lower their gaze and guard their modesty*' (An-Nūr (The Light) 24:30–1). During the counselling interview or assessment, a client of the opposite gender will avoid direct eye contact during a conversation as a sign of modesty or to avoid being disrespectful to the health professional or counsellor. In some cases, minimal eye contact may occur and should not be interpreted by the counsellor as client resistance to interventions. However, intense eye contact between those of the same gender is often used to stress the truthfulness of a point and is considered acceptable. Cultural expectations regarding gender can complicate the helping relationship (al-Krenawi and Graham, 2000). In relation to modesty, a female Muslim client may not wish to be counselled by a male counsellor or vice versa. An opposite-gender client relationship may become problematic during the counselling process and may inhibit appropriate self-disclosure. It is stated that many Muslims believe that a woman who has marital problems should discuss these with another woman (Aziz, 1999).

Ibrahim and Ohnishi (1997) presented a number of worldviews that are critical to South Asians and all Muslims. These include the importance of the family and filial piety, respect and honour for parents, and a strong emphasis on duty to the family. In general, Muslim families are highly valued and strongly patriarchal with a hierarchical structure. Family members are expected to be involved and are consulted in times of crisis. There are also cultural expectations regarding the involvement of the family that may complicate the helping relationship. The important roles that family support can play in recovery from mental health problems are well documented (Jones, 2010; Kaas *et al.*, 2003). The Muslim family's involvement in individual mental health helping is considerable and may play an important role in the healthcare decision-making process. Fonte and Horton-Deutsch (2005) suggest that Muslim clients may want family to be present or consulted during therapy. The head of the extended family or the elder may be involved in decisions regarding counselling interventions or determining the disclosure of psychological

or medical information. Meleis and La Fever (1984) pointed out that 'decisions regarding healthcare are made by the family group and are not the responsibility of the individual' (p. 76). There is the suggestion that, if the client wishes, the counsellor could work in collaboration with Muslim leaders during the therapy and liaise with other health professionals to develop treatment (Tse, 2002).

Another aspect to be taken into consideration in the counselling process is that of self-disclosure by the Muslim client. Self-disclosure is both a conscious and subconscious act of revealing more about oneself to others. This may include, but is not limited to, thoughts, feelings, aspirations, goals, failures, successes, fears and dreams, as well as one's likes, dislikes and favourites (wikipedia.org, n.d.). In a counselling session, the client does the 'self-disclosing', while the counsellor or therapist listens. The goal is to help the client see things from different perspectives. This allows the client to see and evaluate options he or she may not have thought about, which may give the client more power when making important life decisions. There are several relationship aspects concerning self-disclosing information in a counselling session, for example those of client to therapist and therapist to client. The clinical space available for clients to disclose should be far broader than that of the therapist. Male and female differences in self-disclosure are mixed. Women self-disclose to enhance a relationship where men self-disclose relative to control and vulnerability. Research indicates that self-disclosure by males is influenced by cultural factors and that it increases during adolescence (Sinha, 1976). Studies have suggested that more conservative cultures tend to disclose lower-stakes information and less information overall, while more liberal cultures tend to disclose quite a bit more information and information that is more personal (Auter and Elmasry, 2012).

Self-disclosure is often difficult for Muslim clients, particularly if they are perceived as risking damage to family honour. Self-disclosure issues among Muslim clients include under-self-disclosure; difficulty in sharing personal information; and information related to religious sin or unacceptable behavioural practice. The stigmatisation of psychiatric disorders, sexually transmitted diseases, unwanted pregnancy and HIV may hinder Muslim clients from seeking counselling care or disclosing information. Islamic tradition places strong emphasis on legal marriage and pre-marital, extramarital or homosexual intercourse is strictly forbidden. Transgression of these norms is not only sinful, but disclosure of such deviant practices may bring shame upon the family or the community (Boston Healing Landscape Project, 2010).

Muslims often express embarrassment or are offended when questioned about their sexual relationships and other personal aspects of their lives. It is also important to reassure the client regarding the confidentiality of the information. In addition, the client may be less willing to divulge information if the family is present during the counselling session (Aziz, 1999). However, the lack of self-disclosure in a therapy session should not be construed as client resistance. The counsellor needs to take cultural considerations into account in structuring the clinical interview or therapy and to explain the reasons behind the questions. As the rapport and therapeutic alliance

between the therapist and the client increases during the counselling sessions, it may be possible that the level of self-disclosure would also increase.

Examination of sensitive topics

The exploration or examination of certain pertaining issues may be subjected to cultural sanctions in the counselling process. These issues that need to be avoided or are inappropriate include: discussion of distressing issues with the family (Aziz, 1999); challenging traditional values, such as obedience to parental wishes (Azhar and Varma, 1995); some family problems that should be kept private and not shared beyond the family (Cinnirella and Loewenthal, 1999); and discussing religious issues if depression is linked to the client's struggle with religious beliefs (Ali *et al.*, 2004). In addition, sensitive issues that are described as taboo include: alcohol (Nielsen, 2004), sex and sexuality (Ali *et al.*, 2004), rape (Alyamy, 1995; Nielsen, 2004), self-harm (Inayat, 2005) and suicide (Ali *et al.*, 2004; al-Subaie, 1989; Mubbashar, 2000).

However, the notion suggesting the avoidance of the exploration of sensitive topics should be rejected. In practice, that would depend on the client's willingness to explore these issues. For example, the issue of sex and sexuality is not taboo in Islam per se, as some may claim. However, it has lost its openness over time in the Muslim community. Islamic sexual jurisprudence and sexuality in Islam are largely described in the Qur'aan, the Hadith and the consensus of the scholars. Sex is confined to marital relationships between men and women for procreation, but it's also for pleasure. The Prophet (ﷺ) said: 'There is no shyness in matters of religion', even entailing the delicate aspects of sexual life (www.islamawareness.net, n.d.). According to Sheikh 'Abd al-Wahhâb al-Turayrî (2013):

> The women of Madinah [Saudi Arabia] were quite bold in asking questions and in speaking their mind. This earned them 'Ā'ishah's praise: 'The women of Madinah are the best of women. They never let bashfulness prevent them from learning about their religion.'

The way the women of Madina asked the Prophet (ﷺ) directly or through his wives is a proof that sexual matters were not taboo but were fully acknowledged and respected (www.islamawareness.net, n.d.).

The question of suicide and suicidal thoughts may also be the object to focus during the counselling process if clinical depression is identified. Al-Subaie (1989) recommends that, although suicide is an unforgivable sin in Islam, therapists should still enquire about relevant thoughts or plans by asking about death wishes rather than suicide.

Diversity in communication styles

Generally, Muslims follow a high-context culture within the Islamic community. It is stated that 'traditional, high-context cultures communicate differently than

other cultures, and some believe that the thought processes developed from birth are actually different' (Ashki, 2006, p. 13). The framework of traditional cultures includes, among other characteristics, formality and indirect communication and body language (Hall, 1971). Western culture, based on a low-context framework, includes the characteristics of more direct and more verbal communication. However, due to globalisation and immigration of Muslims to Northern and Western hemispheres, there is the evolution of a blend of low-context and high-context cultures resulting in a global culture. Islam could be considered traditional in mannerisms, although individuals may be traditional or a global cultural blend (Ashki, 2006).

Muslims interpret counsellors' verbal and non-verbal responses according to their own cultural codes and nuances. This may lead to miscommunication or misinterpretation between the client and the counsellor. The difficulties and complexities involved in communicating and deciphering the client's verbal and non-verbal messages can lead to errant assessments, because of the existence of culture-bound symptoms and syndromes (al-Krenawi and Graham, 1997; Bilu and Witztum, 1995). There is evidence to suggest that native Arabic speakers share common features of a communicative style that may conflict with styles of other language speakers: repetition, indirectness, elaborateness and affectiveness (Feghali, 1997), which means an intuitive-affective style of emotional appeal (Abu Rass, 2010). This style of communication may also be present among Muslim communities due to the impact of Islam.

Communication styles may fluctuate during the counselling sessions. For example, a discussion may transform itself into constructive dialogue or escalate into a debate, even an argument, and transition back to a dialogue (Ashki, 2006). For a non-directive counselling approach, a client response may include a combination of repetitiveness, indirectness, elaborateness and affectiveness and this might appear to a counsellor not sharing the same culture as resembling a debate. It is stated that communication about family problems is more indirect than direct, more closed than open, more reserved than expressive, and more reluctant than forthcoming (Abi-Hashem, 2008).

Muslim clients tend to communicate in long, rich and contextualised sentences that only make sense when properly understood in relation to body and paralanguage. For example, the client may be reluctant to respond openly and frankly to direct questions such as: 'How do you feel about your spouse?', 'What are your major concerns about your marriage?' or 'Did you have extra-marital affairs?' Muslim clients may be reluctant to express negative thoughts or emotions. In addition, the open direct communication patterns or confrontational styles may be viewed as disrespectful. The need to save face and protect honour means that showing emotions is seen to be a negative response.

The open expression of negative feelings is not accepted in many Islamic cultures, because such statements are frequently seen as an unhealthy self-preoccupation (Hodge, 2005). Mental or emotional distress may be expressed somatically, as the locus of emotion, rationality and the soul is located in the physical heart in traditional

Islamic psychology (Boston Healing Landscape Project, 2010). Emotional problems may be expressed as physical ailments due to the lesser stigma associated with physical symptoms (Douki *et al.*, 2007; el-Islam, 2008). Many Muslims come from cultures that use metaphors to symbolise emotional reactions and represent their experience through cultural symbols, idioms and proverbs (Dwairy, 2006, 2009). In counselling sessions, the counsellor would facilitate problem solving or the exploration of problems and issues using metaphoric language.

Use of professional services

The seeking of psychological or medical treatment for ill health does not conflict with seeking help from Allah. Many Muslims do not seek psychological help, as they believe that illness, in general, can and will purify the body. The ruling among scholars is that medical or psychological treatment is either permitted or recommended. Although it is permissible to use physical medicine, the sick person should also look for spiritual remedies in which Allah has put the cure for both physical and mental illnesses, such as *Ruqyah*, as prescribed in Islam (islamqa [b], n.d.).

There is valuable insight into health beliefs and Islamic values in studies conducted with Muslim clients living in the UK and the United States. The findings of a study in the UK showed that respect of the individual's dignity and privacy, community roles and importance, genuineness of the healthcare provider, gender preference of the provider, modesty issues for men and women, language barriers, therapeutic touch and the use of prayer and visitation of the sick for healing purposes were considered important (Cortis, 2000). The findings of a study in the US (Walton *et al.*, 2014), on the specific health beliefs important to Muslim women as they relate to participation in medical or psychological care, suggests that Muslim women (1) prefer to make autonomous healthcare decisions without the assistance of a male family member; (2) prefer to have a female healthcare provider; (3) are willing to access medical and rehabilitation services if provided by a female, but not when provided by a male healthcare provider; (4) believe the use of prayer, recitation of the Qur'aan, fasting and charity to be beneficial to their physical health; and (5) are comfortable with the use of physical touch in medicine and rehabilitation evaluation and treatment, if the provider is female. Religious and cultural beliefs, such as the value placed on modesty and pre-marital virginity, contribute to reluctance to seek healthcare (Matin and LeBaron, 2004).

When facing psychological problems, marital problems or financial difficulties, many Muslims are reluctant to seek traditional counselling services. Knowledge of, and familiarity with, formal services, perceived social stigma and the use of informal-indigenous resources often hinder use of professional services (Aloud, 2004). For example, ethnic Arab clients, like those in other non-Western societies, find psychiatric and psychological intervention (Fabreka, 1991) and family and marital therapies (Savaya, 1995) stigmatising. However, it has been suggested there is now more evidence that Muslims are seeking professional counselling both within the mainstream counselling service and Muslim community-based formal counselling

(Ali *et al.*, 2004; Lum, 2010). Many of those who do seek mental healthcare prefer a counsellor with an understanding of Islam (Kelly *et al.*, 1996).

Conclusion

Counsellors have a need to understand Muslim clients from sociological, cultural, psychological and religious perspectives. There is much diversity in cultural practices among Muslims, which may or may not fully integrate Islamic values and practices. It would be good practice for counsellors to have an understanding of the health beliefs of Muslim clients, along with their religiosity and religious identity. This means that, while cultural and religious components are important to understand, sensitivity to the uniqueness of each individual client may be a prerequisite for good practice in therapy (Carolan *et al.*, 2000). Muslims who identify strongly with Islamic values need to know that counsellors are open to an understanding of their perspective and will not try to change it (Kelly *et al.*, 1996). Counsellors could help their clients who are working on religious issues to feel as though their religious values are an accepted part of the counselling process and therefore an important part of the solution to their problems as well (Podikunju-Hussain, 2006). Refer clients to religious leaders and Islamic counsellors for problems and concerns that go beyond the role of the traditional counsellor.

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7

ISLAMIC ETHICS RELATED TO COUNSELLING

Introduction

Ethics is a branch of philosophy dealing with moral problems and moral judgements. Ethics is defined as 'the moral principles that govern a person's behaviour or the conducting of an activity' (Oxford Dictionaries, n.d.), that is, having rules of behaviour based on ideas about what is morally 'right' or 'wrong' and 'good' or 'bad' according to ethical guidelines. Professional organisations in counselling are now moving towards greater specificity in cross-cultural and multicultural counselling, with implications for cultural competence and sensitivity and ethical counselling (Graham *et al.*, 2009; Kelly *et al.*, 1996; Springer *et al.*, 2009; Sue and Sue, 2012). However, ethical codes have been developed for the purpose of setting professional standards for appropriate behaviour, defining professional expectations and preventing harm to people who go to counsellors and psychotherapists. When counsellors are faced with ethical dilemmas that are difficult to resolve, they are expected to consider ethical decision-making processes, consulting available resources as appropriate. There is a variety of concrete frameworks that have been developed to aid practitioners in resolving ethical dilemmas (Bond, 2010, p. 60). These frameworks are often included in the ethical codes of professional certifying and validating bodies for psychologists, counsellors and psychotherapists (ACA, 2014; APA, 2002; BACP, 2013; BPS, 2009).

Professionals with moral and ethical paradigms based on the Judaeo-Christian tradition have historically provided counselling to Muslim clients in a variety of settings. When working with Muslim clients, and in order to prevent ethical dilemmas, the counsellor needs to understand Islamic practices and ethics related to counselling. It is also important to understand the different perspectives of ethical decision making to enable the reduction of misunderstanding and conflict. Corey *et al.* (2011) stated that religions impose their own values on people, whereas

psychologists and counsellors must avoid imposing their own values on their clients as doing so should be considered unethical. This chapter will explore the ethical dimensions of counselling Muslim clients. It will present an introduction to the sources and guiding principles of Islamic law and examine the issue of confidentiality within the patriarchal family system. The ethical considerations examined in this chapter will enable counsellors to have a greater awareness and understanding of Islamic ethics related to counselling.

Ethics: an international perspective

The foundation values that dominate ethical perspectives and ethical decision-making models have been formulated within a Western context. However, these principles are derived from Judaeo-Christian traditions and form the basis of international ethical guidelines such as the Declaration of Helsinki and various codes of ethics of national counselling and psychological associations (ACA, 2014; APA, 2002; BACP, 2013; BPS, 2009; Harper, 2006; Pacquiao, 2003). In addition, these Western ethical principles may or may not reflect the values of developing countries or non-Western cultures, and some of the principles may have been formulated without consideration for linguistic, cultural and socio-economic differences (Harper, 2006; Ray, 2010). However, in the international milieu, there is deliberation as to whether culture defines ethical principles; or whether a basic set of principles exists that can be modified to fit the cultural context; or whether there is a universal set of ethical principles applicable to all cultures (Harper, 2006; Lovering and Rassool, 2014; Ray, 2010).

In the counselling and bio-medical fields, ethical principles include: respect for autonomy; being trustworthy; beneficence – a commitment to promoting a client's well-being; non-maleficence – a commitment to avoiding harm to the client; respect for persons; respect for dignity and the moral demand that the rightness of an ethical act depends on the action, rather than consequences; justice; and self-respect (BACP, 2013; Forester-Miller and Davis, 1996; Ray, 2010). The perspective of respect for persons, beneficence, non-maleficence, fidelity, respect for autonomy, self-interest and justice is universally agreed upon (Beauchamp and Childress, 2001; Harper, 2006; Taft, 2000).

Islamic ethics based on the Qur'aan and Sunnah

In Islam, there are two primary sources of law: the Qur'aan – the Noble Text believed by Muslims to be the direct word of God; and the Sunnah – the example, whether in word or deed, of the Prophet Muhammad (ﷺ) incorporated in Islamic scriptures. The third source is *Ijtihad*, the law of deductive logic. This consensus of the opinion of the learned man and jurists plays an important role in Islamic law. It is recognised as the source of the Islamic legal system, since it provides an instrument to cope with the demands and needs of society (Doi, 1997). Islamic ethics is a framework, set by the Qur'aan, within which all practical conducts are deemed permissible (Umaruddin, 1962, cited in Islamic Worldview, n.d.). Thus:

> The purpose and end of ethics in Islam is ultimately to the individual; what the man of Islam does, he does in the way he believes to be good only because God and His Messenger say so and he trusts that his actions will find favour with God.
>
> *(al-Attas, 1993, cited in Mazwati, 2011)*

Within this framework, Islamic law covers both medicine and medical practices and includes all the aspects of professionalism required to appropriately serve the individual, the family and the community (el-Hazmi, 2002). A number of clear values exist in Islamic ethics. These values 'honour the dignity of man as a human being honoured by God almighty, and maintain man's essential rights, including: life, freedom, the preservation of property, health and sufficiency, throughout man's life' (WHO, 2005). These ethical values and framework help resolve some moral and ethical dilemmas.

Principles of Islamic ethics

'The first principle is that Man is honoured' (WHO, 2005, p. 1). Allah says in the Qur'aan (interpretation of the meaning):

> *And indeed We have honoured the Children of Adam.*
>
> *(Al-'Isrā' (The Night Journey) 17:70)*

Allah tells us how He has honoured the sons of Adam and made them noble by creating them in the best and most perfect of forms (Ibn Kathir, n.d.):

> This honouring implies that he should be kept in full health and well-being. It also implies respect for his personality, his private affairs and secrets, his right to receive all the information relevant to any medical procedure he will be subjected to, and his right to be the only person entitled to make any decision that concerns his health affairs, so long as that remains within the framework of these values.
>
> *(WHO, 2005, p. 1)*

The second principle is that every human being has the right to live and to the maintenance of life. Allah says in the Qur'aan (interpretation of the meaning):

> *And whoever saves one – it is as if he had saved mankind entirely.*
>
> *(Al-Mā'idah (The Table Spread) 5:32)*

It should be noted that this life saving, as seen in Islam, is not only saving a person physically; it goes beyond that to include psychological, spiritual and social life-saving (WHO, 2005).

The third principle is based on equity. Muslims consider justice in its general context to be one of the most obligatory and necessary obligations, since Allah commanded it in His sayings (al-Jaza'iry, 2001) (interpretation of the meaning):

> *Indeed, Allah orders justice and good conduct and giving to relatives and forbids immorality and bad conduct and oppression.*
>
> *(An-Naĥl (The Bee) 16:90)*

> *Indeed, Allah loves those who act justly.*
>
> *(Al-Ĥujurāt (The Rooms) 49:9)*

> *My Lord has ordered justice.*
>
> *(Al-'A'rāf (The Heights) 7:29)*

God indicates that equity should be applied in everything and gives a general order to people to practice equity – in statements: '*And when you testify, be just*' (Qur'aan 6:152); in judgement: '*when you judge between people to judge with justice*' (4:58); in conciliation: '*then make a settlement between them in justice and act justly*' (49:9); and in guardianship: '*and concerning the oppressed among children and that you maintain for orphans [their rights] in justice*' (4:127). This means having justice with Allah by worshipping Him Alone without associating any partner; justice in judgements between people by giving every rightful person his or her due; justice between wives and children by not giving one preference over another; justice in speech by not testifying falsely, nor saying what is false or a lie; and justice in what is believed, by not believing other than the truth and not lending faith to what is not realistic or what did not occur (al-Jaza'iry, 2001). In relation to healthcare and counselling:

> this means the greatest possible degree of equality in the distribution of health resources among society members and in providing them with preventive and therapeutic care, without the slightest discrimination on the basis of gender, race, belief, political affiliation, any social or judicial consideration, or any other factor, as expressed in the motto of the World Health Organization: 'Health for all'.
>
> *(WHO, 2005, p. 2)*

The fourth principle is striving to do well or excel in doing things well. Such high quality is desired in everything. It is one of the fundamental values enjoined by God (interpretation of the meaning): '*God enjoins equity and doing well*' (Qur'aan 16:90). The Prophet (ﷺ) said, 'Verily Allah has prescribed perfection (*Ihsan*) in all things' (Muslim, cited in www.40hadithnawawi.com, n.d.). The concept of *Ihsan* is one of the most important principles of Islam. It means doing everything in an excellent manner and it also means doing acts of charity and kindness to people in society who are weak, needy and poor.

The fifth principle is 'no harm and causing no harm'. This principle is the text of a Hadith of the Prophet Muhammad (ﷺ): 'There is not to be any causing of harm nor is there to be any reciprocating of harm' (Ibn Majah, cited in hadithaday.org, n.d.). This unequivocal statement means that all forms of harming others and all forms of wrongly reciprocating harm are illegal and prohibited in Islam. The

scholars have broken down 'harm' into two categories. The first category includes acts that only harm others. The second category includes acts that bring some benefit to the individual, but may also cause harm to society in any shape or form.

The above principles have been implemented since the early days of Islamic state. Accordingly, since the lifetime of the Prophet (ﷺ), ethical controls and principles have been established for medicine to guide physicians' behaviour (WHO, 2005). During the Islamic Caliphate, the state not only introduced inspection and control (*Hisbah*) in medicine to supervise physicians and investigate the extent of their compliance with proper and virtuous conduct, but also made physicians accountable for their practices. Scholars in Islamic law explain that an individual must be proficient in the particular field in which she or he is a practitioner. The Prophet (ﷺ) said: 'There is no clement person who has not stumbled, nor is there no wise person who possesses no experience' (Tirmidhî, cited in al-'Adl, n.d.). The Prophet (ﷺ) also said that: 'If a person who practises medicine while he is not known to be medically proficient, causes death or a lesser injury, he is held accountable' (cited in WHO, 2005, p. 3).

Ethical dilemmas in counselling

An ethical dilemma is defined as a debate between two moral principles or values in a decision-requiring circumstance or when there is a difficulty in deciding about which one is better, as a result of which the existing necessities cannot be met by present alternatives (Lindsay and Clarkson, 1999; Noureddine, 2001). Akfert (2012) suggested that encountering an ethical dilemma during the psychological counselling process is when the counsellor experiences a conflict between suitable ethical standards. Other reasons why ethical dilemmas occur include: when the counsellor has the option or is forced to choose between doing the right thing ethically and bending the professional ethical guidelines; when there are conditions that prevent the application of standards; the complexity in the application of ethical standards; or facing the dichotomy of choosing to follow the professional ethical guidelines and disregarding the client's cultural context (Ergene, 2004; Gümüş and Gümüş, 2010; Pedersen and Marsella, 1982). The most common ethical dilemmas faced by counsellors in the counselling relationship and process include: privacy, blurriness of boundaries, and multiple or conflicting relationships (Hendrix, 1991; Herlihy and Corey, 2006; Lindsay and Clarkson, 1999; Pope and Vasquez, 2007). The findings of a study by Akfert (2012) showed that common ethical dilemmas experienced in all institutions by school counsellors were limitations to privacy, entering into multiple relations, and transfer of competences and values.

The importance of counsellors upholding ethical guidelines is beyond dispute. In addition, the codes of ethics from professional organisations require counsellors to take responsibility, 'for respecting their client's best interests when providing therapy' (UKCP, 2009, p. 3), for 'protecting the safety of clients' and for 'alleviating personal distress and suffering' (BACP, 2013, p. 1). However, when working with Muslim clients, adherence to these codes may not be the best option or course

of action for the clients. That is 'Where respecting cultural differences does not necessarily lead to protecting safety or "alleviating personal distress and suffering", and where it is not clear whether challenging a client's cultural norm will or will not lead to increased distress' (Magnus, 2014). The author, commenting on a case of domestic abuse, suggested that ethical dilemmas:

> come about when it is not clear which course of action will exacerbate distress and suffering: respecting such a client's right to choose her own situation for the benefits it affords her, or helping her to get out of an abusive situation. It is from this nuanced and complex place, where personal ethics, professional guidelines and the guidelines of the setting I am working in collide, that I am required to make an ethical decision as a practitioner.
>
> *(Magnus, 2014)*

The ethical dilemma for Islamic counsellors or faith-perspective counsellors is the fear of having to condone or support their clients' requests for help with choices in life that might be considered in conflict with an Islamic worldview, such as issues related to abortion, pregnancy, assisted suicide, homosexuality, pre-marital sex, addiction and gambling. For example, Muslim and non-Muslim (Western) ethical perspectives on sterilisation and abortion procedures highlight different views on the value of patient autonomy and sanctity of life (Lovering and Rassool, 2014). Both abortion and sterilisation are not supported in an Islamic bio-ethical view as they are interpreted as interfering with reproduction and God's will. The only exception is when the mother's life is at risk, as the mother's life takes precedence over that of the unborn child (Moawad, 2006; Rassool, 2000).

When ethical dilemmas arise, counsellors need to carefully consider the actions that need to be undertaken. According to Welfel (2010), the failure to do so presents an ethical problem in itself, given the greater risk to the public when a professional relies on his or her intuitions alone. A variety of concrete frameworks have been developed to aid practitioners in resolving ethical dilemmas (Bond, 2010; Pope and Vasquez, 2007; Sperry, 2007). There is 'no single framework can suit every client, nor cover every possible ethical conflict' (Corey *et al.*, 2011, p. 22). One model for dealing with ethical dilemmas is based on a six-step process (adapted from Bond, 2010, p. 228):

1 Elicit a description of the dilemma.
2 Decide who is facing the dilemma (client, counsellor or both).
3 Consult a professional code of conduct or ethics.
4 Identify courses of action.
5 Choose the course of action.
6 Implement the decision/evaluation of outcome.

In addition, to complement the above steps, counsellors need to consult their supervisors and colleagues about what options are preferred. Those who are

affected by the ethical dilemma may be multiple stakeholders (Imam, co-workers, the agency, the community, the profession). Once a decision is taken, the actions need to be documented. Two ethical problems will be examined briefly: abortion; and suicide and euthanasia.

Abortion

Abortion is not permissible in Islam unless the mother's life is at risk, therefore cases of abortion are highly sensitive and feelings of guilt are very real for the mother:

> Aborting pregnancy is not permissible, whether the soul has been breathed into the foetus or not, but after the soul has been breathed into it, the prohibition is more emphatic . . . If the soul has been breathed into this foetus and it has begun to move, then [the mother] aborted it after that and it died, then she is regarded as having killed a soul, so she must offer expiation . . . That applies if it was four months old, because in that case the soul had been breathed into it. If she aborted it after that, then she must offer expiation.
>
> *(Sheikh Saalih al-Fawzan al-Muntaqa, cited in islamqa, n.d.)*

There is a ruling on aborting a pregnancy in the early stages. The Shar'iah allows abortion only when doctors declare with reasonable certainty that the continuation of pregnancy will endanger the woman's life. This permission is based on the principle of the lesser of the two evils, known in Islamic legal terminology as the principle of '*al-ahamm wa 'l-muhimm*' (the more important and the less important). In this case, abortion is permitted to save a life (*Syed*).

With regard to the ruling on aborting for a child whose mother has HIV/AIDS, this is not permissible. This is because HIV is not usually transmitted by a mother to the foetus until the later stages of pregnancy, after the soul has been breathed into the child, or during delivery, so it is not permissible according to Shar'iah for her to abort the foetus. It is, however, permissible for a mother with HIV/AIDS to take care of her healthy child and breastfeed him or her. Current medical knowledge indicates that there is no definite risk to the child from a mother who has HIV/AIDS, because the way she deals with the child is the ordinary way of mixing with people, from the point of view of Shar'iah, so there is no reason why the mother should not take care of, and breastfeed, her child, so long as there is no medical report to state that she should not do so.

Suicide and euthanasia

Islam has made human life sacred and has safeguarded its preservation. No one knows where, how and when he or she will die. Allah says (interpretation of the meaning):

> *Verily, Allah! With Him (Alone) is the knowledge of the Hour.*
>
> *(Luqmān (Luqman) 31:34)*

Muslims believe that the time of death is predetermined by God and may feel that it is wrong to struggle once God's will is clear (Ott *et al.*, 2003). Therefore, suicide, euthanasia and denial of nutrition or hydration are forbidden in Islam, but discontinuation of life support can be authorised by the elder son or senior male member of the family (Hedayat and Pirzadeh, 2001). Since God is the creator of life, a person does not 'own' his or her life and, therefore, cannot terminate it. Allah says (interpretation of the meaning):

> *And do not throw yourselves into destruction (by not spending your wealth in the Cause of Allah), and do good.*
>
> *(Al-Baqarah (The Cow) 2:195)*

> *And do not kill yourselves (nor kill one another). Surely, Allah is Most Merciful to you.*
>
> *(An-Nisā' (The Women) 4:29)*

Wishing for death is discouraged, and so is praying for it, if this is done because a person is going through difficulties such as sickness, poverty or other worldly afflictions. The six canonical compilers of Hadith narrated that the Prophet (ﷺ) said:

> Let no one among you wish for death due to any hardship that may befall him. But if one has no other choice, but to do so, one should say: 'O Allah! Grant me life as long as life is good for me, and cause me to die when death is better for me.'
>
> *(Fiqh As-Sunnah, n.d.)*

This also indicates that Islam is against euthanasia, because it is seen as interfering in a person's destiny and in what God has decided for each person, and the purpose of the person's life or death.

Conclusion

Ethics is a complex issue involving national and universal principles and codes of ethics, and takes into account the context of culture, setting and client characteristics. The ethical principles provide a framework to either clarify the dimensions of the ethical problem or formulate an acceptable course of action. Corey *et al.* (2011) point out that all of the contemporary therapeutic models and ethical codes tend to reflect the values of their cultural context. Pedersen (2008) suggested that this statement seems to imply that 'each Western-based code of ethics is based on a preference for individualism rather than collectivism as the preferred worldview' (p. 12). These insights support the ethical relativism view that ethical principles are culturally bound and context dependent (Lovering and Rassool, 2014). This may have implications for counsellors working with Muslim clients. However, both Islamic and Western ethical systems consider the actions and outcomes of ethical decision making and share the principles of doing good (beneficence), avoiding

harm (non-maleficence), fairness, equity and justice. There is a need to develop an ethical framework for Islamic counselling based on spiritual, cultural and professional perspectives. This is the challenge.

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PART II

Assessment, models and intervention strategies

8

GENERAL GUIDELINES FOR THE ASSESSMENT OF MUSLIM CLIENTS

Introduction

Assessment is a continuing process and a foundation of good clinical practice in counselling and psychotherapy. It is a fundamental component within the framework of both process and content within counselling practice. The practice of the assessment process involves the collection of information in order to identify problems, plan interventions and evaluate and/or diagnose clients. It is a dynamic and interpersonal process in which clients are given the opportunity, in the counselling relationship, to understand their 'problems and issues' and related needs, and provides information on what interventions are required. Assessment involves identifying statements, actions and procedures to help individuals, groups, couples and families make progress in the counselling environment (Balkin and Juhnke, 2013). It is stated that the focus of the assessment process in counselling and psychotherapy is to take into account both a pathological approach (focusing on what makes people unhealthy) and a salutogenic approach (focusing on what makes people healthy) for understanding clients and their problems (Kleinke, 1994, p. 195). Counselling assessment is a comprehensive analysis of an individual's needs and related problems, which is based on the collection of data on the physical/medical, psychosocial and spiritual needs of the individual. However, counsellors approach assessment according to the particular orientation or theoretical model to which they adhere and may or may not use screening tools. The aim of this chapter is to provide an overview of assessment and screening of Muslim clients in the counselling process and the challenges faced.

Purpose of assessment in counselling practice

The counselling assessment is an integral component of the counselling process. Formal and informal assessments help counsellors more accurately assess client

issues, create case conceptualisations, select effective, empirically proven therapies and evaluate ongoing progress (Whiston, 2009). The process of assessment is a therapeutic tool where the therapeutic alliance is initiated, rapport is developed, and full engagement with the client is created. Furthermore, assessments can be therapeutic, offering objective information for the client's self-discovery and may engage the client in self-reflection, which can be valuable in maintaining psychological health (Whiston, 2009). Some counsellors may utilise a range of assessment procedures and techniques, including initial assessment or pre-counselling interviews and diagnostic testing.

The initial counselling interview is critical in the counselling relationship and process. Meyer and Melchert (2011) described intake assessment as one of the critical stages of counselling. The quality of information gathered during the first meeting with the client has a direct effect on diagnosis, case conceptualisation and the intervention chosen by the counsellor. Rapid and effective assessments are necessary for individuals in crisis or those who may require bio-psychosocial interventions. Assessment in counselling should be seen as an ongoing process throughout the counselling relationship. Continuous assessment is important because it enables the counsellor to identify and explore the client's ever changing needs.

The use of psychometric tests in counselling assessment may be regarded by some client-centred counsellors as being inappropriate or inconsistent with the non-judgemental principles basic to positive counselling. Tests, according to some counsellors, create an elitist attitude and do not really add to what is already known about the client (Rao, 1991, p. 134). The concepts of assessment and diagnosis are perceived by most people-centered therapists as compromising 'genuineness' (Palmer and McMahon, 1997, p. 15). As Rogers (1975) stated, it is the development of a counsellor–client relationship, based on unconditional regard, that enables the counsellor to clarify the client's feelings without imposing external assessments or values. However, formal psychological assessment may also be used to determine an individual's progress during therapy (Ey and Hersen, 2004, p. 4).

The purposes of assessment are to:

- engage with the client;
- build a therapeutic relationship and rapport with the client;
- intervene in urgent psychological problems;
- assist clients in a better understanding of themselves;
- enable clients to learn about potentially desirable changes in their lives;
- gather information for the planning of counselling interventions;
- provide feedback for clients;
- identify the areas that require interventions;
- facilitate clients' self-actualisation (humanistic approach);
- evaluate the efficacy of counselling interventions.

One of the roles of assessment in the counselling relationship is to understand the client. Psychological problems are usually complex in nature and assessments

can provide the counsellor with a broader and more accurate perspective of the client (Laureate Education, 2010). Palmer and McMahon (1997) reiterate that 'assessment must begin with an open mind on behalf of the counsellor, a readiness to enter into another's world' (p. 93). It is important to assess the client's worldview within a framework that helps determine the client's problems and the intervention strategies required. This purpose of assessment means understanding clients on their own terms. That means:

- how they see the problem
- the solution they want
- the goals they would like to achieve
- the resources they feel they can draw on
- the strengths that they can draw on
- their sense of their own deficits, barriers, limitations and other negatives that could interfere with reaching their desired outcome.

(CAMH, 2005)

The understanding aspect of assessment has several components. First is the worldview of the client, that is, literally the way he or she views the world (Sue *et al.*, 1992); this is the *subjective* component. Others include *collateral* information based on observations and comments that people who know the client offer to the counsellor; the *impressionistic* – the clinical observations and questions that the counsellor and other professionals involved in the client's care have; and the *objective* – the client's signs and symptoms as measured, using objective instruments such as screening and assessment tools or diagnostic frameworks (CAMH, 2005).

Barriers in the assessment process

Individuals with psychological problems often have complex or multiple needs that are difficult to assess comprehensively. It may become apparent during the assessment process that the counsellor does not have the skills or competence to help the client. In such cases, one option is to refer the client to an appropriate counsellor or another service provider. The adherence to a specific counselling approach or assessment method may also limit the effectiveness of the assessment. Another assessment counselling barrier is language. Language differences may be perhaps the most important stumbling block to effective multicultural counselling and assessment (Romero, 1985). Physical limitations or people whose first language is not English may hinder the development of trust and the therapeutic relationship. In addition, the language barrier may impede the counselling assessment and process when clients have difficulties in expressing their thoughts and feelings or are reluctant to discuss sensitive personal issues. Other barriers may include: the client's beliefs about psychological problems or traditional counselling; the client's attitudes towards accepting counselling; or counselling services that may be culturally inappropriate.

Guidelines for the assessment of Muslim clients

At the initial or pre-counselling interview, it is important to assess the client's preferred language in case the client does not share the same language as the counsellor. The use of a professional translator may be necessary. Issues of confidentiality should be discussed with the client and the family. The counsellor needs to be aware of the beliefs about the client's illness, its causes and when and from whom to seek care, as this may have a significant influence on the presentation of illness or sickness behaviours (Rassool and Gemaey, 2014). During the process of engagement and the development of the therapeutic relationship, the counsellor will be in a better position to explore the client's cultural, religious and spiritual beliefs. A comprehensive assessment is necessary when considering using spiritual interventions with clients, as it helps the therapist to understand 'the client's belief system, values, and religious practice' in order to 'engage the client in a way that is ethno-religiously congruent and that does not potentially violate their religious tradition and practices' (Eck, 2002, p. 269).

The assessment of cultural identity, worldview, acculturation and spirituality/religiosity of the client ensures good practice from the counsellor in the provision of culturally sensitive interventions. Counsellors also need background information (demographics of the Muslim group, Islamic values and beliefs) about the particular community or ethnic group of Muslims that are locally based. According to Ibrahim and Dykeman (2011), cultural assessment requires an 'exploration with the client in relation to his or her presenting problem, his or her culture, religion/spirituality and acculturation' (p. 389). When assessing a Muslim client and constructing a cultural formulation, it is important to examine the client's cultural and religious identity, his or her explanatory model of the problem or illness, cultural factors related to the psychosocial environment, the counsellor–client therapeutic relationship, and treatment interventions (Rassool and Gemaey, 2014). A cultural assessment tool such as the Cultural Identity Check List Revised (CICL-R) can be used to identify the client's cultural identity, including race, culture, gender identity, sexual orientation, religion, age, languages spoken, region of the world or country where socialisation took place, and ability/disability (Ibrahim, 2008).

The worldview (beliefs, values and assumptions due to the socialisation process) of the client can also be assessed by validated instruments such as the Scale to Assess World View (Ibrahim and Owen, 1994). There is also the Muslim Religiosity-Personality Inventory (MRPI) (Krauss and Hamzah, 2009), which purports to assess Islamic religiosity in terms of the Islamic worldview and religious personality. The Islamic worldview reflects the Islamic *Tawheed* paradigm: the doctrine of divine unity/oneness of God. The Islamic worldview defines God as the Creator and law-giver and considers worship and service in His way as the very object of life (al-Attas, 2001).

Muslim clients are not a homogeneous group and, due to the pluralism among Muslims, it is important for a counsellor to assess the degree of acculturation. Halim (2006) stated that there are varying levels of acculturation among Muslims

based on migration and generation and their commitment to live their lives within the context of Islamic principles and practices in any Western European country or in North America. Based on the assessments of cultural identity, worldview and degree of acculturation, the counsellor is able to identify the conflicts and issues resulting from the level of acculturation and the adjustment made by the client in the host culture. It has been suggested that understanding the role of socialisation (maybe in the country of origin), which has a 'direct impact on cultural identity development, worldview, spiritual/religious commitment, and acculturation, is essential to the development of a productive working alliance' (Ibrahim and Dykeman, 2011, p. 392).

The inclusion of spiritual assessment in the counselling of Muslim clients is important for a number of reasons. According to Koenig *et al.* (1996), the spiritual assessment undertaken 'validates religion as an important part of the client's life and identifies a potential coping resource. It also provides vital information that is necessary in designing any future interventions that may include the client's religious faith' (p. 169). Richards and Bergin (1997) provided five reasons for including spiritual assessments in counselling: they help counsellors to obtain a better understanding of clients' worldviews; to determine if a religious orientation is positive and negative; to evaluate whether a client's religious or spiritual community is a potential coping resource; to enable counsellors to make decisions regarding which spiritual or religious interventions will be helpful to a client; and to assist counsellors in determining how a client's presenting problems and spiritual issues are related.

A range of assessment tools, both self-report measures and interview protocols, can be used to help the assessment process (Hill and Hood, 1999). An instrument that can be used universally with both Shiite and Sunni Muslims is the Religiosity of Islam Scale (RoIS) (Masri and Priester, 2007).The RoIS is a nineteen-item instrument with two subscales: Islamic Beliefs and Islamic Behavioural Practices. The scope and nature of the assessment will depend on the specific type of presenting issue. For some Muslim clients, the primary presenting counselling issue may be psycho-spiritual in nature, so a full spiritual assessment is warranted. One valuable point to consider is that the religious commitment of some Muslims could be the result of external (societal or familial) pressure, internal commitment, or some combination of the two (Rahiem and Hamid, 2012). Taking a spiritual history and using appropriate spiritual assessment tools can enable information to be gathered about spirituality relative to the nature of the presenting problem (Proctor, 2009). A spiritual assessment may explore such issues as the client's religious practices, beliefs, religious coping style, special celebrations and religious support network, that is, to assist the client by putting them in touch with his or her religious network. The support network or religious group may be a source of support or religiously oriented coping mechanism. According to Isgandarova (2007), the use of spiritual assessment tools 'is not to control the clients' beliefs and creeds, rather . . . to reveal [the] mental state of clients, and help them according to the results' (p. 2).

Instead of using a structured tool, counsellors should ask non-judgemental and open-ended questions. The wording of questions will vary depending on the characteristics or personality of the client, the problem presented and the setting. Questions should be asked sensitively and clients should be given plenty of time to consider their responses. The following sample questions are adapted from Rahiem and Hamid (2012). Counsellors may consider beginning with 'Tell me about . . . ' or 'I would like to learn more about . . . ':

- whether you consider yourself a religious person?
- what religion you practise?
- how you came to incorporate spirituality or religion into your life?
- how your religious beliefs affect your day-to-day life?
- whether you find comfort in religious practices such as prayer, making supplications and/or fasting?
- whether you have a family and/or social network that practises your religion?
- whether you are attached to any religious groups in your community? Do you find this to be a source of support?
- whether you find that your religious connection is helpful to you in dealing with stress?

The principles of assessment of Muslim clients in counselling are presented below:

- A holistic assessment of a client includes cultural and religious beliefs, presenting problems and collateral information from significant others.
- Inquire about clients' cultural identity to determine their ethnic or racial background.
- Identify language ability and the client's preferred method of communication. Make necessary arrangements if translators are needed.
- Identify religious and cultural considerations that the counsellor needs to be aware of.
- Assess the degree of religiosity of the client.
- Identify the cultural or religious beliefs the client holds about her or his illness.
- Examine the incorporation of religious practices into the client's day-to-day life.
- Examine the client's perceived religious discrimination.
- Explore the religious beliefs may promote or interfere with help-seeking behaviours.
- Examine the client's perception of the current problems and issues.
- Explore the meaning of the problems and issues from the client's worldview.
- Assess the degree of acculturation, if appropriate.
- Examine how the experiences of the client with parents or significant others has affected his or her perception of religion or religiosity.
- Identify the personal and social meaning the client attaches to his or her psychological state.

- Examine the expectations of the client about her or his problem.
- Examine the client's (and significant others') therapeutic goals or what their expectations are of the counselling interventions.
- Identify the client's degree of religious conservatism as reflected in his or her choices of clothing; eating and drinking habits; and many traditions, customs and beliefs.
- Explore the fears and hopes of the client.
- Identify the client's use of traditional healers or remedies.
- Consider religious and cultural factors related to the psychosocial environment and levels of functioning.
- Examine the spiritual/religious interpretations of social stressors, available support and the client's levels of functioning and ability/disability.
- Identify the client's major support, social network and family configurations and include the family in the assessment process and counselling interventions.

Risk assessment

Risk assessment and management are core elements of good practice in counselling. The aim of risk assessment is to identify risk factors that can be used to determine the likelihood of 'harm' to self and others. This information is subsequently used to provide appropriate counselling or other health interventions. Risk assessment should fully involve the individual being assessed, relevant professionals and any informal carer or significant other. An individual may fail to disclose 'risky behaviours' or self-harm, and that is why it is important to seek information from a variety of sources (Rassool, 2009). The principal elements of risk assessment and management are:

- risk of suicide or self-harm – ideas, plans and intentions;
- risk of overdose and polydrug use;
- risk of harm or violence to others;
- risk of harm or abuse/exploitation by others;
- risk of severe self-neglect;
- risk related to physical condition.

There is no specific method of predicting 'risky behaviour', but there are several factors that have been reported in the literature to be associated with an increasing probability of risky behaviours (Rassool, 2009). There may be patterns of past and current factors of psychosocial and physical problems that may be indicative of risky behaviours. The precipitating factors may include: neurological (organic) disorders; continuing high suicidal and behavioural intent; hopelessness; hallucinations and persecutory delusions; social isolation; recent loss or separation; relationship breakdown; unemployment; imprisonment or threat of imprisonment; homelessness; intoxication with alcohol or drugs; and cultural and diversity issues (for example, shame). The predisposing factors may include: previous history of harm to self or others; family history of harm or mental illness; borderline or impulsive personality;

social exclusion; lack of support network; past sexual or physical abuse; depression; schizophrenia; and substance misuse.

Assessment of a risk of violence to others should be notified to informal carers and all agencies and key people involved in the client's care and support. Where there is such a risk, it is crucial that adequate personal care, supervision and treatment are provided. It is worth exploring the issues of the likely victims and whether the victims are aware of the risks posed to them and to others. The elements of risk assessment that require attention from counsellors include the assessment of a risk of violence to others, and the individual's vulnerability to dangers or exploitation – sexual, financial, occupational and familial, particularly when the person's judgement or cognitive functioning is seriously impaired (Rassool and Winnington, 2006). By acknowledging the thoughts and feelings relating to the 'risk' behaviour, counsellors can work through with the client using techniques such as anger management, individual therapy and group work (Rethink & Turning Point, 2004).

Conclusion

During the phases of counselling assessment, the counsellor needs to be aware that Muslim clients tend to demonstrate passivity in the presence of a professional figure. Delving into spiritual or religious aspects of the client's life may give the counsellor insight into religious-oriented psychological stressors or coping mechanisms. However, counsellors should explain the need for requesting clients to disclose personal information, as Muslim clients may be reluctant to share such content with others. An existential approach in sharing some bit of personal information to gain the client's trust and enable the therapeutic alliance may be required. In relation to the formulation of the client's problems (or diagnosis), Lukoff *et al.* (1992) pointed out that assessments help counsellors to differentiate between problems that are entirely religious or spiritual, those that are mental disorders with religious or spiritual content, and those that are psycho-religious or psycho-spiritual problems but are not considered to be mental disorders. In addition, from the perspective of the client, assessment is valuable in providing the time for self-reflection (Stanard *et al.*, 2000). While assessment can provide both the client and counsellor with a picture of the client's internal and external world, there is a need to remember that the client's needs can often be met quickly, and that the priorities of needs can change rapidly. The assessment process is the first phase of the counselling journey and it is important to ensure that comprehensive data are collected in a systematic manner. This would enable counsellors not only to identify future outcomes, but also to evaluate the appropriateness and relative success of different counselling interventions.

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9

PSYCHOANALYTIC THERAPY AND COUNSELLING

Introduction

There are various approaches to counselling and psychotherapy and these therapies generally fall into five categories. These are behavioural therapies, psychoanalytical and psychodynamic therapies, cognitive therapy, humanistic therapies and integrative or holistic therapy. Most of the approaches to counselling and psychotherapy are based on the Judaeo-Christian tradition with Western values and objectives. It is argued that the Western value system has a profound impact upon counselling approaches, techniques and processes, for it reinforces what is considered good according to the prevalent social standards, values and norms (Jafari, 1993, p. 330). There will be situations when traditional or Western-oriented counselling approaches are inappropriate when dealing with Muslim clients. This is because the relevant repertoire of counselling techniques and practices is based on the Western socio-moral value structure, and these values are often expressed as the desired behavioural outcomes of the therapeutic process (Jafari, 1993, p. 330). The question then arises as to whether the counselling approaches and techniques carry any legitimacy and are congruent with Islamic beliefs and practices. The central role of Islam in the lives of Muslims living in Western countries necessitates culturally sensitive and religiously congruent methods of approaching psychological treatment with this large population (Ahmed and Amer, 2012). Western-oriented counselling varies in its approach to spirituality and religion (West, 2000). This chapter focuses on psychoanalytic therapy and counselling and its congruence with Islamic beliefs and practices.

Psychoanalytic counselling and therapy

Psychoanalytic principles and techniques, evolved from the work of Sigmund Freud (1856–1939), have had an impact on the development of most of the theories of

psychotherapy and counselling, bringing about many different schools of thought and practice. Some of these therapeutic approaches extended the psychoanalytic model, others modified its concepts and procedures, and others emerged as a reaction against it (Corey, 2009, p. 60). Although the roots of psychodynamic therapy and counselling lie predominantly in Freud's psychoanalytical approach, others including Carl Jung, Alfred Adler, Otto Rank, Eric Fromm, Karen Horney, Anna Freud and Melanie Klein are all widely recognised for further developing the concept and application of psychodynamics.

Freud postulated that human nature is basically deterministic and is influenced by irrational forces, unconscious motivations, and biological and instinctual drives evolving through psychosexual stages of development in the first six years of life (Corey, 2009, p. 61). In Freud's view, both sexual and aggressive drives are powerful determinants of an individual's behaviour. According to the psychoanalytic perspective, the personality consists of three systems: the id, the ego and the superego. The stages of psychosexual and psychosocial development, completed in a pre-set sequence, can lead to the completion of a healthy or unhealthy personality. Freudian stages of psychosexual development include: the oral stage, the anal stage, the phallic stage, latency and the genital stage (Freud, 1962). The unsuccessful completion of each stage means that a child becomes fixated and that certain issues are not resolved at the appropriate stage. Until this conflict is resolved, the individual will remain fixated in this stage and this often brings individuals to therapy. For example, a person who is fixated at the oral stage may have a stronger tendency to smoke, drink alcohol, overeat or bite his or her nails. According to Corey (2009), the anal stage deals with the inability to recognise and express anger, leading to the denial of one's own power as a person and the lack of a sense of autonomy. In terms of personality, an individual may have an obsession with cleanliness, perfection and control, or the opposite of these characteristics. A fixation at the phallic stage could result in immaturity, narcissism, egoism and an overtly sexualised personality that may include serial marriage, polygamy and polyandry (Ellis *et al.*, 2009). It is during the latency stage that no further psychosexual development takes place. Those fixated at the genital stage of psychosexual development may develop paraphilia (the experience of intense sexual arousal to atypical objects, situations or individuals) (APA, 2000) in men, frigidity in women and other arousal disorders (Ellis *et al.*, 2009).

Core principles and the therapeutic process

Psychodynamic therapy and counselling is goal-oriented and is available to individuals, couples, families or groups as a short-term or long-term process. The primary purpose in psychodynamic counselling is to release repressed emotions and experiences so as to make the unconscious motives conscious; that is, to enable individuals to review feelings, thoughts, early-life experiences and beliefs to gain insight into current problems and patterns of behaviour. It is stated that, by identifying recurring patterns, individuals may perceive the ways in which they avoid

distress or develop defence mechanisms as a method of coping, so that they can take steps to change those patterns (www.goodtherapy.org, n.d.). Freud's stages of psychosexual development (and Erikson's psychosexual stage of development) form a framework that the counsellor may use for the understanding of key developmental tasks characteristic of the various stages of life. The core principles of psychodynamic approaches to counselling include the following:

- There is a belief that early childhood experiences and past events, often unconscious, determine how people feel about themselves and their world.
- There is a view that all internal experiences relate to interpersonal relationships.
- The processes and techniques of psychodynamic therapy and counselling include: identification of recurring themes and patterns of behaviour; discussion of past experience (developmental focus); focus on affect and expression of emotion; and focus on the therapeutic relationship and exploration of fantasy life (Shedler, 2010).
- Among the core features are the concepts of transference, resistance, the dynamic unconscious, countertransference, a developmental lens to view adult experience and psychic determinism (Gabbard, 2005).
- The past experiences of both the patient and the therapist have a role in determining the valence and power of the therapeutic relationship (Kay, 2006).
- Psychodynamic therapy focuses on recognising and addressing defence mechanisms.
- Free association is used as a major method of psychodynamic therapy and counselling, along with other techniques for the exploration of internal conflicts and problems.
- There is an acknowledgement that insight is critically important for positive outcomes in therapy.

Some of the features of psychodynamic therapy or counselling as compared to traditional psychoanalysis (Corey, 2009) are: the therapy is geared more to limited objectives than to restructuring one's personality; the therapist is less likely to use the couch; there are fewer sessions each week; there is more frequent use of supportive interventions, such as reassurance, expressions of empathy and support, and suggestions, and more self-disclosure by the therapist; and the focus is more on pressing practical concerns than on working with fantasy material. The working alliance or therapeutic relationship is central to psychodynamic therapy and counselling in bringing about change in the client's behaviour. However, it is argued that in psychodynamic therapy the establishment of the therapeutic alliance is inherently more difficult, 'because the analyst must scrupulously avoid revealing any aspects of his personality' (Ellis *et al.*, 2009, p. 118). According to Luborsky *et al.* (2008), contemporary psychodynamic therapists view the emotional communication between themselves and their clients as a useful way to gain information and create connection. According to Ellis *et al.* (2009), the other phases of the therapeutic journey include: analysing the resistance; analysing the transference;

and interpretation (late phase). The techniques most commonly used by psychodynamic therapists are maintaining the analytic framework, free association, interpretation, dream analysis, analysis of resistance and analysis of transference (Corey, 2009, p. 74).

The main limitations of the Freudian psychoanalytical approach include: the use of a small sample of neurotic middle-class Viennese women, and generalisation of findings; difficulty in empirically finding support for its hypothetical constructs such as the id, ego and superego; and the focus on the sexual rather than the social world in personality development (Fisher and Greenberg, 1985, 1996; Luborsky *et al.*, 2008; Scaturo, 2001; Shedler, 2010; Strupp, 1992). However, the findings of a recent meta-study showed that long-term psychodynamic psychotherapy was superior to less intensive forms of psychotherapy in complex mental disorders (Leichsenring and Rabung, 2011). But this study has been refuted and challenged on its methodology (Kliem *et al.*, 2012).

Religion, spirituality and psychoanalysis

Spirituality and religious belief form one of the most important parts of life for many clients and are an important consideration in therapy. Addressing a client's religious beliefs is required by ethical codes and codes of conduct, and the ways to integrate spirituality/religion into the therapeutic process in counselling and psychotherapy have undergone continuing development.

Tan (1996) has highlighted how religion can be integrated into the therapeutic process and how the responsibility may fall on the therapist to search for ways in which this can be done. However, there are ethical and clinical considerations in involving the integration of religion into the therapeutic process. Hamdan (2008) has cautioned therapists with some concerns of integrating religion into therapy, including: the fear of imposing values, informed consent and collaboration, and professional competency to do this work. The guiding principles (Hamdan, 2008, p. 102) include:

- respect for client's autonomy and freedom;
- sensitivity to, and empathy for, the client's religious and spiritual beliefs;
- flexibility and responsiveness to the client's religious and spiritual beliefs.

There is a growing literature on the incorporation of religious beliefs and practices into psychological treatment for Muslim clients (Ahmed and Amer, 2012; Ahmed and Reddy, 2007; Ali *et al.*, 2004; al-Krenawi and Graham, 2000; Azhar and Varma, 1995a, 1995b; Azhar *et al.*, 1994; Carolan *et al.*, 2000; Daneshpour, 1998; Graham *et al.*, 2008; Hamdan, 2007, 2008; Hedayat-Diba, 2000; Hodge and Nadir, 2008; Johansen, 2005; Kobeisy, 2004, 2006; Meer and Mir, 2014; Razali *et al.*, 1998, 2002; Sabry and Vohra, 2013; Springer *et al.*, 2009; Williams, 2005).

There is a dominant and legitimate view of the hostility between Freudian psychoanalysis and religious thinking and a longstanding suspicion of psychoanalysis

has been manifest within the Islamic context. Much of the scepticism seems to derive from the common assumption that psychoanalysis propagates secularism, from the writings of Freud on religion, and because of the hostility of theologians to Freud and psychoanalysis in particular. Akhtar (2009) stated that 'psychoanalytic thinking . . . took Freud's atheism at face value and regarded psychoanalysis and religion (and mysticism and spirituality) as antagonistic' (p. 269). In addition, while religion teaches that humans have souls, 'Freud demolished this conception and denied the existence of God, the soul, the here-after and human free will' (Badri, 2002, cited in Mura, 2014). According to Freud (1933), 'Religion is an illusion and it derives its strength from the fact that it falls in with our instinctual desires.' Freud (1927) also compared religion to childhood neurosis and distress. Jones (1991) has challenged Freud's view of religion as one-way transference. Using examples from clinical cases, he argues instead that religious experiences, doctrines and practices reflect the internalised interpersonal patterns that constitute our sense of ourselves. Freud said that God is nothing other than an idealised father figure from whom the faithful anticipate protection and salvation (Benslama, 2006) However, from an Islamic perspective, the Qur'aan contradicts Freud's thesis and states that '*God was not born and God did not give birth to . . .* ' (112:1–4). Thus, the notion that God is assumed to have a paternal function is refuted.

Despite the psychoanalytical encounter and flirtation with Sufism as a religious or spiritual experience (Nurbakhsh, 1978a, 1978b), Islam has rejected psychoanalysis on the basis of: its Jewish origins; its atheism; the equation of God as an idealised father-figure; the embrace of modernity, rejecting past traditions (Keller, 2006); and the affirmation of values and objectives of psychoanalysis at the expense of others (Jafari, 1993). However, the situation has begun to change and there has been a rapprochement between spirituality and the psychodynamic approach to counselling and therapy (Arden, 1998; Beit-Hallahmi, 1996; Black, 2012; Coltart, 1993; Field, 2005; Jones, 1991; Marcus, 2003; Meissner, 1984; Safran, 2012; Tan, 1996). This rapprochement has also been seen in literature, albeit limited, on psychoanalysis and the nature of Islamic thoughts and practices (Ad-Dab'bagh, 2001; Akhtar, 2008; Akhtar and Parens, 2001; Benslama, 2009; Etezady, 2001; Fayek, 2004).

The conciliation between Islam and psychoanalysis may be possible on the basis of the enhancement in quality of the therapeutic relationship rather than any psychoanalytic analysis and interpretation (Ad-Dab'bagh, 2001, p. 283). Muslim patients, according to Etezady (2001), may be helped at an intra-psychic level by removing 'obstacles from access to their own personal truth and ultimate judgement' (p. 318). Fayek (2004) identifies issues in Islam that can benefit from psychoanalysis, but sees that, despite the tensions existing between the two, they can complement each other. He claims that his lack of religious affiliation enables him to practise psychoanalysis because his view of religion could affect his interpretation of clients' religious affiliations. He suggested that 'Religion as an active ethnic identity in patients could, and maybe should, be considered part of character defenses, because the ethnic religious identity is not a matter of choice' (Fayek, 2004, p. 457).

Since the practice of Islam encourages self-knowledge, values, morality and transcendence, and teaches the primacy of meaning, psychoanalysis similarly seeks to deepen self-knowledge through introspection, searching for value and the personal meaning of one's experience (Etezady, 2008). According to Etezady (2008), the faith is perceived as a transformative force and is the central core of a believing Muslim's integrity and sense of self. In this context, transformation in the course of psychoanalytic treatment involves conflict resolution, removal of fixation points and repair of deficits in self-regulation. These authors have made inroads in the analysis of the relationship between Islam, Muslims and psychoanalysis. However, some of the treatise is based on secular thinking, fosters distortions about Islam, overexposes Sufism and perpetuates some of the negative stereotypes about Islam.

Psychodynamic therapy and counselling: congruence with Islamic beliefs

In Islamic communities, psychoanalytic approaches are not widely accepted as a form of therapy and counselling (al-Abdul-Jabbar and al-Issa, 2000; Azhar and Varma, 2000; Sabry and Vohra, 2013), because some of the conceptual framework and modalities of the psychoanalytical school have a degree of incongruence with Islamic values and practices. Although it is reported that some aspects of Freudian psychoanalytic treatment mirror Islamic concepts, in general psychoanalytic theory may not work for many Muslim clients (Amer and Jalal, 2012). Cognitive-based therapies are more congruent with the religious beliefs of Muslim clients than, for example, psychoanalysis (Amer and Jalal, 2012, pp. 96–7). Because the Freudian tradition has generally ignored or discounted religion, the integration of religiosity in treatment has not been a characteristic of the psychodynamic tradition, and this is not compatible with Muslim culture (Badri, 1979).

Freudian psychoanalysis, like behaviourist and humanistic psychology, is based on a secular notion of human nature. Freudian theory posits that human nature is essentially in conflict and is primarily driven by unconscious sexual and aggressive instincts. It is the unconscious mental processes (id, ego and superego) that are capable of influencing our behaviour. This secular approach neglects the moral and spiritual phenomena within mankind and leaves it up to the individual to practise religion (Haque, 2004). In addition, the nature of psychoanalytic doctrines remains dominated by rationalist theories of human nature and these theories are, in turn, based on forms of mind–body dualism that are rooted in Judaeo-Christian religious teachings (Webster, 2005). This state reduces humans to 'here and now' status in meeting their physical, psychological and socio-cultural needs. From an Islamic perspective, there is a comprehensive understanding of humans, their true nature, their origin before coming into this world, their supposed mission and role in this life and also of their eventual return upon completing this earthly life (Abdul Razak and Hisham, 2012).

Islam teaches that God created humans differently from non-humans because everything is created *for* humans, as mentioned in the Qur'aan (interpretation of the meaning):

> *It is He who created for you all of that which is on the earth.*
>
> *(Al-Baqarah (The Cow) 2:29)*

> *We have certainly created man in the best of stature, then We return him to the lowest of the low, except for those who believe and do righteous deeds, for they will have a reward uninterrupted.*
>
> *(At-Tīn (The Fig) 95:4–6)*

Allah tells us that He has created humans in perfected order and, thus, He has perfected everything in man:

> *You do not see in the creation of the Most Merciful any inconsistency.*
>
> *(Al-Mulk (The Sovereignty) 67:3)*

The purpose of human creation is explained in the Qur'aan (interpretation of the meaning):

> *And I did not create the Jinn and mankind except to worship Me.*
>
> *(Adh-Dhāriyāt (The Winnowing Winds) 51:56)*

This means, 'So that they worship Me, willingly or unwillingly' (Ibn Kathir, n.d.). Allah says in the Qur'aan (interpretation of the meaning):

> *[Adhere to] the fitrah of Allah upon which He has created [all] people.*
>
> *(Ar-Rūm (The Romans) 30:3)*

This verse means that all humans have been created on *fitrah*, that is, the innate instinct that acknowledges the truth of Allah's existence. (*Fitrah* is discussed more fully in Chapter 4.)

Freud completely denied free will, believing instead that our thought processes and behaviours are the result of our minds. This concept is contrary to the Islamic theory of human nature where there is substantial room for free will. From an Islamic perspective, humans have been given free will to make choices regarding their beliefs and deeds. As mentioned in the Qur'aan (interpretation of the meaning):

> *The truth is from your Lord, so whoever wills – let him believe; and whoever wills – let him disbelieve.*
>
> *(Al-Kahf (The Cave) 18:29)*

But this free will is not absolute; it has limits. The will of a human being is connected to the will of Allah and nothing happens by the will of the individual alone. As mentioned in the Qur'aan (interpretation of the meaning):

> *And you do not will except that Allah wills.*
>
> *(Al-'Insān (The Man) 76:30)*

This doesn't mean that humans are forced to do anything, but it means 'that humans are free to make choices, but the outcome of the choice depends upon the will of Allah. Else the concept of accountability will lose its purpose' (Ashraf, 2013).

As discussed earlier, Freud's psychosexual development theory postulates that the sexual 'drives' of children pass through the distinct developmental phases of the oral, the anal and the phallic. The development of neurosis or perversion could be explained in terms of fixation or regression to these phases. In contrast, Islam stresses that humans are essentially creatures of goodness, and that any deviance is the influence of upbringing and social influences. From an Islamic perspective, psychologists explain that a newborn child starts the journey of life in this world in the state of *fitrah* (primordial nature without sin and evil), while Freud's ideas state that a child is all id during birth until the other contending parts of the psyche develop, namely the ego and superego (Abdul Razak, 2011). The Prophet Muhammad (ﷺ) said: 'Each child is born upon the primordial nature, but it is his parents that make of him a Jew, Christian, or a Magian' (Muslim, n.d.). Unlike Christianity, Islam rejects the notion that everyone is born into a state of original sin. However, it is widely accepted that every individual is affected by his or her childhood experiences and it is childhood sexuality and unconscious motivations that influence the development of personality. But the emphasis on early childhood experiences is clearly not in harmony with the perspective of Islam, because Islam's view on human nature is more optimistic and believes it has continuous potential for growth and self-development (Samsudin, 2009). In addition, Samsudin (2009) argues that the remarkable transformation in the personalities of the companions of the Prophet (ﷺ), Umar al-Khattab and Abu Dhar al-Ghifari in particular, who changed from being the greatest of bullies during the pre-Islamic period to among the most pious Muslims upon conversion to Islam, is an outstanding example of how radical personality changes and improvements can occur even during adulthood.

In Islam, the importance of childhood experiences cannot be overemphasised. It is during this stage of a child's development that a parent's or caregiver's consistent emotional attachment to the child will play a central and crucial role in shaping the child's experiences. In addition, childhood experiences and religious orientation are influenced by a stable, strong, loving family where parents pay proper attention towards developing a sense of self-worth and dignity. Thus, in this environment, the child develops trust and self-confidence and has ingrained the love and authority of parents and God. This is highlighted in the Noble Qur'aan about healthy parent–child relationships and parents' responsibility towards upbringing. Dover (2014) suggested that:

> one of the ways parents can shape their child's behaviour, while still maintain[ing] a positive and true view of God is to associate doing good with God. For example, 'Allah loves those who are good to their parents' or 'Allah is most pleased with you when you are doing your homework so you can learn because Allah loves his creation to gain knowledge through education.'

In this way, Dover (2014) suggested that 'a child's brain can be nurtured with love, good thoughts, and the cultivation of good and righteous behaviour manifest'.

Although the theory of the nature of man, religion and psychosexual development is antithetical to Islamic beliefs, some of the techniques used in the Freudian approach are relevant in some contexts. The therapy, which is long term, focuses on exploring unconscious issues through catharsis, interpretation, dream analysis, free association, transference and other methods. Psychoanalysis developed the idea of talking therapy, and 'individuals are encouraged to express freely aggressive and sexual desires, which further contribute in changing the sexual attitudes and lack of inhibition in society at large' (Ahmed, 2006). It is possible for an Islamic counsellor or psychotherapist to use some Freudian techniques without subscribing to his secular views, for assessment purposes or for insight and behavioural interpretation. Despite the theoretical incongruence between psychoanalytic and Islamic principles, Freud's trilogy of the id, ego and superego has been matched with the *Nafs al-Ammara Bissu'*, *Nafs al-Mutma'innah* and *Nafs al-Lawwammah* (Aydin, 2010). (The different states of the *Nafs* are examined in Chapter 4.)

Dream analysis and interpretation

One of the techniques of Freud's psychodynamic approach is dream interpretation and analysis, which is valid in Islam but based on different principles. According to Freud, dream analysis is an important procedure for uncovering unconscious material or 'unfinished business' and giving the client insight into some areas of unresolved conflict. The recollection of dreams can often be traumatic and emotional and these are 'the royal road to the unconscious'. Some motivations are so unacceptable to the client that they are expressed in disguise or symbolic form rather than being revealed directly (Corey, 2009, p. 76). The role of the therapist is to uncover hidden meanings by studying the symbols in the manifest content of the dream.

From an Islamic perspective, the Prophet Muhammad (ﷺ) said, 'There are three types of dreams: a righteous dream which is the glad tidings from Allah, the dream which causes sadness is from the devil (*Shaytaan*), and a dream from the ramblings of the mind' (Bukhârî and Muslim, cited in islamqa, n.d.). In another saying, Prophet Muhammad (ﷺ) said:

> If any one of you sees a dream that he likes, this is from Allah, so let him praise Allah for it and talk about it to others. If he sees other than that, a dream that he dislikes, this is from the *Shaytaan*, so let him seek refuge with Allah from its evil and not mention it to anyone, for it will not harm him.
>
> *(Bukhârî and Muslim, cited in islamqa, n.d.)*

Al-Haafiz Ibn Hajar said that dreams are either of two types: true dreams and mixed up false dreams:

> [True dreams are] dreams of the Prophets and of the righteous people who follow them. They may also happen to the other people, but this is very rare . . . True dreams are those which come true in real life as they were seen in the dream . . . Mixed up false dreams, which warn of something, are of different types. [For example,] games of the *Shaytaan* to make a person distressed, . . . or other dreams that cannot possibly make sense. [Or] when he sees something that happens to him in real life, or he wishes it would happen, and he sees it very realistically in his dream; or he sees what usually happens to him when he is awake or what reflects his mood. These dreams usually speak of the future or the present, rarely of the past.
>
> *(Cited in islamqa, n.d.)*

For those who have good dreams, Ibn Hajar said that 'a person should praise Allah for the good dream; he should feel happy about it and should talk about it to those whom he loves but not to those whom he dislikes'. In relation to bad dreams: the individual 'should seek refuge with Allah from the evil of the dream; seek refuge with Allah from the evil of the *Shaytaan*; should spit to his left three times when he wakes up; and should not mention it to anyone at all' (cited in islamqa, n.d.). In addition, it is recommended that one should pray. The wording of the narration is: whoever sees something he dislikes (in a dream) should not tell anyone about it; rather he should get up and pray (Bukhârî, cited in islamqa, n.d.). In addition, one should to turn over from the side on which one was lying (Muslim, cited in islamqa, n.d.).

According to Imam al-Baghawi, the interpretation of dreams:

> falls into various categories. Dreams may be interpreted in the light of the Qur'aan or in the light of the Sunnah, or by means of the proverbs that are current among people, or by names and metaphors, or in terms of opposites.
>
> *(Cited in islamqa, n.d.)*

It is narrated that an individual should not tell anybody about the dream except a very close friend who loves him very much, or who is very wise (Tirmidhî, cited in islamqa, n.d.). According to another report, the individual should not talk about it except for a scholar or one who will give sincere advice. Al-Qaadi Abu Bakr Ibn al-'Arabi said:

> as for the scholar, he will interpret it in a good way for him as much as he can, and the one who will give him sincere advice will teach him something that will be of benefit to him and will help him to do that. The one who is wise is the one who knows how to interpret it and will tell him only that which will help him, otherwise he will keep quiet. The one who is dear, if he knows something good he will say it, and if he does not know or he is in doubt, he will keep quiet.
>
> *(Cited in islamqa, n.d.)*

(For more information about the rules of dream interpretation see islamgreatreligion.wordpress.com, n.d.)

Conclusion

There is a general consensus that the psychodynamic approach to therapy and counselling is not congruent with Islamic principles. It is questionable whether it is possible to present Islam in a positive light when operating from a psychoanalytic perspective. It has been suggested that, if a psychologist starts with a model of psychology based on secular presuppositions, it is impossible to subsequently view religious belief or practice in a healthy light (Priester *et al.*, 2008). There is evidence to suggest that Muslim clients view psychotherapy as unnecessary (and exhibit preferences for spiritual healing, help from friends and family and/or medical advice). They also view it as an ineffective practice and there are perceived conflicts between psychotherapy and Islam (Smith, 2011). However, there is wide diversity in the psychodynamic model of therapy and counselling that can generate points of congruence for successful client–therapy airings (Amer and Jalal, 2012, p. 144). In a review of the literature, Fisher and Greenberg (1977) conclude that psychoanalytic theory cannot be accepted or rejected as a package: 'it is a complete structure consisting of many parts, some of which should be accepted, others rejected and the others at least partially reshaped'. Whether some of the techniques of psychodynamic therapy are valuable and effective with Muslim clients needs further investigation.

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10

HUMANISTIC APPROACH

Client-centred therapy

Introduction

Humanistic therapy is a multifaceted approach that embraces a diverse collection of practical approaches: existential, constructivist and transpersonal. The existential approach emphasises freedom, experiential reflection and responsibility; the constructivist approach focuses on personal and social constructions of psychological growth processes; and the transpersonal approach emphasises spiritual and transcendent dimensions of psychological wellness. Despite their multifarious perspectives, these philosophies within the humanistic paradigm explore (1) what it means to be fully, experiential human; and (2) how that understanding illuminates the vital or fulfilled life (Schneider and Leitner, 2002). Humanistic psychology and philosophy 'are time-honoured folk and academic traditions that stress deep personal inquiry into the meaning and purpose of life' (Schneider and Leitner 2002, p. 949). In this chapter, client-centred therapy (also known as client-centred counselling) will be examined. The implications of the theoretical framework and its applications to Muslim clients will be discussed.

The humanistic view of human nature

Humanistic therapy adopts a holistic approach to human nature and focuses on self-development, growth and responsibilities. The humanistic perspective views human nature as inherently good, with the potential to maintain healthy, meaningful relationships and to make choices that are in the interest of oneself and others. Rogers (1987) firmly maintained that people are trustworthy, resourceful, capable of self-understanding and self-direction, able to make constructive changes, and able to live effective and productive lives. Human nature, according to this approach, is the product of genetic factors, early development, environmental and societal influences

and an innate self-drive striving for growth throughout life. However, the potential for humans to grow and develop in a positive and constructive manner depends upon the establishment of a climate of respect and trust (Corey, 2009). In humanistic theory, the self is an organised set of characteristics that the person perceives as unique to him- or herself. It is our awareness of being and daily functioning, developed in relationships with others, and primarily formed through conditions of worth. However, our self has a real self and an ideal self, and the point of overlap is called 'congruence'. The ideal self is who we want to be, and the real self is who we actually are, who wants to move towards the ideal self. The increasing psychological gap between the real self and the ideal self would result in psychological problems.

According to Rogers (1987), a fully functioning person is one open to experience, with both positive and negative emotions, and with the ability to interpret experiences and innermost feelings. These individuals understand their own emotions and place a deep trust in their own instincts, gut reactions and urges and they have the ability to change through experiences. In addition, these individuals do not feel the need to distort or deny experiences and are open to feedback and willing to make realistic changes. These individuals also show creativity and have fulfilled lives. The fully functioning person:

> is completely congruent and integrated. Such a person, Rogers believes, is able to embrace 'existential living.' By this he means they are able to live fully in the here and now with personal inner freedom, with all its accompanying exciting, creative, but also challenging, aspects.
>
> *(Freeth, 2007, p. 38)*

Some of the essential characteristics of humanistic therapy (CSAT, 1999) are:

- Empathic understanding of the client's frame of reference and subjective experience.
- Respect for the client's cultural values and freedom to exercise choice.
- Exploration of problems through an authentic and collaborative approach to helping the client develop insight, courage and responsibility.
- Exploration of goals and expectations, including articulation of what the client wants to accomplish and hopes to gain from treatment.
- Clarification of the helping role by defining the therapist's role, but respecting the self-determination of the client.
- Assessment and enhancement of client motivation both collaboratively and authentically.
- Negotiation of a contract by formally or informally asking, 'Where do we go from here?'
- Demonstration of authenticity by setting a tone of genuine, authentic encounter.

The goals of person-centred therapy are different from those of psychoanalytical or cognitive behaviourist approaches. The person-centred approach aims towards setting clients free to engage in self-exploration and enabling clients to achieve a

greater degree of independence and integration. Rogers (1977) did not believe the aim of therapy was to solve problems, but to nudge clients in their growth process so they could better cope with their current and future problems. The focus of the therapy is not on the individual's presenting problem, but on the person. In addition, the aims of person-centred therapy are to increase greater openness to experience and to enhance self-esteem. The personal growth and development that this form of therapy seeks to foster in clients includes a closer agreement between the client's idealised and actual selves; better self-understanding; lower levels of defensiveness, guilt and insecurity; more positive and comfortable relationships with others; and an increased capacity to experience and express feelings at the moment they occur (www.minddisorders.com, n.d.).

The Rogerian approach to counselling

The Rogerian approach is the most widely used humanistic approach in the field of counselling and psychotherapy. Since it shares the principles of the humanist tradition, it puts emphasis on experiential processes, rather than on the aetiology of clients' problems in their early childhood relationships with their parents, as psychoanalysis does. The Rogerian mode of therapy is also known as the non-directive or person-centred approach. It is called so, because the role of the expert is transferred from the therapist to the client, who is regarded as responsible for, and capable of, reaching his or her own solutions for his or her own problems (McLeod, 2009; Nelson-Jones, 1982).

Rogers' form of therapy and counselling is characterised by three core conditions that offer a basis on which to build a healthy therapeutic relationship: (1) congruence between the therapist and the client; (2) unconditional positive regard towards the client; and (3) empathy with the client. Mearns and Thorne (1999) define the role of each of the core conditions: they see empathy as a 'process'; unconditional positive regard as an 'attitude'; and congruence as a 'state of being' in the therapeutic relationship with the client (p. 81). The first core condition of congruence is explained by Rogers (1980):

> The first element could be called genuineness, realness, or congruence. The more the therapist is himself or herself in the relationship, putting up no professional front or personal facade, the greater is the likelihood that the client will change and grow in a constructive manner. This means that the therapist is openly being the feelings and attitudes that are flowing within at the moment. The term 'transparent' catches the flavor of this condition: the therapist makes himself or herself transparent to the client; the client can see right through what the therapist is in the relationship; the client experiences no holding back on the part of the therapist. As for the therapist, what he or she is experiencing is available to awareness, can be lived in the relationship, and can be communicated, if appropriate. Thus, there is a close matching, or congruence, between what is being experienced at the gut level, what is present in awareness, and what is expressed to the client.
>
> *(pp. 115–16)*

Thus, congruence (also known as genuineness) is the most important concept in therapeutic counselling, according to Rogers. That is, the counsellor's ability is to be authentic and share his or her feelings regarding the client's experiences. This is not about the self-disclosure of the counsellor's problems. By being genuine and authentic, the counsellor can help teach the client to also develop this important skill.

In the core condition of unconditional positive regard, the counsellor must value, accept and care for the client, whatever her or his problems or behaviour or what the client is facing or experiencing. According to Rogers (1980):

> Unconditional positive regard means that when the therapist is experiencing a positive, acceptant attitude toward whatever the client is at that moment, therapeutic movement or change is more likely. It involves the therapist's willingness for the client to be whatever feeling is going on at that moment – confusion, resentment, fear, anger, courage, love, or pride . . . The therapist prizes the client in a total rather than a conditional way.
>
> *(pp. 115–16)*

Rogers believed that people often develop psychological problems largely because they are used to receiving only conditional support. That is, an individual would be accepted if he or she conformed to another's certain expectations. However, when acceptance or approval of the individual is based on certain conditions, the individual is being denied unacceptable aspects of him- or herself. Thus, by distorting the self-concept, the individual develops unhealthy, unproductive behaviours. When the counsellor establishes a climate of unconditional positive regard, the client feels able to express his or her emotions without fear of rejection. However, having unconditional positive regard does not mean approval of the attitude or the dysfunctional behaviour.

The third facilitative aspect of the relationship is empathic understanding. According to Rogers (1980):

> This means that the therapist senses accurately the feelings and personal meanings that the client is experiencing and communicates this understanding to the client. This kind of sensitive, active listening is exceedingly rare in our lives. We think we listen, but very rarely do we listen with real understanding, true empathy. Yet listening, of this very special kind, is one of the most potent forces for change that I know.
>
> *(pp. 115–16)*

That is, counsellors need to be reflective, acting as mirrors of their clients' feelings and thoughts without contaminating that understanding with their own thoughts or feelings. According to Watson (2002), full empathy entails understanding the meaning and feeling of a client's experience and is the most powerful determinant of client progress in therapy. She also maintained that:

> Therapists need to be able to be responsively attuned to their clients and to understand them emotionally as well as cognitively. When empathy is operating on all three levels, interpersonal, cognitive, and affective, it is one of the most powerful tools therapists have at their disposal.
>
> *(pp. 463–4)*

According to Rogers, if therapists communicate these attitudes, their clients are able to grow psychologically, become less defensive and more self-aware, and change their behaviour in a positive way. The basic drive to fulfilment implies that people will move towards health if the way seems open for them to do so (Corey 2009, p. 169).

Self-actualising tendency

Rogers (1951) believed that every individual has the potential to achieve his or her goals, wishes and desires in life: 'The organism has one basic tendency and striving – to actualize, maintain, and enhance the experiencing organism' (p. 487):

> This means that self-actualization occurs when a person's 'ideal self' (i.e., who they would like to be) is congruent with their actual behaviour (self-image). Rogers describes an individual who is actualized as a fully functioning person. The main determinant of whether we will become self-actualized is childhood experience.
>
> *(McLeod, 2007)*

According to the client-centred approach, the existence of three conditions is sufficient for the individual to be able to make use of his or her own resources, for self-understanding and to become a fully functioning person (McLeod, 2009). It is when the counsellor can be a certain way by embodying certain attitudinal qualities, that the client's actualising tendency is promoted (Bozarth, 1998). In summary, the actualising tendency develops growth, promoting capacities within the organism, moves towards autonomy, and is directional, constructive and present in all organisms. It can be suppressed or corrupted, but never destroyed as long as the organism is alive. It removes guilt and stress, for example, and controls needs, drives, pleasure seeking and creativity.

Rogers (1961, pp. 125–59) developed his theory of the seven stages of how change takes place in individuals through counselling and what a client might experience. A brief outline of these stages is as follows:

- *Stage One*: The client is very defensive and extremely resistant to change.
- *Stage Two*: The client becomes slightly less rigid and will talk about external events or other people.
- *Stage Three*: The client talks about him- or herself, but as an object, and avoids discussion of present events.

- *Stage Four*: The client begins to talk about deep feelings and develops a relationship with the counsellor.
- *Stage Five*: The client can express present emotions and is beginning to rely more on his or her own decision-making abilities and increasingly accepts more responsibility for his or her actions.
- *Stage Six*: The client shows rapid growth towards congruence and begins to develop an unconditional positive regard for others. This stage signals the end of the need for formal therapy.
- *Stage Seven*: The client is a fully functioning, self-actualising individual who is empathic and shows unconditional positive regard for others. This individual can relate her or his previous therapy to present-day real-life situations.

These stages are not linear and it is normal and natural to regress, to attain one stage only to fall back to a previous stage. This is just a normal part of making behavioural changes as shown in the Stages of Change model (Prochaska and Di Clemente, 1992).

The role of the counsellor

The role of the person-centred counsellor is embedded in the behaviour and attitude of the counsellor rather than in techniques and strategies. Research on person-centred therapy seems to indicate that the attitude of therapists, rather than their knowledge, theories or techniques, facilitates personality change in clients (Rogers, 1961). So, basically, this type of therapy is about relationships, not about techniques. It is the therapist's attitude and belief in the inner resources of the client that create the therapeutic climate for growth (Bozarth *et al.*, 2002). The counsellor always stays with the client and strives to understand the client's worldview or the client's frame of reference. The counsellor, being non-directive, does not interfere with, or direct the flow of, the conversation and the client has complete freedom to choose what to talk about, or not talk about. It is the counsellor who creates the right atmosphere to allow clients to find their own solutions and help.

Person-centred theory holds the view that the counsellor must be willing to be real in the relationship with clients by being congruent, accepting and empathic; the therapist is a catalyst for change (Corey, 2009, p. 171). Person-centred counsellors are antithetical to taking a history, asking leading and probing questions, making interpretations of the client's behaviour, evaluating the client's ideas or plans, or deciding for the client on the frequency or length of the therapeutic venture (Broadley, 1997). One reason why Rogers rejected interpretation in client-centred counselling was that he believed that, although symptoms did arise from past experience, it was more useful for the client to focus on the present and future than on the past (McLeod, 2008).

Client-centred therapy from an Islamic perspective

The applicability of the person-centred counselling approach to non-Western clients or in the Islamic context has been under ongoing deliberation (Abdallah,

2011; al-Thani, 2012; Badri, 2014; Mohamad *et al.*, 2011; Nassar-McMillan and Hakim-Larson, 2003; Poyrazli, 2003; Sue and Sue, 1999). Although Islamic counselling exhibits Islamic spirituality and religiosity as a way of life (Lubis, 2011), the framework of client-centred counselling in its purest form is not fully congruent with Islamic principles and practice. Somehow, spirituality is not formally addressed or recognised in person-centred theory (Barrineau, 1990), but it is not unfamiliar with it. Rogers (1980) expressed this spiritual or mystical direction in several of his writings: 'The transcendent, the indescribable, the spiritual' (p. 130). He describes it thus:

> When I am somehow in touch with the unknown in me . . . then whatever I do seems to be full of healing. But these strange behaviours turn out to be right in some odd way. At those moments it seems that my inner spirit has reached out and touched the spirit of the other. Our relationship transcends itself and becomes part of something larger.
>
> *(Rogers, 1980, p. 129)*

Al-Thani (2012) stated:

> both Islamic society and the Person-Centred Approach (PCA) are interested in applying 'spirituality' to helping and supporting clients psychologically. Irrelevant as to how the term is applied, both approaches seek to provide a safe atmosphere where people feel accepted and loved.
>
> *(p. 18)*

Spirituality has different meanings and this depends on the context in which the concept is used. In most secular societies, it is acknowledged that not every individual who seeks self-awareness, self-empowerment and self-actualisation pursues a particular religious belief (Rassool, 2000). However, spirituality is often seen as broader than religion. But there is a resemblance between religio-spirituality and counselling as both offer solutions to the struggles of man (Corey, 2013). In the Islamic context, there is no spirituality without religious thoughts and practices, and the religion of Islam provides the spiritual path for salvation and a way of life (Rassool, 2014).

However, al-Thani (2012), in a review of the literature, found that there are remarkable positive similarities between the patient-centred approach and the Islamic perspective in relation to the nature of the human being, including spirituality, self-responsibility, the fully functioning person and the core conditions. According to al-Thani (2012), human beings are highly appreciated in both Islam and the person-centred approach. Both approaches view the individual as responsible or accountable for her or his personal actions and as having responsibility for inner changes. Both Islamic and person-centred counsellors 'tend to encourage the client to become fully functioning with a positive attitude to the direction of the self and others, taking responsibility for their own actions and choices' (p. 19).

In addition, both perspectives believe in the importance of self-awareness in the process of change for the individual. The person-centred approach is the closest approach to Islamic counselling, as it focuses on the counselling relationship and encourages clients to be active and take responsibility for their behaviours (al-Shenawi, 1998).

The main argument against the application of client-centred counselling to Muslim clients is due to the inherent values or cultural differences. Values such as assertiveness, open expression of emotion, individual decision making and personal freedom are greatly valued in Western-oriented society (Sue and Sue, 1999). Islam disagrees with the underlying philosophical principles of all approaches of counselling based on individualism, relativism and humanism (Abdallah, 2011; Badri, 1996). In the Islamic context, traditional and authoritarian values such as privacy with regard to family matters, respect for authorities, little expression of emotion and group decision making are present (Nassar-McMillan and Hakim-Larson, 2003; Poyrazli, 2003).

From an Islamic perspective, the main concern about using the person-centred approach is the lack of direction in its egalitarian counsellor–client relationship style, and its dependence on the counsellor's personal qualities of genuineness, unconditional positive regard and empathy in facilitating the client's process of personal growth (Mohamad *et al.*, 2011). There is an assumption that the rapport in the therapeutic relationship and the characteristics of the counsellor are there to 'nudge' the client in their personal growth and development. This non-directive and egalitarian approach to counselling may be counterproductive in working with Muslim clients. The counsellor is perceived as a professional, an expert and an authority figure, which is expected to provide structure and direction for clients in coping with their problems. From this clinical point of view, Dwairy (2006) states that non-directive and non-judgemental therapy can be very confusing, especially in the early stages of therapy. A more active and structured approach with clients is effective and the non-directive approach will not work (Basit and Hamid, 2010).

One of the criticisms of client-centred counselling is the contradictory nature of the genuineness of the counsellor and the unconditional acceptance of the client. Badri (2014) argued that no one can have a genuine artificial social relationship with anyone without being judgemental as we are making judgements about people all the time. It is unfeasible for counsellors to be neutral and devoid of personal and professional values. A potential drawback is that counsellors may try so hard to be non-judgemental and supportive of clients, that their counselling responses may deprive clients of congruence and genuineness (Yusoff, 2011). A counsellor may in theory be committed to unconditional positive regard, but, in practice, may find this difficult when working in a multicultural counselling context (MacDougall, 2002). This is particularly so in societies where moral and religious teachings are highly valued (Badri, 2014), such as Islamic communities. The idea of unconditional positive regard is not in congruence with the Islamic faith. There are certain facets of human behaviour that are not acceptable within the realm of Islam. Allah says in the Qur'aan (interpretation of the meaning):

> *their hearts are disapproving, and they are arrogant . . . Assuredly, Allah knows what they conceal and what they declare. Indeed, He does not like the arrogant.*
>
> *(An-Naḥl (The Bee) 16:22–3)*

The Prophet (ﷺ) said: 'He who has in his heart the weight of an atom of pride shall not enter Paradise' (Muslim, n.d.). In another saying, the Prophet (ﷺ) also said: 'The Fire complained saying: "I am the dwelling of the arrogant and the tyrants"' (Bukhârî and Muslim, cited in islamweb, n.d.). Other unacceptable behaviours include: mischief (Qur'aan 2:11–13); corruption (2:205; 16:88; 30:41); transgression (4:14); lying (6:21); evil (17:11; 30:10); and adultery or fornication (24:2–3).The Prophet (ﷺ) said

> Whosoever possesses these four characteristics, is a sheer hypocrite; and anyone who possesses one of them, possesses a characteristic of hypocrisy till he gives it up. (These are:) When he talks, he tells a lie; when he makes a covenant, he acts treacherously; and when he quarrels, he utters foul language.
>
> *(Bukhârî and Muslim, cited in Sunnah.com, n.d.)*

In Islamic terminology, self-actualisation corresponds to the *fitrah*, 'which guides humanity to the true faith of Allah and complete fulfilment of their potential' (Utz, 2011, p. 47). That is:

> Everyone is born already self-actualized (*fitrah*) and his upbringing might disrupt how he perceives the 'realities' once he's 'mature'. He might have to rediscover or refresh the reality. And when he knows that the reality is beyond the evidence, he'd look for the divine guidance, and revealed steps to reach self-gratification through them.
>
> *(Tahir, 2011)*

Within the client-centred counselling approach, self-actualisation is the agent that allows therapy to improve the 'self' of the client. In this process, the client's 'self' must not be directed or influenced by the counsellor. However, the 'ultimate goal, realizing one's potential, . . . necessitates a balanced view of the self . . . such as self-esteem, self-concept, or self-confidence . . . [which] is a prerequisite for understanding self-actualization' (Ozsoy, 2010).

Self-actualisation, it has been suggested, 'dovetails nicely with the Islamic belief systems because both the humanistic approach and the Islamic faith stress the prospects of self-transformation and human potential (Amer and Jalal, 2012, p. 104). According to the Qur'aan (2:30), the human being is the 'vicegerent on earth', representing God. Thus, the need of human beings is to fulfil that goal by actualising their full potential (physical, social, psychological and spiritual). For Muslims, the route of self-actualisation is only possible through the path laid down by Allah and the guidance of the last Messenger of God (ﷺ). Allah says in the Qur'aan (interpretation of the meaning):

> *Except for those who repent, believe and do righteous work. For them, Allah will replace their evil deeds with good. And ever is Allah Forgiving and Merciful.*
>
> *(Al-Furqān (The Criterion) 25:70)*

That is, 'those who repent in this world to Allah for all of those deeds, for then Allah will accept their repentance . . . and will replace the evil deeds with good merits' (Ibn Kathir, n.d.). Other verses in the Qur'aan reinforced this, saying (interpretation of the meaning):

> *And whoever does a wrong or wrongs himself, but then seeks forgiveness of Allah will find Allah Forgiving and Merciful.*
>
> *(An-Nisā' (The Women) 4:110)*

> *Know they not that Allah accepts repentance from His servants.*
>
> *(At-Tawbah (The Repentance) 9:104)*

> *Say, 'O My servants who have transgressed against themselves [by sinning], do not despair of the mercy of Allah. Indeed, Allah forgives all sins. Indeed, it is He who is the Forgiving, the Merciful.*
>
> *(Az-Zumar (The Troops) 39:53)*

Amer and Jalal (2012, p. 104) suggested that this aspect shows how Islamic beliefs do not promote the idea of dwelling in the past but promote self-actualisation.

There have been a few criticisms regarding the promotion of self-actualisation in the counselling process with Muslim clients. Al-Bahadel (2004) argues that self-actualisation is not acceptable in Islamic collective society, where individuals are considered part of the whole. The maintenance of the collective structure by means of community obligation (*Fard kifaya*) is more important than the autonomy of the self; that is, some sort of community self-actualisation rather than individual actualisation. In Qatari society, "self-actualisation may be regarded as selfishness that threatens the harmony of the collective, and therefore the client must expect to face rejection and social sanctions, which may be rendered unendurable" (al-Thani, 2012). It is assumed that this phenomenon may also apply to most Muslims. Dwairy (2009) has warned that attempting to reveal unconscious content and promoting self-actualisation may be counterproductive for clients who come from collectivistic cultures. Such treatment goals may expose clients to confrontations with the family and the social environment. As an alternative viewpoint, it has been suggested that the way towards self-actualisation and social reform is gained through the practice of fasting, prayer and caring. All of these are heightened during the blessed month of *Ramadhan* (Choudhury, 2010).

Client-centred counselling: applying the core conditions in an Islamic context

Client-centred counselling's real value lies in the recognition that its application will need to be modified to accommodate Muslim clients. In Islamic counselling, the

counsellor plays a direct role and enables the client to understand and apply the beliefs and practices prescribed in Islam. In Islam, the ideal self is in living and following the Qur'aan and Sunnah. It has been suggested that some of the common behaviours of self-actualisers are built into the Islamic code of conduct (Nafla, 2014), including: living with mindfulness (*khushoo*), concentration and being fully absorbed (prayer, remembrance of God, recitation of the Qur'aan); honesty and avoiding false appearances; accepting criticism and opposition with ease; commitment to hard work and sense of responsibility; and honest self-assessment and spiritual improvement (*Tazikiyyah*).

There is a set of six 'core conditions' that are necessary and sufficient for therapeutic change: psychological contact; client incongruence; therapist congruence, or genuineness; unconditional positive regard; empathic understanding; and client perception (Rogers, 1957, 2004). In addition, from an Islamic perspective, there is an emphasis on spiritual solutions based on love and fear of Allah and the duty to fulfil our responsibilities as the servants of Allah on this earth (Hallen, 2002, cited in Sandarwati, 2013). Al-Thani (2012) stated that the person-centred approach's core conditions, view of the self, and importance of warmth and gentleness are applicable within an Islamic context. There are some similarities between Rogers' core conditions and those from the Qur'aan and Sunnah. Some of the Islamic 'core conditions' include: working perfectly, trust, acceptance, understanding, genuineness, respect, humility and good habits such as loving what is good for the self and others. The instillation of Islamic values, such as moral behaviour, is based on the Qur'aan and Sunnah. A Muslim needs to try to emulate the behaviour and the morality of the Prophet Muhammad (ﷺ). Allah confirms that in a verse (interpretation of the meaning):

> *There has certainly been for you in the Messenger of Allah an excellent pattern (model) for anyone whose hope is in Allah and the Last Day and [who] remembers Allah often.*
> *(Al-'Aĥzāb (The Combined Forces) 33:21)*

Allah has described the Prophet's (ﷺ) patience in listening to others (interpretation of the meaning):

> *And say, 'He is an ear.' Say, '[It is] an ear of goodness for you that believes in Allah and believes the believers and [is] a mercy to those who believe among you.'*
> *(At-Tawbah (The Repentance) 9:61)*

Prophet Muhammad (ﷺ) is our model and example in showing compassion about others' concerns. The following verse describes the character of the Prophet (ﷺ) in dealing with his followers (interpretation of the meaning):

> *So by mercy from Allah, [O Muhammad], you were lenient with them. And if you had been rude [in speech] and harsh in heart, they would have disbanded from about you. So pardon them and ask forgiveness for them and consult them in the matter. And when you have decided, then rely upon Allah. Indeed, Allah loves those who rely [upon Him].*
> *('āli 'Imrān (The Family of Imran) 3:159)*

According to al-Qarnee (2002), gentleness and goodness are essential in making relationships with the self and others healthy and effective, as the Prophet (ﷺ) stated: 'Whenever gentleness is present in something, that thing is beautified; when gentleness is removed from something, that thing becomes spoiled' (p. 437).

The following is a summary of client-centred counselling from an Islamic perspective:

- Client-centred counselling should conform to Islamic principles to help Muslims with life and psychosocial problems.
- The counsellor needs to have a deep understanding of the religious (and cultural) background of the Muslim client, but to be aware that different clients have different levels of religious understanding. Having trust in Allah (*Tawakkul*) is one of the Islamic 'core conditions'.
- Gratitude should be shown to Allah when there is improvement in the client's state or circumstances (core condition, if appropriate).
- The counsellor needs to understand the worldview of the Muslim client.
- Structuring is necessary whenever a client does not know what is involved in the therapeutic relationship – how the counsellor will function and what is expected of the client – or holds misconceptions about the process (Patterson, 1996).
- The discussed similarities, especially that of 'self-actualisation', can be modified when counselling a Muslim client to accommodate Islamic values, the Noble Qur'aan and Prophetic teachings (al-Thani, 2012, p. 309).
- There should be use of directive and non-directive approaches (psychological and spiritual direction; guiding and advising; making suggestions, disclosing thoughts and feelings).
- Communication/counselling styles should be adapted because of cultural and socio-political factors (Wehrly, 1995).
- The counsellor needs to exhibit reflective feelings. In some cases the focus should be beyond the individual to religious issues.
- The counsellor sensitively encourages the Muslim client to follow the Qur'aan and the teachings of Prophet Mohammad (ﷺ).
- Family and other significant relationships need to be considered as part of the counselling process.
- The counsellor encourages the client to work from within and build a healthy relationship with the self (al-Thani, 2012, p. 309).
- The use of spiritual interventions (see Chapter 14) and religious support should also be applied when working with Muslim clients.

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11

COGNITIVE BEHAVIOURAL THERAPY

An Islamic perspective

Introduction

Cognitive behavioural therapy (CBT) is a widely recognised intervention strategy for psychological problems. CBT is an effective form of psychotherapy for a variety of psychological conditions, including anxiety and stress, depression, eating disorders, panic disorder and phobias (Butler *et al.*, 2006; Chambless and Ollendick, 2001; Hofmann *et al.*, 2012; Leahy and Holland, 2000). Modern CBT refers to a family of therapies including meta-cognitive therapy, mindfulness-based therapy, mindfulness-based cognitive therapy, dialectical behaviour therapy, acceptance and commitment therapy, internet-based CBT and the utilisation of mobile devices as an augmentation to CBT (Beck and Haigh, 2014; Bee *et al.*, 2008; Hofmann, 2011; Hofmann and Asmundson, 2008; Hofmann *et al.*, 2013; Khoury *et al.*, 2013; Linehan, 2000; Mundy and Hofmann, 2014; Sauer-Zavala *et al.*, 2012; Segal *et al.*, 2013; Swain *et al.*, 2013). In general, cognitive theories maintain that maladaptive or irrational thinking (cognitions) contribute to the maintenance of emotional and psychological problems (Beck, 1976; Ellis, 1962). That is, it is the maintenance of cognitive factors that is responsible for the development of emotional distress and behavioural problems. Within this approach, physiological, emotional and behavioral aspects, in combination with cognitive factors, are also recognised for their contributions to the maintenance of psychological problems. The intervention strategies combine a variety of cognitive, problem-solving, behavioural and emotion-focused techniques to change or modify these maladaptive cognitions, and replace them with more constructive thoughts in order to positively affect emotion and behaviour. The strategies and techniques within this approach vary, but the underlying philosophy is the same (Hamdan, 2008). One of the key features of CBT is that its action-oriented and problem-solving approaches to managing thoughts, emotions and behaviours are more effective. So, the overall goal of

therapy is symptom reduction, improvement in functioning and remission of the disorder (Hofmann *et al*., 2012). This chapter will examine the use of cognitive behavioural therapy and its application to Muslim clients.

Cognitive theory – the nature of man

Cognitive behavioural therapy is based on a view that humans have potential for both rational and irrational thoughts. The rational thoughts include self-preservation, happiness, thinking, verbalising, loving, interpersonal communication, growth and self-actualisation. Irrational thoughts include intolerance, avoidance of thought, self-blame, avoidance, procrastination, endless repetition of mistakes, superstition, intolerance and self-destruction. The cognitive theory of human nature views psychological and behavioural problems as a result of the role of an individual's belief system and his or her internal dialogue. Faulty thinking or irrational thoughts begin during childhood and these irrational thoughts result in attitudes and beliefs leading to dysfunctional behaviour. However, it is the behaviour that is often identified as the problem or issue when, in reality, it is the symptom of irrational cognitions. Within this framework, it is fully acknowledged that we are largely responsible for creating our emotional problems and accepting we have the ability to change.

Cognitive behavioural therapy

CBT is a form of psychotherapy that emphasises that our cognitions (thoughts) cause our feelings and behaviours, not external things such as people, situations and events. Beck (1976) suggested that some individuals develop systematic patterns of negative or irrational thoughts based on the way they interpret information, which helps to explain their vulnerability to emotional problems. Cognitive behavioural theory is based on the principles that an organism's activity has three modalities: behaviour, emotion and cognition. An elaborated definition of CB theory has been proposed by Dobson and Dozois (2010) in the form of three essential propositions: (1) thinking and cognitions affect behaviour; (2) cognitive activity is accessible and is amenable to change; and (3) desired behavioural change may follow from changes in thinking. In relation to the first assumption, cognitive activity affects behaviour and is based on the assumption that the way an individual evaluates an event can affect the response to those events (Dobson and Dozois, 2010; Steiman and Dobson, 2002). The second shared assumption of cognitive behavioural therapies is that cognitive activity is accessible, and may be monitored and altered. The third common assumption is that desired behaviour change may be effected through cognitive change. That is, changes in thinking would result in behavioural changes.

There is a general consensus among cognitive behavioural theorists and clinicians that individuals possess cognitive entities or structures, known as *schemas*. Schemas are defined as 'cognitive structures that organize and process incoming

information' (Dobson and Dozois, 2010, p. 14). A schema is basically a system of information that dictates how people think about things and interpret the world. Schemas are often considered to be synonymous with terms such as 'core belief' and 'irrational belief' (DeRubeis *et al.*, 2010) and are acquired by developmental influences and accumulated life experiences. These core beliefs play a major role in regulating self-worth and behavioural coping strategies. The schemas of well-adjusted individuals permit the realistic appraisal of life events, whereas those of maladjusted individuals result in distorted perceptions, faulty problem-solving and psychological disorders (Beck, 1976; Dozois and Beck, 2008). Schemas are a frequent target of CBT interventions.

The role and function of the counsellor

The principal role of a counsellor is to help a client to identify her or his style of thinking and to modify it through the use of evidence and rationality. It has been suggested that cognitive behavioural practitioners often structure their treatment in a serial manner, and the first target for change focuses on any maladaptive automatic thoughts (Beshai *et al.*, 2012a). For example, the counsellor will show clients how they have incorporated many irrational beliefs such as 'should', 'ought' and 'must' as part of their repertoires. These irrational beliefs are challenged and the clients are nudged to engage in activities and to replace their rigid 'must' with preferences. A second step in the therapeutic process is to 'demonstrate how clients are keeping their emotional disturbances active by continuing to think illogically and unrealistically' (Corey, 2009, p. 280). Subsequent phases of therapeutic interventions involve helping clients to modify their thinking and minimise their irrational ideas, and challenge clients to develop a rational philosophy of life (Corey, 2009). In a later phase of treatment, the counsellor may explore the core beliefs of the client, with the aim of changing the dysfunctional core schemas as the goal (Persons and Davidson, 2001).

The counsellor may use a number of cognitive and behavioural techniques as part of the therapeutic process. Open-ended questions are used to enable clients to recognise the rigid patterns of dysfunctional thinking and to see new perspectives. This type of questioning involves 'Socratic' questioning (asking questions that guide the patient to become actively involved in finding answers) and guided discovery (a series of questions that help the patient explore and change maladaptive cognitive processes) (Wright, 2006). Other activities that distinguish CBT from other therapeutic approaches include: the use of homework and outside-of-session techniques; the therapist's direction of session activity, as cognitive behavioural therapists exert relatively more control over the process of therapy than seen in other treatment modalities; the psychoeducational nature of CBT; a focus on current and future functioning of the client; an emphasis on providing clients with information regarding their disorders and associated symptoms; and the allocation of a relatively large amount of time to evaluate, challenge and modify clients' cognitions (Beshai *et al.*, 2012a; Blagys and Hilsenroth, 2002; Dobson and Dozois, 2010).

Cognitive behavioral therapy for Muslim clients: effective philosophy

The philosophical and theoretical bases of CBT are examined in Beshai *et al.* (2012a). Their paper highlights the potential philosophical dissonance between CBT and the Islamic tradition, but also illuminates several ways in which the seemingly divergent underlying principles are complementary. The philosophical and theoretical bases of CBT and Islamic principles include the nature of reality (empiricism/science); the source of individual misfortune; behavioural or emotional change; self-control; and individual rights (Beshai *et al.*, 2012a). However, several factors have been identified that may cause potential conflict between CBT and Islam.

First, Islamic principles are more in line with rationalism than with constructivism, which is the basis of cognitive theory. That is, 'rationalism maintains that an absolute, objective reality exists and is accessible through the senses' (Beshai *et al.*, 2012a). Second, Muslim clients are not necessarily viewed as the architects of their own tribulations or hardships, since everything from good to bad that happens to Muslims is determined by Allah. The belief in destiny or fate (*Qadar*) is the sixth pillar of faith (*Iman*). Belief in predestination means accepting that Allah is the architect of everything and has predestined everything. This is clearly stated in the Qur'aan. Allah says (interpretation of the meaning):

> *Indeed, all things We created with predestination.*
>
> *(Al-Qamar (The Moon) 54:49)*

This is further reinforced in many other verses in the Qur'aan, including (interpretation of the meaning):

> *Say, 'Never will we be struck except by what Allah has decreed for us; He is our protector.' And upon Allah let the believers rely.*
>
> *(At-Tawbah (The Repentance) 9:51)*

> *Say, 'I possess not for myself any harm or benefit except what Allah should will. For every nation is a [specified] term. When their time has come, then they will not remain behind an hour, nor will they precede [it]'.*
>
> *(Yūnus (Jonah) 10:49)*

So good, evil and whatever happens in this world happens by Allah's will. Allah says in the Qur'aan (interpretation of the meaning):

> *But if good comes to them, they say, 'This is from Allah'; and if evil befalls them, they say, 'This is from you.' Say, 'All [things] are from Allah.' So what is [the matter] with those people that they can hardly understand any statement?*
>
> *(An-Nisā' (The Women) 4:78)*

This is explained by Sheikh Muhammad Ibn al-'Uthaymin:

> They may be reconciled by noting that the first verse refers to the decree of Allah, for example, it is from Allah; He is the one who decrees it. The second verse refers to the cause for example, i.e., whatever of evil befalls you, you are the cause, and the One Who decrees evil and decrees the punishment for it is Allah.
>
> *(Cited in islamqa, n.d.)*

Psychological disorders are perceived to emanate from (or at least to be allowed by) God and may also be perceived as a test or punishment from God (Abu-Ras *et al.*, 2008; Beshai *et al.*, 2012a; Haque, 2004a; Padela *et al.*, 2012; Rassool, 2000). Trials and tribulations in life teach us that we must adhere to Allah's natural and moral laws.

In relation to behavioural/emotional change, CB theory posits that desirable change in behaviours and emotions necessarily follows a change in cognition. From an Islamic perspective, 'desirable changes in behaviours and emotions do not necessarily follow from cognitive change, but do so if God wills' (Beshai *et al.*, 2012a). This is because 'everything that takes place in creation happens according to God's will, whether it is the result of God's action or what is done by humans' (Philips, 2007, p. 146). It seems that whatever action takes place is by His own wish. In the Qur'aan, Allah says (interpretation of the meaning):

> *It is not except a reminder to the worlds. For whoever wills among you to take a right course. And you do not will except that Allah wills – Lord of the worlds.*
>
> *(At-Takwīr (The Overthrowing) 81:27–9)*

This is clear evidence indicating that the actions of Allah's creatures are according to Allah's will. If Allah did not wish them to act, the action would not have occurred (Philips, 2007, p. 147).

In cognitive theory, individuals are free and thus capable of controlling their thoughts, assumptions and core beliefs, whereas Islamic principles view that individuals' actions are not entirely free. Metaphysical entities act upon, and to some extent control, human behaviour (Beshai *et al.*, 2012a). It is important to understand that the concepts of predestination and free will do not negate one another: both are considered equally true. Bynum (2006) stated:

> everything that occurs in the reality of the material world we live in is a direct result of Allah's will. Human will is but an instrument of the will of Allah and therefore does not have an independent existence in the overall trend of Islamic thought. Even though the concept of 'testing' is present, Allah's will is never subservient to human will.

In CBT 'the self is separate and discernible from others. Thus, self-interests and individual rights are promoted. Whereas, the Islamic principle states that "The self

is not separable from others. The collective's rights and interests eclipse those of the individual'" (Beshai *et al*., 2012a).

Despite Islam's heavy emphasis on individual free will and accountability, collectivism plays a central role in Muslim society. Both Qur'aanic principles and Hadiths stress the importance of working for the collective good, taking care of others, maintaining unity in the face of opposition or threat, and striving towards common goals. Collectively on a community level, according to Imam Dr Mufti Abduljalil Sajid (2012):

> a Muslim's obligation is to establish what is right and eradicating what is wrong; Strive for an Islamic identity supporting, promoting and protecting a Muslim way of family life; Dealing with health and educational issues and for the creation of a condition wherein perseverance of mutual compassion and well-being prevail for the benefit of the individual.

The Qur'aan sees no contradiction between unity and commanding good and forbidding wrong. Allah says (interpretation of the meaning):

> *The believing men and believing women are allies of one another. They enjoin what is right and forbid what is wrong and establish prayer and give zakat and obey Allah and His Messenger. Those – Allah will have mercy upon them. Indeed, Allah is Exalted in Might and Wise.*
>
> *(At-Tawbah (The Repentance) 9:71)*

By commanding what is right and forbidding what is wrong, collectivism provides a mechanism whereby the Muslim Ummah can fight off various social, moral and spiritual ills and maintain a healthy and dynamic life (Shafaat, 1987). The Prophet (ﷺ) said: 'None of you truly believes until he loves for his brother what he loves for himself' (IslamToday, n.d.). The importance of this Hadith is to show how people are supposed to relate to each other. It also negates the base emotions such as envy and establishes the vision of a society built upon love and compassion, where every member works for the good of all members (al-Nawawî, cited in Zarabozo, 1999). In summary, the strongest evidence of Islamic collectivism can be found in Muslim families; fundamental collectivist Islamic principles such as brotherhood, equality and compassion form the backbone of the Muslim social order (Bradley, n.d.). The main areas of dissonance between CBT and Islamic ideology include: the religious fervour exhibited by the client; the nature of the presenting problem; the level of modification therapists introduce to standardised forms of CBT for Muslim clients; the level of cognitive change targeted in treatment (Beshai *et al*., 2012a); and the language used in the therapeutic process (Thomas and Ashraf, 2009).

CBT: an Islamic perspective

Humans have always looked to faith and religious belief for answers to psychological and spiritual problems. During the time of the Prophet Muhammad (ﷺ),

alcohol was forbidden through several separate verses revealed in the Qur'aan at different times. However, the stages for prohibition of alcoholic drinks, where heavy and problem drinkers were gradually weaned off this habit, had some striking similarities with modern behaviour therapy called systematic desensitisation (Badri, 1976; Mufti, n.d.). A large number of Muslim scholars have specialised in the field of psychology, including 'purification of the soul' (*Tazkiat un-Nafs*) or 'refinement of the soul' (*Tahdhib un-Nafs*). During the golden era of Islamic civilisation, the Islamic scholars claimed that the body, like the human soul, would become sick and unhealthy and, thus, it requires treatment such as psychotherapy and counselling (Omar, 2004).

The methods of psychotherapy were introduced by the Muslim physician Abu Bakar Muhammad Zakaria al-Razi; cognitive therapy by Ahmed ibn Sahl al-Balkhi; Islamic psychotherapy by Ibnu Sahl Rabban al-Tabari; and spiritual counselling by Imam al-Ghazali (Abdullah *et al.*, 2012; Abdul Razak *et al.*, 2013). Al-Ghazali described the self as made up of four elements – heart, spirit, soul and intellect – and these can be respectively linked to CBT domains such as emotions, behaviours, thoughts and the capacity for reflection (Haque, 2004b). Muhammad ibn Abu Bakr (more commonly known as Ibn al-Qayyim al-Jawziyyah) introduced the concept of inner thought, a concealed speech or an internal dialogue (Arabic word, *khawatir*). According to Badri (n.d.), 'modern cognitive psychologists can compare this with the idea of "automatic thoughts" which the cognitive therapist Aaron Beck claims to have discovered in the 1970's!' Cognitive restructuring (changing belief patterns), another commonly used cognitive behavioural technique, is fundamentally characteristic of the Islamic thinking style prescribed by early Muslim scholars, for example, Ibn al-Qayyim (Yusaf, n.d.).

In the Western world, CBT in its present form was developed and promoted by individuals such as Albert Ellis (1962) and Aaron Beck (1976). However, from an Islamic narrative, Abu Zayd Ahmed ibn Sahl Balkhi, known as al-Balkhi, was the first known cognitive psychologist, the first to consider that faulty thinking leads to psychological problems of anxiety, anger and sadness and the first to suggest cognitive therapies for anxiety and mood disorders (Badri, 2013, p. 17). Al-Balkhi, born in 850 CE in the province of Balkh, Khorasan (in modern-day Afghanistan), was a polymath: a geographer, mathematician, physician, psychologist and scientist. He was the first to differentiate between neurosis and psychosis. Neuroses were classified into four emotional disorders: fear and anxiety, anger and aggression, sadness and depression, and obsessions. Al-Balkhi also focused on how to eliminate emotional disorders by simply concentrating on changing one's inner thinking and irrational beliefs (Badri, 2013, p. 17). Al-Balkhi introduced the concept of reciprocal inhibition (*al-ilaj bi al-did*), and his therapy could be termed today as 'rational cognitive therapy' (Badri, 2013; Haque, 2004b). Al-Balkhi used four therapeutic techniques: relaxation, to enable the client to become aware that his or her present psychological problems (or worldly troubles) are only natural and expected; reciprocal inhibition (the same graded technique used in systematic desensitisation); rational cognitive therapy, to change cognitions and beliefs; and

the psycho-spiritual religious cognitive approach (Badri, 2013, pp. 32–3). In recent years, modifications have been added to different psychotherapeutic techniques in order to comply with Islamic values (Abudabbeh and Hays, 2006; Abu Raiya and Pargament, 2010; Ahmed and Reddy, 2007; Alavi, 2001; Azhar and Varma, 1995a, 1995b; Azhar *et al.*, 1994; Beshai *et al.*, 2012b; Carter and Rashidi, 2004; Hamdan, 2008; Hedayat-Diba, 2000; Hodge and Nadir, 2008; Khodayarifard *et al.*, 2007; Naeem *et al.*, 2010; Razali *et al.*, 1998).

CBT: what works for Muslim clients?

A recent review of CBT identified 269 meta-analytic studies and 106 meta-analyses examining the efficacy of CBT (Hofmann *et al.*, 2012). The following psychological problems were examined: substance use disorder, schizophrenia and other psychotic disorders, depression and dysthymia, bipolar disorder, anxiety disorders, somatoform disorders, eating disorders, insomnia, personality disorders, anger and aggression, criminal behaviours, general stress, distress due to general medical conditions, chronic pain and fatigue, distress related to pregnancy complications and female hormonal conditions. The findings showed that the evidence base for CBT is very strong for anxiety disorders, somatoform disorders, bulimia, anger-control problems and general stress. Similar findings have been reported for the effectiveness of CBT in the treatment of anxiety disorders, somatoform disorders, bulimia, anger-control problems and general stress (Butler *et al.*, 2006).

Several studies have found that a form of religious or spiritual therapy may be effective with Muslim clients who suffer from anxiety, depression and bereavement (Azhar and Varma, 1995a, 1995b; Azhar *et al.*, 1994; Hook *et al.*, 2010; Razali *et al.*, 1998). However, in the case of depression, the effectiveness of the therapy is more pronounced when combined with medication. Hamdan (2008) suggested that, in religious psychotherapy, unproductive beliefs are identified and modified or replaced with beliefs derived from Islam, which is a variation of cognitive therapy making use of religious themes. A review of these studies by Hook *et al.* (2010) maintained that:

> It is difficult to distinguish whether the improvement of participants in the religious condition is specifically due to the religious therapy, or whether it is a general dose-response effect as a result of having more therapy per week. Thus, there is limited evidence for the specificity of Muslim psychotherapy for depression.
>
> *(p. 60)*

There is also limited evidence for the specificity of Muslim psychotherapy for anxiety (Hook *et al.*, 2010). In relation to the religiosity of the clients, there is some evidence to suggest that religious therapy may improve outcomes for highly religious clients, but not for clients who are not highly religious (Razali *et al.*, 2002). The findings of Wahass and Kent's (1997) study showed that Muslim accommodative

CBT for schizophrenia (CBT integrated with religious beliefs and practices), combined with medication, may have beneficial effects. However, there is not enough evidence to support the efficacy of Muslim accommodative CBT for schizophrenia. A randomised clinical trial study by Ebrahimi *et al.* (2013) showed that, for patients with dysthymic disorder, spiritually augmented psychotherapy is more effective than medication and cognitive behavioural therapy to modify dysfunctional attitudes. However, there is no difference between spiritually augmented psychotherapy and CBT in reducing the severity of depressive symptoms. These findings supported the efficacy of psychotherapy enriched with cultural dimensions and religious teachings.

However, the effectiveness of CBT among Muslim populations still raises some concerns (Hodge, 2004). Most of the studies that have examined the efficacy of CBT have been conducted with individuals of a Western, Judaeo-Christian background (Beshai *et al.*, 2012b). Although these research efforts point to the efficacy of cognitive interventions based on Islamic principles for Muslim clients, there are concerns regarding various methodological issues (Hamdan, 2008). More research is necessary to study modified CBT with Islamic spiritual interventions to make definitive statements about the empirical soundness and robustness of such approaches.

Unique facets and techniques of CBT appropriate for Muslim clients

There are unique facets and several techniques in the Islamic cognitive therapy approach that have been developed by Muslim scholars. The significant cognitions from the Islamic faith that can be incorporated into the counselling process with Muslim clients include: the understanding of the reality of this world and its temporality (Qur'aan, 28:60; 29:64); the focus on the Hereafter (Qur'aan 3:15); recalling the purpose and effects of distress and afflictions (Qur'aan 2:155–6); trusting and relying on Allah (*Tawakkul*) (Qur'aan 3:159); understanding that after hardship there will be ease (Qur'aan 94:5–6); focusing on the blessings of Allah, remembering Allah and reading the Qur'aan (13:28); and supplication (*Du'as*) (Qur'aan 2:186). Hodge and Nadir (2008) provide some examples of spiritually modified cognitive interventions focusing on self-control and change; self-worth (Worth in Allah); high frustration tolerance; acceptance of others; achievement; needing approval and love; accepting responsibility; accepting self-direction; and self-acceptance.

In the cognitive restructuring model, Hamdan (2008) suggested that it is important first to teach clients to identify and evaluate automatic thoughts and dysfunctional core beliefs and assumptions that lead to problem behaviours. Clients are guided to examine and discuss their most distressing and recurrent problems and modify their automatic thoughts. Following realisation of this aspect, clients are assisted in modifying their core beliefs and assumptions through the examination of the evidence and looking for alternative explanations. In this model, clients would be assisted to question, evaluate and restructure dysfunctional thoughts and beliefs.

Hamdan (2008) also proposed that cognitions from the Islamic faith can be used as alternative explanations for dysfunctional thoughts, and the specific ones chosen would depend upon the presenting problem and the needs of each particular client. Opposite therapy is a technique stated in al-Ghazali's writings. To overcome spiritual weaknesses, al-Ghazali suggested the therapy of opposites ('use of imagination in pursuing the opposite'), such as ignorance and learning, or hate and love. This technique is based in the imagination and the client has to imaginatively act as if the opposite is there (Rosila and Yaacob, 2013). For example, clients can gain knowledge by reading, talking or interacting with pious and knowledgeable Muslims and, if they hate someone, they should start loving the person in their imagination. Then the hate will vanish and love will persist (al-Ghazali, 1998; Badri, 2000; Rizvi, 1989).

Contemplation or deep thought is another technique in Islamic cognitive therapy. It is acknowledged that it is possible to see why the Qur'aan and Sunnah are so concerned with meditation and the contemplation of the creation of the heaven and the earth, because an individual thinking is 'centred on the creation and bounties of Allah, their faith will increase and their deeds and behaviour will improve (Badri, 2000, p. 17). 'Deep thought (contemplation) . . . is the beginning of and key to all good . . . it is the best function of the heart and the most useful to it' (Ibn al-Qayyim al-Jawziyyah, n.d.). The following verses in the Qur'aan indicate some fundamentals about contemplation: 'āli 'Imrān (The Family of Imran) 3:190–1; Al Mulk (The Sovereignty) 67:3–4; and Al-Mu'minūn (The Believers) 23:62. The focus of contemplation also applies to the life in the Hereafter, which is the ultimate aim of every individual (Rosila and Yaacob, 2013). Other techniques that can be accommodated within CBT include the use of supplications, prayers, the power of suggestion (Rosila and Yaacob, 2013) or remembered wellness (Benson, 1996). The more directive approach advocated by cognitive behavioural therapists and the focus on current and future functioning is congruent with Islamic values and may be fairly effective with Muslim clients (Carter and Rashidi, 2004; Hamdan, 2008). CBT's emphasis on homework – practical and outside-of-session assignments – meshes particularly well with the Islamic traditions and may be particularly appealing to Muslim clients (Abudabbeh and Hays, 2006; Hodge and Nadir, 2008).

Conclusion

There is wide consensus among Islamic scholars and practitioners that the underlying principles on which cognitive therapy rests are congruent with Islamic values. It is the nature and the methodology in which cognitive therapy is operationalised in the Western counselling paradigm that creates the dissonance. Accordingly, to increase the level of congruence with Islamic values, counsellors need to use a spiritually modified cognitive therapy model. The brief and time-limited nature of cognitive behavioural therapy, its collaborative effort between the counsellor and the client, the directive nature of the therapeutic process, its evidence-based practice, its flexible goals and strategies depending on clients and counsellors, its

cost-effectiveness and its efficacy make it prime as a therapeutic tool for Muslim clients. In addition, reason, logical discussion, psychoeducation and consultation are widely affirmed in Islamic discourse and these features form the basis for cognitive approaches (Hodge and Nadir, 2008). Some of the current models used require greater development and refinement backed by evidence-based research. In fact, the more religious-oriented Muslim clients would derive substantial benefits from cognitive therapy modified with Islamic tenets.

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12

SOLUTION-FOCUSED BRIEF THERAPY

Introduction

Solution-focused brief therapy (SFBT) is a short-term, goal-oriented approach to working with clients and has been gaining momentum as a powerful therapeutic approach since its inception in the 1980s. SFBT is different from traditional modes of psychotherapy due to its emphasis on minimal self-disclosure, short-term treatment, empowerment and a positive orientation (Chaudhry and Li, 2011). The SFBT model evolved out of the brief family therapy approach of the late 1970s, long before the term evidence-based practice became an integral part of the medical and mental health vocabulary (Lipchik *et al.*, 2012). SFBT is different from traditional approaches to treatment as the aims are to enable clients to focus on solutions instead of problems, or to reach a point where the problem is minimised, manageable or is no longer defined as a problem. SFBT holds the basic belief that concentrating on solutions to problems and times when clients' problems do not occur (for example, exceptions) matters more than focusing on the problems themselves (De Jong and Berg, 2008). Clients develop and set concrete goals and draw upon their existing potentials and strengths in their lives to bring about the desired change. SFBT has been found to be effective across the whole range of problem presentations with a diverse variety of populations across a number of treatment settings (Bond *et al.*, 2013; Franklin *et al.*, 2012; Gingerich and Peterson, 2013; Jacob, 2001; Kim, 2008; Lethem, 1994; MacDonald, 1997). SFBT is an approach within the framework of an Islamic model of counselling. The aims of this chapter are to examine the rationale, goals, therapeutic processes and techniques of SFBT and its congruence with Islamic principles and practices.

Solution-focused brief therapy – the evidence

SFBT is an evidence-based approach to counselling and therapy and one of the few therapeutic approaches that began as 'evidence-based' as compared to being

'theory-driven' (Institute for Solution-Focused Therapy, n.d.). SFBT has been the subject of many empirical studies – outcome studies, meta-analyses, systematic reviews and randomised controlled trials – showing the benefits of solution-focused approaches as opposed to intervention strategies. There are two meta-analyses on the effectiveness of SFBT (Kim, 2008; Stams *et al.*, 2006). The findings from Stams *et al.*'s (2006) study showed modest and positive effects of SFBT, at the same level as other forms of therapy. The authors concluded that SFBT is as effective as traditional forms of therapy, achieves a positive effect in less time and values client autonomy. Kim (2008) undertook a meta-analysis to evaluate the effectiveness of SFBT. The findings showed that SFBT was effective in dealing with internalising behaviour problems such as anxiety, depression, self-concept and self-esteem, but not so in externalising behaviour problems such as conduct problems, hyperactivity and aggression, and in dealing with family and relationship problems. However, the meta-analysis of Kim (2008) has been criticised on the grounds of potential for bias and error inherent in the methodology of single-author reviews and the poor quality and variability of the included studies. Thus, the author's conclusions may not be reliable (Centre for Reviews and Dissemination, 2009).

A systematic qualitative review of controlled outcome studies' findings showed that SFBT is an effective treatment for a wide variety of behavioural and psychological outcomes and is cost-effective (Gingerich and Peterson, 2013). The conclusion of the meta-analyses and the systematic reviews, and the overall conclusion of the most recent scholarly work on SFBT, is that SFBT is an effective approach to the treatment of psychological problems, with effect sizes similar to other evidenced-based approaches, such as cognitive behavioural therapy, and with a successful outcome rate averaging 60 per cent in three to five sessions (Institute for Solution-Focused Therapy, n.d.). The effects of SFBT are found in fewer average sessions, and it uses an approachable style that is more compassionate (Franklin *et al.*, 2012; Trepper and Franklin, 2012). Reviews from Lovelock *et al.* (2011) have shown effectiveness of SFBT for depression, anxiety and substance misuse. Given its shorter duration, cost-effectiveness and less conditional confrontation or interpretation, SFBT is considered to be an excellent first-choice evidenced-based therapeutic approach for psychological, behavioural and family problems.

Principles of solution-focused brief therapy

SFBT differs from traditional therapies by focusing on the 'here and now' and the future. Counsellors do not have the need to know the cause of a problem to solve it and there is no relationship between the causes of problems and their solutions (de Shazer, 1988, 1991). In this type of therapy, the clients choose the goals they wish to accomplish, and little interest is given to diagnosis, history taking or exploring the problem (de Shazer *et al.*, 2007; Gingerich and Eisengart, 2000). In SFBT, there is a general priority about goal setting as a component of the counselling process. There is also collaboration between the client and the counsellor in the construction of goals. However, both client and counsellor do not have the authority to modify or

change the goal, even if they feel the goal is not relevant (Powers, 1996). It is important to focus on small, attainable and realistic goal construction and help the client move towards small steps to achieve those goals. De Shazer (1985), Walter and Peller (1992, 2000) and Corey (2009) proposed the following principles of SFBT:

- Solution-focused counsellors nudge clients to view different perspectives of solutions to the problem.
- The solution may or may not be directly related to the problems or issues.
- Each solution is unique to the individual based on her or his specific needs and problems.
- Clients have the readiness to change.
- Clients are experts in their problems and solutions.
- Incremental changes lead to bigger changes.
- If something works, be pragmatic and continue to use the approach(es).
- Focus is on the strengths of the individual and not on his or her weaknesses.
- The potential to change is sometimes blocked by negative cognitions.
- For every problem, there are exceptions.
- Solution-focused counsellors facilitate clients to view their problems from a different perspective.

In addition, Trepper *et al.* (2012) have proposed that the basic tenets that inform SFBT should be to encourage clients to increase the frequency of current useful behaviours and that solution behaviours already exist for clients. Furthermore, it is asserted that small increments of change lead to larger increments. It has often been suggested that small changes are all that are needed to resolve problems that clients bring to therapy (Corey, 2009, p. 380). SFBT helps clients 'develop a desired vision of the future wherein the problem is solved, and explore and amplify related client exceptions, strengths, and resources to co-construct a client-specific pathway to making the vision a reality' (Trepper *et al.*, 2010, p. 2). The essence of therapy involves building on clients' hope and optimism by creating positive expectations that change is possible and focusing on the existing resources and strengths of clients. Clients are invited to reflect on what they would like to replace their problems with and at what stage they would consider the therapy a success (Bakker *et al.*, 2010).

The therapeutic process

The therapeutic relationship is a fundamental part of the counselling process and outcome. It is often identified as the most significant process variable that influences the counselling outcome, and the quality of the client–counsellor alliance is a reliable predictor of positive clinical outcomes (Ardito and Rabellino, 2011). The core of the therapeutic process is the collaborative team composed of counsellor, client and significant others. However, it is collaborative and cooperative relationships (Bertolino and O'Hanlon, 2002) that create a context for change and the necessary conditions for clients to recognise that they are the experts in their own

lives. Martin *et al.* (2000) support the theory that the therapeutic relationship, in and of itself, may be beneficial in creating client change. So, it is the therapeutic relationship that conceptualises the process of change. Walter and Peller (1992) describe four areas of exploration that characterise the process of SFBT:

- Find out what the client is hoping to achieve from the collaboration. SFBT is about finding out what clients want rather than searching for what they do not want.
- Do not look for pathology, and do not attempt to reduce clients by giving them a diagnostic label. Instead, look for what clients are doing that is already working and encourage them to continue in that direction.
- If what clients are doing is not working, encourage them to experiment with doing something different.
- Keep therapy brief by approaching each session as if it was the last and only session.

SFBT operates in the same way regardless of the client's presenting problem. During the therapeutic process a new common ground between counsellor and client is created and questions are carefully posed that set in motion a conversation. This constructed communication process subsequently enables clients to discover and construct themselves as individuals with potential positive qualities and is believed to be a key component in helping clients to change (Bavelas *et al.*, 2000a; Berg and De Jong, 1996). The changing of perception is through the use of co-constructive language, combined with collaborative goal setting, and the use of solution-building techniques that occur between counsellor and client (Bavelas *et al.*, 2000a, 2000b, 2002; McGee *et al.*, 2005). The therapeutic process in SFBT involves the development of a picture of the 'solution' and discovering the resources to achieve it. It is maintained that the questions used during the assessment interviews are:

> intended to set up a therapeutic process wherein practitioners listen for and absorb clients' words and meanings (regarding what is important to clients, what they want, and related successes), then formulate and ask the next question by connecting to clients' key words and phrases.
>
> *(Trepper et al., 2010, p. 2)*

The counsellor listens and responds appropriately in response to the client's worldview. It has been suggested that 'It is through this continuing process of listening, absorbing, connecting, and client responding that practitioners and clients together co-construct new and altered meanings that build toward solutions' (Trepper *et al.*, 2010, p. 2). The key points of the steps involved in solution building and problem solving include (De Jong and Berg, 2008):

- Presentation of problems by the clients. The counsellor listens respectfully and carefully as clients answer the counsellor's question, 'How can I be useful to you?'
- The counsellor collaborates with clients in developing well-formed goals. The question is posed, 'What will be different in your life when your problems are solved?'

- The counsellor asks clients about those times when their problems were not present or when the problems were less severe. Clients are assisted in exploring these exceptions, with special emphasis on what they did to make these events happen.
- At the end of each solution-building conversation, the counsellor offers clients summary feedback, provides encouragement and suggests what clients might observe or do before the next session to further solve their problems.
- The counsellor and clients evaluate the progress being made in reaching satisfactory solutions by using a rating scale. Clients are asked what needs to be done before they see their problems as being solved and also what their next steps will be.

The role of the counsellor and therapeutic goals

Contrary to psychoanalytical and human approaches, which view the counsellor as an expert (Raskin and Rogers, 2000), the solution-focused counsellor is less direct and authoritarian and takes the role of a facilitator on the client's journey. The role of the counsellor is to facilitate clients' thinking about their future and what they want to be different in their lives. It is the clients who are experts about their own lives. According to Guterman (2006), counsellors have expertise in the process of change, but clients are the experts on what they want changed. The counsellor's task is to nudge clients in the direction of change without dictating what to change. The counsellor's role is also to focus on what is right and what is working. The main therapeutic task consists of helping clients imagine how they would like things to be different and what it will take to bring about these changes (Gingerich and Eisengart, 2000). Counsellors should identify and discuss the goals of brief therapy with their clients early in the counselling relationship, preferably in the first session. The solution-focused counsellor 'believes people have the ability to define meaningful personal goals and that they have the resources required to solve their problems' (Corey, 2009, p. 381). It is through the collaborative process that the goals of therapy are determined. The potential treatment goals for SFBT are:

- Clients' goals should be stated positively in the client's language, are process- or action-oriented, are structured in the here and now, are attainable, concrete and specific, and are controlled by the client (Walter and Peller, 1992).
- Goals should be small, realistic and achievable, so that changes can lead to additional positive outcomes.
- Counsellors mirror the language of their clients, using similar words, pacing and tone. Therapists use questions such as those that presuppose change, posit multiple answers and remain goal-directed and future-oriented: 'What did you do, and what has changed since last time?' or 'What did you notice that went better?' (Bubenzer and West, 1993).
- There is a variety of goals from changing the view of a situation or a frame of reference, changing the performance of the problematic situation, and enhancing client strengths and resources (O'Hanlon and Weiner-Davis, 2003).

In SFBT, a variety of goals may be identified, but given time constraints, only the most important to the client may be addressed. It is important for counsellors not to impose their own goals on the client and also not to shape the goals from their own worldview. Walter and Peller (2000) caution against too rigidly imposing an agenda of getting precise goals before clients have a chance to express their concerns.

Techniques used in solution-focused brief therapy

Solution-focused counsellors have a range of intervention strategies when assisting clients in discovering solutions and creating more satisfying lives. Both de Shazer (1988) and Walter and Peller (1992) offer useful mapping of the practice of SFBT, helping counsellors facilitate the construction of solutions. However, the techniques describe briefly below must be implemented from the foundation of a collaborative working relationship.

Pre-therapy change

In the first counselling session, SFBT counsellors typically ask, 'What have you done since you made the appointment that has made a difference in your problem?' (de Shazer, 1985, 1988). Or 'What changes have you noticed that have happened or started to happen since you made the appointment for this session?' By asking about such changes, the counsellor can elicit, evoke and amplify what clients have already done by way of making positive change (Corey, 2009, p. 384).

Miracle questions

This is a core technique in SFBT. The miracle question is a goal-oriented question that is useful when a client simply does not know what a preferred future would look like or is pessimistic. In addition, this kind of question would be to assist clients to think and examine new possibilities and outcomes for the future. The counsellor asks 'If a miracle happened and the problem you have was solved overnight, what would be different in your life?' Or:

> Now, I want to ask you a strange question. Suppose that while you are sleeping tonight and the entire house is quiet, a miracle happens. The miracle is that the problem which brought you here is solved. However, because you are sleeping, you don't know that the miracle has happened. So, when you wake up tomorrow morning, what will be different that will tell you that a miracle has happened and the problem which brought you here is solved?
>
> *(de Shazer, 1988, p. 5)*

Exception questions

These questions are used to direct clients to times in their lives when their problems did not exist. By helping clients identify and examine these exceptions, the

chances are increased that they will work towards solutions (Guterman, 2006). This helps empower clients to seek solutions. Examples of exception questions are:

- Tell me about the times when you don't get angry.
- Tell me about the times you felt better about yourself.
- When was the last time you feel you had a better day?
- Was there ever a time when you felt happy in your relationship?
- Was there ever a time when you felt happy in your life?
- What was it about that day that made it a better day?
- Can you imagine a time when the problem was not present in your life?

Questions and techniques that can be used when exploring for exceptions related to the miracle include: elicit, amplify, reinforce (verbally and non-verbally), explore how the exception happened and project exceptions into the future (see De Jong and Berg, 2008, pp. 302–3).

Scaling questions

An intervention in SFBT that can be used when there is not enough time to use the miracle question, the scaling question is also useful in helping clients evaluate their own feelings, track their own progress or monitor incremental change. For example, the counsellor can ask about clients' panic or anxiety, motivation, hopefulness, depression, confidence or a host of other topics. The counsellor asks 'On a scale of zero to 10, where zero is the worst you have been and 10 represents the problem being solved, how would you rate your anxiety right now?' Solution-focused counsellors also use scaling questions when changes in human experiences are not easily observed, such as in feelings, moods or communication (de Shazer and Berg, 1988). It has also been suggested that scaling questions 'enable clients to pay closer attention to what they are doing and how they can take steps that will lead to the changes they desire' (Corey, 2009, p. 385).

Formula first session tasks

Solution-focused counsellors routinely ask clients at the end of the first session to think about what they want to continue to happen in their lives (for example, relationships, family). This focuses them on the strengths in their lives and begins the solution-generating process. These experiments or assignments are based on something the clients are already doing (exceptions), thinking, feeling, etc. that is heading them in the direction of their goals (de Shazer *et al.*, 2007, p. 11). The counsellor might say: 'Between now and the next time we meet, I would like you to observe, so that you can describe to me next time, what happens in your (family, life, marriage, relationship) that you want to continue to have happened' (de Shazer, 1985, p. 137). The homework that is tied to their own goals and solutions comprises suggestions for the clients to try, not assignments they are commanded to do. This type of intervention strategy tends to increase clients' optimism and hope about their situation (de Shazer, 1985).

Counsellor feedback to clients

At the end of each session, the counsellor takes a break of 5 to 10 minutes towards the end of each session to provide summary feedback for clients. Some feedback acknowledges that a client has not completely attained a goal; other types are more of the reassuring variety, especially when client progress has been limited but reasonable, or are complimentary about what the client has done towards effective solutions. Walter and Peller (1992) emphasise the importance of normalising setbacks, letting clients know that success is not a simple, linear path, as lapse and relapse are parts of the treatment's journey.

The termination phase of SFBT

Guterman (2006) maintains that the ultimate goal of solution-focused counselling is to end treatment. For some counsellors and clients, the end of the counselling relationship is a difficult phase. Termination starts with a discussion about whether it might be a good time to end therapy. Most experienced counsellors start the termination process early from the very first solution-focused interview. In fact, once the client is able to construct a satisfactory solution or the client is no longer benefitting from the therapy, the therapeutic relationship can be terminated.

It is stated that through the use of scaling questions, counsellors can assist clients in monitoring their progress to determine whether to continue with the therapy (De Jong and Berg, 2008). Prior to ending therapy, counsellors assist clients in identifying things they can do to continue into the future the changes they have already made (Bertolino and O'Hanlon, 2002). So, in this termination phase, the counsellor prepares clients to maintain positive change through difficult times despite the occurrences of relapse, and to identify potential stressors and challenges in the maintenance phase and their solutions. Due to the nature of SFBT, and because this model of therapy is brief and present-centred, and addresses specific complaints, it is very possible that clients will experience other developmental concerns at a later time (Corey, 2012, p. 408).

Solution-focused brief therapy: congruence with Islamic principles

The SFBT model of counselling is permeated with values and indicators of success that are mostly congruent with Islamic beliefs. SFBT is different from traditional modes of counselling and psychotherapy, due to its emphasis on minimal self-disclosure, and its focus on competencies, rather than pathology or problems, and on individuals solving their own problems. There is limited literature on the congruence of SFBT with Islamic principles in relation to its cultural sensitivity and potential efficacy with Muslim clients. In a review of the available literature, Chaudhry and Li (2011) provide support for the cultural sensitivity of SFBT and its potential efficacy with Muslims. The support for the use of SFBT is related to its minimal self-disclosure, short-term treatment, empowerment and a positive

orientation. However, when using SFBT, it is important to accommodate culture, religion and the gender and social hierarchy in the society through the use of family members and intermediaries (Lambert, 2008). From an Islamic standpoint, SFBT captures the view of individual responsibility for one's own actions, which not only impact the self, but others, as well as the larger society. From an Islamic perspective SFBT should integrate Islamic values, ethics and codes of behaviour in counselling Muslim clients.

Valiante (2003) has linked Qur'aanic concepts with parallel aspects of SFBT, including action, free will, the ability to make choices, responsibility for one's own actions and behaviour, kinship and the ability to change (*jihad*) oneself and society. She maintained that the purpose of the Qur'aan 'is not to be rigid and dogmatic, but to guide humanity to find solutions to heal the whole person – body, mind and soul – as part of social reality'. So, the solution is to understand that Islam relates to our daily lives in applying solutions through action. Allah says in the Qur'aan (interpretation of the meaning):

> *That is instructed to whoever should believe in Allah and the Last day. And whoever fears Allah – He will make for him a way out. And will provide for him from where he does not expect.*
>
> *(Aṭ-ṭalāq (The Divorce) 65:2–3)*

Similar to the tenets of SFBT, Islamic principles also focus on individual behaviour and strengths, and place stronger emphasis on action than on retrospective insight. Our successes in this 'life and in the Hereafter are measured not solely in terms of personal inter-psychic growth, but in terms of personal growth as shown in relationship to others and to God' (Valiante, 2003). This is endorsed in the Qur'aan (interpretation of the meaning):

> *Indeed, Allah will not change the condition of a people until they change what is in themselves.*
>
> *(Ar-Ra'd (The Thunder) 13:11)*

Further congruence between SFBT and Islamic principles includes the notions of individuality, free will and accountability. There is no difference in relation to individuality, based on faith, deeds and actions, between the genders (see An-Naĥl (The Bee) 16:97). Likewise, SFBT's approach is that, no matter how complex and difficult the situation, making only a small change can lead to profound and far-reaching behavioural differences. This approach applies the same Qur'aanic principle that '*a small change is all that is necessary*' (Yūnus (Jonah) 10:61); and 'change is inevitable'. There is also prominence given to goal setting in SFBT, which reflects the Qur'aanic worldview that there is no divorce between thought and action (Valiante, 2003). This is parallel with the Qur'aanic statement that '*And that there is not for man except that [good] for which he strives*' (An-Najm (The Star) 53:39). Valiante (2003) also claimed that 'SFBT's emphasis on individual behaviour for the locus of change, rather than

race and culture, is parallel to the Qur'aanic concept of "vicegerency," or being representatives of God.' Allah says in the Qur'aan (interpretation of the meaning):

> *Indeed, I will make upon the earth a successive authority.*
>
> *(Al-Baqarah (The Cow) 2:30)*

Hope and possibilities are also central to the theory of SFBT. Bidwell (1999) suggested that 'Change always brings a chance to make life better. Problems and difficulties of living are temporary, they exist only because of the power we give to them by naming them as problems' (p. 10). This is compatible with Islamic beliefs. The believer meets trials and tribulations with hope and patience and, at the same, an indication of his or her faith. Muslims place their hope in Allah according to their degree of faith, their trust in Allah, their closeness to Him, and their submission and sincerity in their religious practices. Those who are patient in hardship do not lose hope and have been given the glad tidings in both this world and the Hereafter. (The concepts of hope and fear are discussed in Chapter 6.)

However, there is also dissonance between Islamic principles and SFBT, including the technique of the miracle question, the issue of sin and evil, and the understanding of social hierarchy in Islamic society. Solution-focused counsellors often make use of the miracle question (Berg and Miller, 1992) to assist the client family to create concrete therapeutic goals and envision a future of what their lives would be like in the absence of the problem. Clients are asked to envision not just a wish but a common ground upon which the counsellor and client agree to build new foundations (Nau and Shilts, 2000, p. 135). If the client can name a certain reality, the counsellor can help to uncover ways in which the reality is already happening (Bidwell, 1999). Valiante (2003) suggested that the miracle question has a dual connotation: clinical (set specific and concrete goals) as well as religious (a belief in change beyond the control of the individual), which parallels the concept of the unicity of God (*Tawheed*).

Muslim clients may not feel comfortable with the idea and/or the language of a miracle. For Muslims, miracles are only the work of Allah, who is the Creator and Upholder of the universe and has the ultimate power to change human conditions and situations. There are many miracles mentioned in the Qur'aan, and 14 miracles done by the Prophets that have been mentioned explicitly. However, the biggest of all miracles is the Qur'aan itself. According to Muhammad (2012), the miracle question 'links actions to change which further establishes the Islamic view of . . . God as the ultimate controller to ease trials and tribulations of life through miracles' (p. 35). However, Allah answers the prayers of those who call upon Him (interpretation of the meaning):

> *do not despair of the mercy of Allah . Indeed, Allah forgives all sins. Indeed, it is He who is the Forgiving, the Merciful.*
>
> *(Az-Zumar (The Troops) 39:53)*

It is stated that: 'Everyone who offers supplication receives a response, but the response may vary. Sometimes he will get exactly what he asked for, and sometimes

he will be compensated (with something equivalent)' (al-Haafiz Ibn Hajar, cited in islamqa, n.d.). The Prophet (ﷺ) said:

> There is no Muslim who offers supplication in which there is no sin or severing of ties of kinship, but Allah will give him one of three things in return for it: either what he asked for will be hastened for him, or (reward) will be stored up for him in the Hereafter or an equivalent evil will be diverted from him.
>
> *(Ahmad, cited in islamqa, n.d.)*

An alternative to miracle questions is to use questions that reflect cultural/religious beliefs in phrasing outcome questions. That is, counsellors should use future-oriented outcome questions for achieving the same therapeutic purpose (Lee and Mjelde-Mossey, 2004), for example: 'Suppose when you awake tomorrow morning, what would be some of the things you would notice that would tell you your life had suddenly changed?'; 'How do you see yourself in three months from now?'; 'How do you know that you are different?'; or 'If God accepts your prayer, how would you be different from what you are now?'

There is a flaw inherent in the theoretical assumption of SFBT: 'a failure to recognize sin and evil both in individuals and in social/cultural systems' and an assumption that 'human intentions are always good . . . and that clients will choose possibilities that do not harm themselves or others' (Bidwell, 1999, p. 11). From an Islamic perspective, Islam rejects the notion that humankind is evil in its basic nature because of the *fitrah*; that is, the basic neutral state with an inclination to do good, but which can be adversely affected by external factors. Even though Allah is the Creator of those things, people fall into evil by their own free choice. That is, we have free will, and an individual can choose evil or good, and has the power to carry out that choice in his or her actions and attitudes. Bidwell (1999) also raised the question of the preferred 'solutions' that contain elements of sin, that is, substituting an undesirable behaviour with another undesirable behaviour. Generating solutions that are not compatible with Islamic principles would be rejected by most Muslim clients. This is the area where the counsellors should be cautious in imposing their values or worldviews on to clients.

In order to accommodate culture, religion and the hierarchy of the society an adaptation of the SFBT model would be required. The model would include strategies in the form of 'culture-infused counselling' (Arthur and Collins, 2005) and 'religious/spiritual-infused counselling'. According to Lambert (2008), this model 'obliges a determination of the most salient points of the complaint in order to generate solutions from within the family, extended family, religion, and culture for support, and locating intermediaries for advocacy' (p. 110). Lambert (2008) has suggested the use of the following questions (adapted):

- Who else in your family has had this problem?
- How did they solve it?
- What does your father (husband, sister, mother) think about the problem?
- Who in your family could help you with this problem?

- What do others normally do in this situation?
- What does the Qur'aan say about this?
- What does the Imam or religious scholar say you should do about this?
- Would that work in this situation? Why or why not?
- Who could help with the barriers you've identified?
- What strategy could help make this change?
- What (or who) make you feel better when this happens?

Conclusion

Solution-focused brief therapy provides counsellors with a framework for exploring and utilising clients' existing resources – their strengths and support networks. SFBT employs a non-confrontational approach and, for Muslim clients, face-saving techniques are preferred to overt conflict. This non-confrontational approach is a good fit for the valued importance of saving face in East Asian cultures (Lee and Mjelde-Mossey, 2004). This would also be relevant for most Muslim clients. Clients expecting depth therapy or analysis may dismiss the solution-focused approach for its simplicity, and if the counsellor failed to take time to build the therapeutic alliance. There is evidence to suggest that the therapeutic alliance is more important at the beginning of treatment than at the end (Boghosian, 2011). With some basic modifications and the integration of religious or spiritual considerations, SFBT would be an appropriate psychological intervention for Muslim clients.

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13

PRE-MARITAL AND MARITAL COUNSELLING

Introduction

For Muslims, encouraging and supporting healthy marriages is a cornerstone of the Islamic culture. However, it is becoming increasingly recognised that healthy marriages are critical to society given the associated physical, emotional and financial benefits for families (ISPU, 2014). There are now spiralling rates of marital problems and divorce in Muslim communities around the world and these have a negative impact, with physical, psychosocial and financial detriments for families. The implications of these problems are affecting the very foundation of the Muslim community – the family. Divorce can be an extremely stressful life experience and has been recognised, other than the death of a spouse, as the most significant life stressor that an individual can face (Holmes and Rahel, 1967).

To date, there is a dearth of literature to guide counsellors working with Muslim clients. However, there is an emerging body of evidence suggesting that marital education, family counselling and related services can improve couples' communication and problem-solving skills, resulting initially in greater marital satisfaction and, in some cases, reduced divorce, although these effects appear to fade over time (Berlin, 2004). From an Islamic perspective, it is increasingly important for families to understand how to minimise the risk of marital breakdown and divorce and build a foundation for healthy relationships and marriage. The Qur'aan and the Sunnah have the methodology for preventing and resolving the problems facing the community. This chapter will present an overview of the divorce rate in the Muslim world, and examine marriage in Islam, the benefits of marriage, marriage preparation according to Islamic tradition, and pre-marital and marital counselling.

Marriage in Islam

The fact that the divorce rate among Muslim communities is on the increase is a warning sign that Muslims are failing to grasp the rights and benefits of marriage as stipulated in the Noble Qur'aan and Sunnah:

> *They (your wives) are your garment and you are a garment for them.*
>
> *(Al-Baqarah (The Cow) 2:187)*

This verse of the Qur'aan reveals the basic purpose and concept of marriage in Islam. The verse has been explained as follows:

> Just as a garment hides our nakedness, so do husband and wife, secure each other's chastity. The garment gives comfort to the body; so does the husband find comfort in his wife's company. The garment is the grace, the beauty, the embellishment of the body, so too are wives to their husbands as their husbands are to them.
>
> *(Doi, n.d)*

Indeed, spouses are like garments to each other because they provide one another with protection, comfort, support and the adornment that garments provide to humans (Adhami, n.d.). The importance attached to marriage and family life in Islam is reflected in the many Islamic decrees and laws aimed at protecting the institution of the family. Marriage has several meanings and these depend on the context in which it is used. From a *Fiqh* perspective, marriage may be defined as 'a contract that results in the two parties physically enjoying each other in the manner allowed by the Shar'iah' (www.java-man.com, n.d.). Sheikh Muhammad Ibn al-'Uthaymin takes an even more comprehensive view of the institution of marriage: 'It is a mutual contract between a man and a woman whose goal is for each to enjoy the other, become a pious family and a sound society' (cited in Mahmud, 2012). The Qur'aan has given the raison d'être of marriage in the following words:

> *And of His signs is that He created for you from yourselves mates that you may find tranquillity in them; and He placed between you affection and mercy. Indeed, in that are signs for a people who give thought.*
>
> *(Ar-Rūm (The Romans 30:21)*

The Messenger of Allah (ﷺ) considered marriage as a most virtuous act and he enjoined matrimony on Muslims by saying: 'Nikah (marriage) is my Sunnah. He who shuns my Sunnah is not of me' (Muslim [a], n.d.). In addition, the Prophet (ﷺ) also said that: 'If Allah grants a Muslim a righteous wife, this helps him preserve half of his religion (faith). He should, therefore, fear Allah as regards the other half' (al-Tabarani and al-Hakim, n.d.). In summary, Islam regulates the contractual agreement between a man and his wife and sets the law and rules for a blissful marriage. When an increasing number of Muslims decide to put an end

to their marriages, it means that many Muslims fail to reap the good fruits of marriage, which, on a deeper level, means that the foundation hasn't been correctly set up from the beginning. Islamic teachings give great importance to preserving and protecting family ties and married life.

Marital relationships

For Muslims, both men and women have rights and responsibilities. Islam has stated these rights and duties, and it obliges and urges both spouses to fulfil them. Allah says (interpretation of the meaning):

> *And they (women) have rights (over their husbands) similar to (those of their husbands) over them to what is reasonable, but men have a degree (of responsibility) over them.*
> *(Al-Baqarah (The Cow) 2:228)*

The verse states that for every right there is a reciprocal duty that must be fulfilled. In this way a balance is achieved between them in all aspects, which supports the stability of family life. Ibn Abbas said, concerning this verse: 'It means: they have the right to good companionship and kind treatment on the part of their husbands, just as they have to obey their husbands in whatever they tell them to do'; Ibn Zayd said: 'Fear Allah concerning them just as they have to fear Allah concerning you'; and al-Qurtubi said: 'This verse includes all the marital rights and duties' (cited in islamqa [a], n.d.).

Among these rights and duties are: turning a blind eye to faults and mistakes, especially words and deeds by which nothing bad was intended. Allah says (interpretation of the meaning):

> *those who repress anger, and who pardon men; verily Allah loves as the good-doers.*
> *('āli 'Imrān (The Family of Imran) 3:134)*

Both husband and wife must put up with one another, for every child of Adam may slip, and the person whom one should put up with the most is the one with whom one lives and mixes the most. If one spouse sees the other becoming very angry, he or she should restrain his or her own anger and not respond immediately. For this reason Abu'l-Darda' said to his wife: 'If you see me angry, calm me down, and if I see you angry I will calm you down, otherwise we cannot live together' (cited in islamqa [a], n.d.).

Among the most important duties is that each spouse should advise the other to obey Allah. According to a Hadith, some of the companions of the Prophet (ﷺ) asked him: 'Can you tell us which kind of wealth is the best, so that we may strive to acquire it?' He said: 'The best (wealth) is a remembering tongue (one which always remembers Allah), a thankful heart, and a believing wife who will help you with your faith' (Tirmidhî, cited in islamqa [a], n.d.). A man should not hate his wife if he sees in her something that he dislikes, because if he dislikes one of her characteristics, he will like another that will make up for it. It was reported that the

Prophet (ﷺ) said: 'No believing man should hate a believing woman; if he dislikes one of her characteristics, he will be pleased with another' (Muslim [b], n.d.). It is reported that the Prophet (ﷺ) said: 'Woman was created from a rib, and if you try to straighten the rib you will break it, so be gentle with her and you will be able to live with her' (Ahmad and Ibn Majah, n.d.). One of the most important things that can make married life happy is a good attitude, hence Islam raised its status. Abu'l Darda' reported that the Prophet (ﷺ) said: 'There is nothing that can be placed in the scales that will weigh heavier than a good attitude, and a good attitude can help a person reach the status of one who fasts and prays' (Tirmidhî and Abu Dawud, cited in islamqa [a], n.d.). Abu Hurayrah reported that the Prophet (ﷺ) said: 'The most perfect of the believers in faith are those who are the best in attitude, and the best of you are those who are best to their women' (Tirmidhî and Ahmad, n.d.). Both spouses should turn a blind eye and avoid picking on matters great and small, or rebuking and scolding about any matter except duties towards Allah. This is what Allah tells us to do (interpretation of the meaning):

> *And live with them (women) honourably. If you dislike them, it may be that you dislike a thing and Allah brings through it a great deal of good.*
>
> *(An-Nisā' (The Women) 4:19)*

According to Sheikh Muhammed Salih al-Munajjid (cited in islamqa [a], n.d.), it is advisable for a man to consult his wife when making some decisions in which it is appropriate to include her, such as dealing with behavioural problems in their children, finding ways to reconcile disputes between relatives or neighbours, and especially in resolving problems between husband and wife.

Marriage preparation according to Islamic tradition

According to Islamic tradition, marriage should be entered into for the sake of Allah. Marriage is, therefore, a form of worship. Allah's guidance should be sought on all matters, particularly the decision to marry and who to marry. Likewise, when we experience problems, we must call on Allah to help us through the trying times. The prayer of decision making (*Istikhara*), a tradition of Prophet Muhammad (ﷺ), should also be undertaken in the selection of a mate, asking Allah's guidance in the choice of the mate, and how best to assist one in preserving his or her faith (*Iman*), in order to prepare for the life after death (*Ahkirah*). If *Istikhara* is performed sincerely, asking Allah's guidance in the choice of a mate, the marriage will be established at the outset on the best foundation. Allah says (interpretation of the meaning):

> *And your Lord said: Invoke Me (believe in Me alone and ask Me anything) I will respond to your (invocation). Verily, those who scorn My worship (for example, they do not believe in My Oneness or ask Me), they will surely enter hell in humiliation.*
>
> *(Ghāfir (The Forgiver) 40:60)*

The Islamic traditions that facilitate marriage preparation and education, and consequently positive marital outcomes, include prayers, supplications, the requirement of a guardian (*Walî*) (for women who have not been married), the obligation to study religious practices, the use of arbitration and the importance of advice giving (*Naseehah*).

Pre-nuptial agreements

Pre-nuptial agreements or contracts between Muslim couples are also an essential part of pre-marital preparations. The couple can put conditions on the agreement accordingly, making expectations, rights, rules and responsibilities clear from the start of the marriage. This document could also be legalised. This clarity helps avoid many conflicts that crop up after the wedding. It is stated that 'The basic principle with regard to the conditions stipulated by both partners in the marriage contract is that it is a valid condition that must be fulfilled, and it is not permissible to break it' (islamqa [b], n.d.), because the Prophet (ﷺ) said: 'The condition which most deserves to be fulfilled is that by means of which intimacy becomes permissible for you' (Bukhârî and Muslim, cited in islamqa [b], n.d.). Sheikh Muhammad Ibn al-'Uthaymin said:

> The basic principle with regard to conditions in the marriage contract is that they are valid, unless there is proof to show that they are not valid. The evidence for that is the general meaning of the evidence which speaks of fulfilling the covenants [interpretation of the meaning]: 'O you who believe! Fulfil (your) obligations' (al-Mā'idah 5:1), 'And fulfil (every) covenant. Verily, the covenant will be questioned about' (Al-Isra' 17:34).
>
> *(Cited in islamqa [b], n.d.)*

In a Hadith narrated from the Messenger of Allah (ﷺ), it says: 'The Muslims are bound by their conditions, except a condition that forbids what is permissible or permits what is forbidden' (Tirmidhî, cited in islamqa [b], n.d.). And the Prophet (ﷺ) said: 'Whoever stipulates a condition that is not in the Book of Allah it is not valid, even if he stipulates a hundred times' (Bukhârî and Muslim, cited in islamqa [b], n.d.).

Divorce

Divorce is permitted in Islam as a last resort if it is not possible to maintain a marriage. From an Islamic perspective, divorce is the legal route out of an abusive or unsatisfactory marriage for both men and women (Siddiqui, 2009). There are detailed rules outlining the processes involved, and couples need to ensure that all options have been exhausted (trial separation, arbitration, counselling, etc.) before a final decision is taken to end a marriage religiously and legally. However, the whole separation in the divorce process has to proceed in a manner that is merciful

and respectful of the rights and dignity of the two spouses. It is reported that the Messenger of Allah (ﷺ) said: 'Of all the lawful things, divorce is the most detestable thing in the sight of Allah' (Abu Dawud, cited in islamqa [c], n.d.). But although it is most likely that the Hadith cannot be soundly attributed to the Prophet (ﷺ), its meaning is regarded as being sound (islamqa [c], n.d.). Sheikh Muhammad Ibn al-'Uthaymin said: 'Allah hates divorce, but He does not forbid it to His slaves, so as to make things easier for them' (cited in islamqa [c], n.d.). It is well known in *Shari'ah* that divorce takes place when the words are uttered, written or indicated by a gesture that takes the place of speaking. With regard to divorce in writing (islamqa [d], n.d.), via e-mail (islamqa [e], n.d.), by phone, mobile phone or text message (islamqa [f], n.d.), there is no problem regarding the fact that it is valid. For further information about explanation, clarification and fatwas on divorce, see islamqa [g] (n.d.).

Muslim divorce rates, particularly in Western countries, have been on the rise in recent years, and 'online divorce' services have facilitated that even more (Youssuf, 2011). According to Imam Mohamed Magid, 'Divorce is on the rise in the Muslim community of people married for a while and those married for a short time. It is not among a particular race or ethnic background or class or only among the religious or non-religious' (cited in Siddiqui, 2009). According to a study (Ba-Yunus, 2000) conducted in the early 1990s, the North American Muslim divorce rate is estimated to be at 31 per cent. The Maldives has the highest divorce rate in the world (wikiislam.net, n.d.). In the Middle East region, it is reported that Egypt has the highest rate of divorce, followed by Jordan, Saudi Arabia, the United Arab Emirates (UAE), Kuwait, Bahrain and Qatar (Olarte, 2010). The current rate of divorce in the Kingdom of Saudi Arabia stands at 30 per cent (Khan, 2009). The UAE has the highest divorce rate in the region and Dubai, which makes up less than one-fifth of the population of the Emirates, accounts for over one-third of all divorces (Pathak, 2013). The lower divorce rates in the Muslim communities in the Indian subcontinent, Singapore, Indonesia and Malaysia are now catching up with global trends. Divorce rates among Muslims in Malaysia are five times higher than among non-Muslims (wikiislam.net, n.d.). Most recently, it is reported that in India divorce rates are also on the increase, particularly through 'online divorce' services (Youssuf, 2011). While Muslims are accused of 'easy divorce', statistics among Muslims worldwide show a much lower rate of separation than among Western Christians (Smith, 2010).

There are a number of factors being cited as the causes of divorce in Muslim communities, including: conflicts with in-laws, extramarital relationships, addiction to alcohol and drugs, pornography, incompatibility, unrealistic expectations, financial negligence, secular individualism, abuse (physical, emotional, verbal and sexual), complete lack of preparation, lying and denying critical information (physical and mental health) (Ayubi, 2010; Siddiqui, 2009). In an investigation into American Muslims' marital quality (Chapman and Cattaneo, 2013), the findings showed that marital problems most commonly included issues with in-laws, family or friends, finances, differing interests and conflicting attitudes concerning sex.

Women were more likely than men to identify in-laws as a source of conflict in the marriage. The findings of an online study showed that incompatibility was the most cited reason for divorce (16.38 per cent), followed by abuse (13.12 per cent), financial disputes (10.41 per cent), family/in-law interference (10.20 per cent), sexual infidelity/adultery (8.79 per cent) and others (Ghayyur, 2010). Some of the 'internal reasons' are related to:

> [Muslims'] diverse understanding (or rather misunderstanding) of the family structure and values as a result of confusing religious teaching with cultural legacy, . . . and lack of spirituality where people focus on the legal aspect of marriage with a dry and materialistic approach.
>
> *(Saad, 2013)*

In addition, there is also the question of incompatibility in relation to cultural differences and religious understanding. Problems in this realm may occur because of differences in ideological perspectives, or because one of the partners is not adhering to an Islamic family life. It may also mean that the husband and wife are Muslim, but one is more observant in the practice of the faith, while the other may be described as Muslim but is not religious (Nadir, n.d.). However, It can be argued that 'incompatibility' is also a convenient excuse or scapegoat that some couples use to end their marriage due to relatively minor lifestyle inconveniences (Ghayyur, 2010). 'While Islam does not forbid intercultural marriages, they can become a source of tension when Muslims, primarily the couple, but also their families, make their culture more important than Islam' (Mujahid, n.d.).

Pre-marital counselling: approaches and models

Pre-marital counselling is a type of preventive therapy that helps couples in the understanding of marital relationships, expectations and responsibilities attached to marriage, and the development of healthy interpersonal relationships. It refers to 'a process designed to enhance and enrich pre-marital relationships leading to more satisfactory and stable marriages with the intended consequence being to prevent divorce' (Stahmann, 2002, p. 105). According to Imam Mohamed Magid (2008), there are two approaches to pre-marital counselling: group education and individual counselling. The goal of the educational approach is to enable groups of single brothers and sisters to build skills and develop the emotional, coping and communicative tools necessary to have a functioning, healthy marriage. Significant familial, ethnic, cultural or religious differences between couples can prove to be hindrances to open communication, non-judgemental understanding and unconditional acceptance (Smith, 2012). Pre-marital counselling has a preparatory purpose in attempting to remove all uncertainties and misconceptions regarding the marital relationship; and opens a way for individuals (Benjamin, 2008). The findings from meta-analyses have shown strong evidence that couples can learn to communicate more positively and less negatively (Carroll and Doherty, 2003; Hawkins *et al.*,

2008). Pre-marital programme evaluation has shown that couples who received an average of eight hours of pre-marital education had a 31 per cent lower chance of divorce after four years (Stanley *et al.*, 2006).

There are different approaches to pre-marital counselling: skills-based programmes, pre-marital inventories, counselling in church settings and other approaches. The most effective approach is oriented towards a skill-based mode of teaching and counselling. Participants develop these skills through role-playing and discussion. 'Skill-based programmes which teach couples communication and conflict-resolution skills have the strongest empirical support to date for couples' (Williams, 2007, p. 216). Pre-marital inventories are also a commonly used approach and provide couples with individualised feedback on topics such as 'communication, conflict resolution, personality match, marital expectations, financial matters, leisure activities, family, friends, sexuality, spirituality, and children' (Williams, 2007, p. 211). Church-based pre-marital counselling, employing skills-based programmes, pre-marital inventories and private meetings with a cleric, range from one session designed for discussing wedding plans to several sessions of marriage preparation. A review of the literature on church-oriented marriage preparation programmes identified the most common themes: communication, conflict resolution, egalitarian roles, sexuality, commitment, finances and personality issues (Silliman and Schumm, 1999, p. 25). Experienced married couples are used as mentors as part of pre-marital counselling. Finally, many engaged couples are using self-guided learning methods or websites for pre-marital preparation.

The second approach is to have pre-marital counselling sessions with the future married couple, addressing their specific concerns and problem issues. For some couples at risk of marriage dissolution, pre-marital counselling would be deemed a necessity. Smith (2012) suggested that 'One of these is the fact that counselling forces the couple to "slow down" for a while before they rush into marriage and to consider more carefully some of the weighty issues they might have to address.' In addition, there is some evidence to suggest that, when couples continue to attend pre-marital counselling sessions after getting married, their communication skills and techniques and conflict resolution strategies are enhanced (Williams, 2007, p. 214).

Several pre-marital preparation programmes include comprehensive pre-marital assessment questionnaires (PAQs). Their main purpose is to provide individualised and systematic feedback to pre-marital couples regarding how their relationship functions. The PAQs include the Pre-marital Preparation and Relationship Questionnaire (PREPARE); the Facilitating Open Couple Communication, Understanding and Study questionnaire (FOCCUS); and the RELATionship Evaluation (RELATE). The three comprehensive pre-marital assessment questionnaires have been evaluated on their psychometric characteristics and compared. The use of PREPARE is for couples who want structured exercises; FOCCUS is for couples who also have financial problems and wish to see a counsellor; and RELATE is for couples who do not want to see a counsellor or have limited economic resources (Larson *et al.*, 2002). There are many models of pre-material

counselling, mainly Christian-oriented, which are oriented towards coaching, counselling, problem solving, education and empowerment.

Pre-marital Islamic counselling approach

Many Muslim couples mistakenly believe that they do not need counselling before marriage and that conflict should be avoided. In Islam, there is absolutely nothing in the *Shari'ah* that restricts two people who wish to get married seeking counsel with their Imams, scholars or elders. There are several instances in the authentic traditions of the Messenger of Allah (ﷺ), whereby the companions would come and seek his guidance as to whether to marry a particular person or not. A recent study (Macfarlane, 2012) about divorce in the Muslim community found that none of the divorced men and women in the study had formal pre-marital counselling, other than a brief meeting with an Imam. Most of the subjects in the study wished they had been offered more extensive pre-marital counselling and had easier access to counselling services once they were married and experiencing problems. There is evidence to suggest that couples who have gone through a pre-marital counselling course lead happy and satisfied family lives (Chapman and Cattaneo, 2013). For Catholics, engaged couples must participate in a course on marriage called Pre-Cana before they are allowed to marry in the church. This is a form of pre-marital counselling. For Muslims, pre-marital counselling should become a prerequisite before marriage and many Imams and community leaders now require pre-marital counselling and education prior to the marriage ceremony (*Nikah*).

Pre-marriage counselling questionnaires have been developed by Islamic organisations (ICNA, n.d.; Magid, 2008). A set of 100 pre-marital questions (see Table 13.1) has been developed to guide potential couples and to enable them in identifying important issues. The questions are categorised in several sections dealing with marriage, religion, family, self, finance, children and relatives. However, the questions may not be relevant for everyone. The responses may be discussed with an Islamic counsellor or Imam. There is now a plethora of printed resources, audio-visual materials and e-learning courses dealing with preparation for marriage for prospective brides and grooms, family advisers and counsellors (Ezzeldine, 2003; Hartford, 2007; IslamiCity eLearning, n.d.; Islamic Learning Materials, n.d.; Maqsood, 2000).

For potential Muslim couples, it is important to examine spiritual and religious beliefs. Discussing these issues ahead of time will help to prevent any misconceptions in learning to manage different opinions. Research evidence suggests that religious involvement, particularly when shared by both marital partners, generally has significant positive influences on various aspects of marriage and family life, including marital fidelity, marital satisfaction, forgiveness, conflict resolution, physical and mental well-being, self-esteem, life satisfaction and longevity (Christiano, 2000; Dollahite *et al.*, 2004; Marks, 2005, 2006). Intercultural marriages are becoming a feature among Muslim communities, especially those living in European countries, North America and Australia. We are reminded that intercultural marriages are

TABLE 13.1 100 pre-marital questions

Marriage

- What is your concept of marriage?
- Have you been married before?
- Are you married now?
- What are your expectations of marriage?
- What are your goals in life (long and short term)?
- Identify three things that you want to accomplish in the near future.
- Identify three things that you want to accomplish, long term.
- Why have you chosen me/other person as a potential spouse?

Religion

- What is the role of religion in your life now?
- Are you a spiritual person?
- What is your understanding of an Islamic marriage?
- What are you expecting of your spouse, religiously?
- What is your relationship between yourself and the Muslim community in your area?
- Are you volunteering in any Islamic activities?
- What can you offer your *zawj* (spouse), spiritually?
- What is the role of the husband?
- What is the role of the wife?
- Do you want to practise polygamy?

Family

- What is your relationship with your family?
- What do you expect your relationship with the family of your spouse to be?
- What do you expect your spouse's relationship with your family to be?
- Is there anyone in your family living with you now?
- Are you planning to have anyone in your family live with you in the future?
- If, for any reason, my relationship with your family turns sour, what should be done?

Friends

- Who are your friends? (Identify at least three.)
- How did you get to know them?
- Why are they your friends?
- What do you like most about them?
- What will your relationship with them after marriage be?
- Do you have friends of the opposite sex?
- What is the level of your relationship with them now?
- What will be the level of your relationship with them after marriage?
- What type of relationship do you want your spouse to have with your friends?

Health

- Do you suffer from any chronic disease or condition?
- Are you willing to take a physical exam by a physician before marriage?
- What is your understanding of proper health and nutrition?
- How do you support your own health and nutrition?

Finance

- What is your definition of wealth?
- How do you spend money?
- How do you save money?
- How do you think your use of money will change after marriage?
- Do you have any debts now? If so, how are you making progress to eliminate them?
- Do you use credit cards?
- Do you support the idea of taking loans to buy a new home?
- What are you expecting from your spouse financially?
- What is your financial responsibility in the marriage?
- Do you support the idea of a working wife?
- If so, how do you think a dual-income family should manage funds?
- Do you currently use a budget to manage your finances?

Self

- What are the things that you do in your free time?
- Do you love to have guests in your home for entertainment?
- What are you expecting from your spouse when your friends come to the house?

- What is your opinion of speaking other languages in the home that I do not understand (with friends or family)?
- Do you travel?
- How do you spend your vacations?
- How do you think your spouse should spend vacations?
- Do you read?
- What do you read?
- After marriage, do you think that you are one to express romantic feelings verbally?
- After marriage, do you think that you want to express affection in public?
- How do you express your admiration for someone that you know now?
- How do you express your feelings to someone who has done a favour for you?
- Do you like to write your feelings down?
- If you wronged someone, how do you apologise?
- If someone has wronged you, how do you want her or him to apologise to you?
- How much time passes before you can forgive someone?
- How do you make important and less important decisions in your life?
- Do you use foul language at home? In public? With family?
- Do your friends use foul language?
- Does your family use foul language?
- How do you express anger?
- How do you expect your spouse to express anger?
- What do you do when you are angry?
- When do you think it is appropriate to initiate mediation in marriage?
- When there is a dispute in your marriage, religious or otherwise, how should the conflict get resolved?
- Define mental, verbal, emotional and physical abuse.
- What would you do if you felt that you had been abused?
- Who would you call for assistance if you were being abused?
- Who are the people to whom you are financially responsible?
- Do you support the idea of utilising babysitters and/or maids?

Children

- Do you want to have children? If not, why?
- To the best of your understanding, are you able to have children?
- Do you want to have children in the first two years of marriage? If not, when?
- Do you believe in abortion?
- Do you have children now?
- What is your relationship with your children now?
- What is your relationship with their other parent?
- What relationship do you expect your spouse to have with your children and their parent?
- What is the best method(s) of raising children?
- What is the best method(s) of disciplining children?
- How were you raised?
- How were you disciplined?
- Do you believe in spanking children? Under what circumstances?
- Do you believe in public school for your children?
- Do you believe in Islamic school for your children?
- Do you believe in home schooling for your children?
- What type of relationship should your children have with non-Muslim classmates/friends?
- Would you send your children to visit their extended family if they lived in another state or country?
- What type of relationship do you want your children to have with all their grandparents?

Relatives

- If there are members of my family that are not Muslim, that are of different race or culture, what type of relationship do you want to have with them?

Source: Imam Mohamed Magid (n.d.), *Pre-Marital Questionnaire,* www.rahmaa.org/resources/100-questions-by-imam-magid/ (accessed 11 September 2014).

among the signs of the diversity of Allah's creation from a single source; different languages and cultures are signs for those who reflect (Zain, 2012). This is echoed in the chapter of the Qur'aan: Ar-Rūm (The Romans) 30:22.

For intercultural marriages additional efforts are required by the counsellor or Imam to enable the potential couple to plan for raising children, and explore religious expectations and other concerns arising from such a relationship. Differences often emerge during wedding planning, and these can involve the expectations of partners' families of origin about the wedding ceremony and other religio-cultural issues. Child-rearing practices and education can also bring religious and/or cultural differences to the surface for the first time as decisions about religious practices and education are confronted. The key areas of discussion and examination in pre-marital counselling may include: role expectations; spiritual and religious beliefs; family of origin issues; communication and conflict resolution; and personal, couple and family goals (Kift, 2010). A pre-marital counselling programme needs to be based on an educational and skills-oriented approach complemented by counselling. These programmes would involve a multiprofessional and multidisciplinary team of Imam, counsellor, marriage guidance counsellor, psychologist, financial planner, medical practitioner and gynaecologist. The programme needs to be interactive with real-life examples and case studies. The curriculum for a pre-marital educational programme should cover the following important topics:

- The basics of marriage.
- Islamic perspective of marriage.
- Marriage and religion.
- Role of man and woman (role expectations).
- Islamic psychology of relationship.
- Conflict resolution.
- Financial planning.
- Communication and interpersonal skills.
- Intimacy and sexuality.
- HIV and AIDS.
- Cultural diversity in marriage.
- Abuse: verbal, physical and emotional.
- Roles of extended family.
- Decision making.
- Dealing with anger.

Marital counselling

Marital counselling is a branch of counselling that works with families and couples in intimate relationships and enables them to work out their emotional or other personal difficulties. Prophet Mohammad (ﷺ) used to provide counselling on marital issues on a regular basis to couples. The most famous occurrence was between his daughter Fatima and Ali (cousin and son-in-law) (www.rahmaa.

org, n.d.). Marital counselling can help couples to identify and address destructive patterns of relating, enables improvement in conflict and communication and enhances interpersonal relationships. Several methods of marriage counselling have been developed and tested over the years. Benson *et al.* (2012) have synthesised the approaches of the most successful methods of intervention and their findings showed that couples can benefit when they receive treatment that follows five underlying principles: changing the views of the relationship, modifying dysfunctional behaviour, decreasing emotional avoidance, improving communication and promoting strengths.

Throughout the therapeutic process, the counsellor attempts to help both partners see the relationship in a more objective manner and learn to stop the 'blame game'. There is empirical support for a variety of approaches, from behavioural to insight-oriented therapies, but the focus should be on altering the way the relationship is understood; the couple can then start to see each other, and their interactions, in more adaptive ways (Whitbourne, 2012). The counsellor may use cognitive behavioural techniques to help partners change the way they actually behave with each other and to teach them to modify their distorted thinking and dysfunctional behaviours. Risk assessment may be necessary if the clients are engaging in actions that can cause physical, psychological or economic harm. Referral to a specialist agency may be an appropriate course of action if the problem is related to domestic violence, abuse or addictive behaviours. If the level of risk is not sufficiently severe, the couple can benefit from 'time-out' procedures to stop the escalation of conflict.

A solution-focused brief therapy model (see Chapter 12) may be appropriate in which the couples are taught to focus on solutions instead of problems. There are couples, especially Muslim clients, who avoid discussing, or are reluctant to express, their personal feelings with each other or with a counsellor. Couples with emotional avoidance put themselves at greater risk of becoming emotionally alienated and, hence, grow apart. Emotionally focused therapy for couples (EFTC) provides a model that has at its core an understanding of the dynamics of the couple relationship, then tries to expand the emotional responses, create new types of interactions and nurture the bonding process (Crawley and Grant, 2005). The process of change in this approach is achieved through the facilitation of three sequential 'movements': de-escalation of the conflict; re-engagement of the withdrawing partner in the relationship, which involves that partner identifying and owning, in the presence of the other, his or her primary emotional experience in the relationship; and softening, which involves dominant partners owning and expressing their primary vulnerability (Crawley and Grant, 2005).

Communication difficulties are one of the bases for the majority of problems in a relationship and coaching will address the manner of interactions and communication to reduce misinterpretation between the partners. Communication skills need to be relearned and may involve listening skills and verbal and non-verbal communication. One of the goals of marriage counselling is to teach couples how to listen more actively and employ more empathy in the exchange of communication. One

of the areas in working with couples is to focus on the couples' inherent strengths in the relationship and build resilience. It is easy to ignore the perspective of the other areas in which couples function effectively or are less dysfunctional. The point of promoting strength is to help the couple derive more enjoyment from their relationship (Whitbourne, 2012). Several approaches may be employed by counsellors, including the prescription that one partner does something that pleases the other; or getting the couple to develop a narrative (positive) about their relationship. One of the purposes of the counselling is to assist clients to recapture memories and express feelings that have been disallowed in previous relationships (Fosha, 2000), that is, having a coherent and positive narrative about themselves and their relationship. The identification and ownership of the strengths are from the couples and are not those imposed by the counsellor.

Another approach is Gottman Method Couples Therapy, which is a structured, goal-oriented, scientifically based therapy (Gottman Institute, n.d.). The Gottman Method uses counselling techniques to reduce conflict; to increase intimacy, affection, closeness and admiration; and to create a heightened sense of empathy and understanding within the context of the relationship. Gottman Method Couples Therapy approaches include: focusing on emotion (affective couples therapy); focusing on changing interaction patterns (behavioural couples therapy); exploring dreams within conflict (existentially based couples therapy); focusing on how couples think about their relationship (cognitive couples therapy); focusing on the stories of the partners (narrative therapy); focusing on actual interaction patterns that describe the relationship as a system (systemic couple therapy); and focusing on analysis of the role the primary family member and other salient past relationships play in the relationship here and now and the anatomy of a conflict (psychodynamic couple therapy). Some of the approaches may not be compatible with Islamic belief due to the psychodynamic orientation.

Arbitration

Arbitration is another method used as an intervention strategy to provide an opportunity to give the Muslim couple guidance as well as facilitate problem solving and a reconciliation between them. Allah says in the Qur'aan (interpretation of the meaning):

> *And if you fear a breach between them twain (for example, Husband and wife), appoint an arbiter from his folk and an arbiter from her folk. If they desire amendment Allah will make them of one mind. Lo! Allah is ever knower, Aware.*
>
> *(An-Nisā' (The Women) 4:35)*

Other verses on the same theme are:

> *And in whatsoever you differ, the decision thereof is with Allah.*
>
> *(Ash-Shūraá (The Consultation) 42:10)*

> *But no, by your Lord, they can have no Faith, until they make you a judge in all disputes between them, and find in themselves no resistance against your decisions, and accept (them) with full submission.*
>
> *(An-Nisā' (The Women) 4:65)*

> *And if you differ in anything amongst yourselves, refer it to Allah and His Messenger, if you believe in Allah and in the Last Day.*
>
> *(An-Nisā' (The Women) 4:59)*

> *Call to the way of your Lord with wisdom and good admonition, and have disputations with them in the best manner; surely your Lord best knows who goes astray from His path, and He knows best those who follow the right way.*
>
> *(An-Naḥl (The Bee) 16:125)*

The Islamic responsibility is to give advice for commanding the right and forbidding the wrong (*Naseehah*). This indicates the importance of providing good Islamic guidance to those who are straying from the teaching. This tradition of *Naseehah* is an opportunity for individuals before marriage and couples after marriage to obtain good advice from family, community elders, Imams or Muslim counsellors and social workers regarding ways to prevent and intervene early in potential marital problems. In England, the Muslim Arbitration Tribunal (MAT) was established in 2007 to provide a viable alternative for the Muslim community seeking to resolve disputes in accordance with Islamic Sacred Law and without having to resort to costly and time-consuming litigation. The establishment of MAT is an important and significant step towards providing the Muslim community with a real opportunity to self-determine disputes in accordance with Islamic Sacred Law (www.matribunal.com, n.d.).

Islamic-oriented marital counselling

In Islamic-oriented marital counselling, counsellors would utilise the mainstream approaches and techniques of the congruent therapies with Islamic beliefs and practices. However, they need to take into consideration some of the issues pertaining to Muslim couples, including the clients' worldviews and ethics that these entail. If this is their first time seeing a marital counsellor, the couple in most cases will have no idea what to expect. The couple would need to be oriented about the marital counselling process and given the reassurance that the nature of marital counselling is not an arbitration process or obtaining a fatwa by a judge or Islamic scholar. It is important for the counsellor to make it clear from the beginning that he or she is open to their needs and suggestions and would like to try an approach to solving their problems based on their ethical values as Muslims. Below are some adapted guidelines (Siddiqui, n.d.) for marriage counsellors, whether non-Muslim or Muslim, when dealing with Muslim clients.

Assess the religiosity of the couple

A counsellor needs to understand what place Islam has in the life of the couple together and individually. The level of commitment to Islamic beliefs and practices

would determine the nature and approach of the counselling process. Assessing religiosity is not having a checklist of the practices of the clients, but it will be evident in the couple's worldview, together and individually, and how they talk about Islam, as well as the kind of things they disagree about.

Understand the importance of the Qur'aan and swearing on the Qur'aan

Some Muslim couples would probably swear or make an oath on the Qur'aan to have done or not have done something. The Qur'aan is the word of Allah, and His word is one of His attributes, so it is permissible to swear by the Qur'aan. The scholars of the Standing Committee said: 'It is permissible to swear by Allah and His Attributes. The Qur'aan is the word of Allah, which is one of His attributes, so it is permissible to swear by it' (islamqa [h], n.d.).

Assess the level of acculturation

Understand the religion, culture and the worldview of the client. Having an awareness of the ethnic culture of the couple is significant because cultural variations affect views on marriage and divorce. For example, Muslims from India, Pakistan and Bangladesh tend to see divorce as something to be avoided at almost any cost, and remarriage after divorce as something very difficult. Muslims from certain parts of the Middle East, however, tend to have a different view. Divorce is more accepted and remarriage after divorce is considered positive and encouraged (Siddiqui, n.d.). It is also important to understand that the cultural variations may not always be in line with Islamic values; and there is a difference between Muslim culture and Islamic culture. It is important to assess the level of acculturation. Liaise with Muslim professionals through local organisations to obtain a better understanding of what to expect, because there are certain religious particularities Muslims from a particular ethno-cultural group might have. There are issues relating to faith and, in a number of cases, these cause serious friction in Muslim marriages (Siddiqui, n.d.).

Consult with scholars when it comes to matters of Fiqh *(Islamic law)*

There may be a number of issues from both a civil and an Islamic legal perspective that the couple may bring to the counselling session. In these cases, the best thing to do is to consult a reputable Islamic scholar or be part of collaborative care with a scholar or Imam. Islamic jurisprudence matters related to the marriage include custody of children (*Hadana*), validity of divorce, *Khula* (the right of a woman to seek a divorce from her husband in Islam), domestic violence, consigning divorce to the wife, revoking the divorce (*Raj'a*), mutual swearing for accusation of adultery or denial of lineage (*Li'an*), the waiting period (*Iddah*) (menstruation) and expenses/provision (*Nafaqa*) for the divorced wife and for relatives.

Pay attention to language

Language may be a barrier if the husband and/or wife do not speak English or English is not part of their mother tongue. There are verbal and non-verbal communications that have significant variations depending on cultural background. It is important not to take things too literally, as certain phrases may simply be expressions of extreme distress or unhappiness, but do not indicate their literal meaning.

Understand the influence the couple's families have on their relationship

For Muslims, when a couple gets married, an extended family is created and the couple's families may want more control over child-rearing practices or education than those of other religious or cultural groups. It is suggested that 'a new couple struggles to develop loyalty and a new bond with one another and this can be easily fractured if in-laws interfere aggressively' (Ezzeldine, 2011). For instance, 'Don't be surprised if a parent calls you before a session with their child and his/her spouse to tell you what to advise the children or afterwards to ask you to report what they discussed in your session with the couple' (Siddiqui, n.d.). The best course of action is for the counsellor, in these cases, to politely acknowledge their feelings of concern for their children or any other matters. Confidentiality must be maintained. The couples need to learn about setting boundaries as ways of preserving a family and those limits must be decided upon by the couple. Ezzeldine (2011) suggested that boundaries for every couple will be different and these can be set with in-laws, depending on the most pressing needs, including seeking advice, exchanging money, frequency of visits, phone calls, holidays, and raising children. How does a couple set boundaries with overly intrusive in-laws, especially if one spouse does not think there is a problem? (See Ezzeldine, 2011.)

Don't fall into the trap of saying who's right and wrong

There is a danger that counsellors can unwittingly fall into the trap of being resentful or angry and blaming who is 'right' or 'wrong'. Miller and Rollnick (1991) suggested establishing a 'no-fault' policy when counselling a person, and commenting, 'I'm not interested in looking for who's responsible, but rather what's troubling you, and what you might be able to do about it' (p. 70). It is also important in the counselling relationship not to undermine a husband's or a wife's role in the marriage, regardless of how dysfunctional the relationship is.

Understand the dynamics of power

One area of conflict within the Muslim family is the abuse of authority and dominance which validates certain power relations in the family. It is important to keep in mind that, when counselling Muslim couples, the wife and the couple's children

may not feel comfortable talking in front of the husband (Siddiqui, n.d.). This is more so in families in which women and children are in a power relationship with the husband and father. The counsellor needs to be sensitive and avoid being too insistent in the joint counselling sessions to make the wife or, in the case of family counselling, the children participate in the therapeutic session.

Be solution-focused

Individuals need to have ownership of their problems and clients should work in partnership with the counsellor in finding solutions to their problems. However, it is important that the counsellor does not 'rescue' couples by feeling responsible for the clients' work, for 'success' or 'failure' in the session and for attempting to solve couples' problems. If the counsellor refrains from the rescuer role, clients do not learn about personal responsibility and how to deal with resolving conflict and issues on their own (see Whitfield, 1993). Furthermore, clients may become angry when the counsellor crosses the relationship boundary, without the clients' permission, by intervening in family relationships. The role of the counsellor is to ensure that clients take responsibility for their problems and to act as a facilitator in finding solutions.

Contact an Islamic or cultural association

A local or national Islamic or cultural association or Islamic social services association can provide professional help and guidance with issues and problems that are specific to Muslim couples.

Conclusion

For Muslims, there is a need to increase their religiosity in order to fear God in their actions and maintain their marriages. The religion (or *Deen*) can be used as a powerful source to dispel faulty cognitions and to re-educate about roles and responsibilities in marital relationships. Muslims need to remind themselves of the Hadiths of Prophet Muhammad (ﷺ) and start implementing these actions to help decrease the rates of divorce. The Prophet (ﷺ) said:

> If there comes to you to marry (your daughter) one who with whose religious commitment and character you are pleased, then marry (your daughter) to him, for if you do not do that, there will be *fitnah* (tribulation) in the land and widespread corruption.
>
> *(Tirmidhî, n.d.)*

In modern society, there are too many un-Islamic traditions and habits that we expect our spouses to conform to, while ignoring the Qur'aanic injunction to abide with our spouses with '*mutual mercy and love*' (Ar-Rūm (The Romans)

30:21). Many distressed Muslim couples seek to follow religious teachings that urge spouses to seek mediation from family in times of marital conflict. But immigrant Muslims may not have easy access to their extended family or resources to deal with their problems. However, the counselling services provided should be culturally appropriate and sensitive to the needs of Muslim communities.

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14

RELIGIOUS COPING STRATEGY AND SPIRITUAL INTERVENTIONS

Introduction

In Islamic counselling, spiritual and religious activities can be practised to alleviate and treat spiritual and psychological problems. It has been suggested that 'the blending of spirituality with the tenets of alternative, complementary, and integrative therapies provides individuals with a means of understanding how they contribute to the creation of their illness and to their healing' (Micozzi, 2006, p. 305). Religion and spirituality also directly affect mental and physical health, for they influence coping strategies, health behaviours and healthcare-seeking attitudes (Bonelli and Koenig, 2013; Koenig, 2009; Larson *et al.*, 2002). Richards and Bergin (1997) differentiate between religious and spiritual interventions on the basis of structure. Religious interventions are more structured, denominational, external, cognitive, ritualistic and public, whereas spiritual interventions are more cross-cultural, affective, transcendent and experiential. There is evidence to suggest that religious and spiritual dimensions of counsellors are related to the use of religious and spiritual interventions (Cornish *et al.*, 2012; Frazier and Hansen, 2009).

From an Islamic perspective, religious and spiritual interventions are interrelated. For Muslims, spirituality and religiosity can be seen to link the personal to the transcendental domains and both include striving for this life and the Hereafter. Muslims report being the most spiritual and engaging most frequently in private religious practices compared to other religious groups (Johnstone *et al.*, 2012). It is stated that a 'client's relationship with God is likely to feature for most people from Muslim backgrounds, including those who are ambivalent about religion or struggling to make sense of their identity' (Meer and Mir, 2014, p. 3). Within the framework of religious and spiritual interventions, Muslims may use religion and spirituality as resources in coping. Religious coping strategies involve the observance of religious practices and acting on religious beliefs. This is perceived by

Muslims as providing a more hopeful perspective and encouraging resilience (Meer and Mir, 2014). This chapter will examine religious and spiritual coping, types of coping strategies, positive and negative coping strategies, strategies of religious coping and Islamic spiritual interventions.

Religious and spiritual coping

A growing body of literature suggests that people often turn to religion when coping with stressful events, or psychological and spiritual problems. Religious coping is a multidimensional construct that covers a range of negative and positive, problem- and emotion-focused strategies (Harrison *et al.*, 2001; Pargament, 1997). Religious coping can be classified as an organisational religious behaviour, private religious or spiritual practices and non-traditional spiritual practices (Maltby *et al.*, 1999). Organisational religious behaviour refers to congregational attendance (Idler, 1999), institutional behaviours including prayer, the study of scriptures, saying grace and watching religious television (Levin, 1999). There is a growing evidence base on how individuals use religious and spiritual coping strategies. The ways that people use religion to cope with life events may be intimately connected with the meaning they assign to events, which is referred to as 'perceptions of significance' (Park and Folkman, 1997). That is, different people perceive different things about the same situation and assign different meanings. For example, people will attribute events such as illness or tragedies to a religious agent, for example God, Satan or evil derived from the self. It is stated that the attributions to God may help individuals to uphold their beliefs so as to maintain a sense of personal control when confronted with uncontrollable situations (Pargament and Hahn, 1986; Spika and Schmidt, 1983). Religious coping has demonstrated associations with a variety of social, personal and situational factors, as well as links to psychological and physical health (Harrison *et al.*, 2001).

People use positive or negative strategies, or both, in managing and reducing stress. Positive coping strategies are any actions undertaken so as to limit harmful or detrimental ways in which to reduce stress. Negative coping skills can impede progress in dealing more positively with stress and can have implications for both physical and psychosocial health. The research literature has consistently shown that the use of religion to cope with situations of distress is more common among disadvantaged groups, such as women, ethnic minorities, the sick and those with lower levels of education, income and job status (Ellison, 1991; Krause, 1995; Levin and Taylor, 1997). Similarly, Muslim refugees from Kosovo and Bosnia who resettled in the United States used positive religious and spiritual coping considerably more than negative religious coping (Ai *et al.*, 2003). It is suggested that individuals benefit from both psychological and spiritual interventions aimed at fostering positive coping strategies and reducing negative psychological and spiritual coping strategies (Johnstone *et al.*, 2012; Richards, 2002).

Religious coping methods that have commonly been practised include prayer, listening to religious radio, using amulets, talking to God, having a relationship

with God and having trust in God (Bhui *et al.*, 2008). Abu-Raiya *et al.* (2011) argued that religious coping methods play an important role in the lives of Muslims, and several studies on religious coping among Muslim populations have been reported (Fischer *et al.*, 2010; Gardner *et al.*, 2013; Mehta, 1997; Saffari *et al.*, 2013; van der Ven, 2012). Muslims use religious coping (praying, fasting, attending a mosque or reading the Qur'aan), negative religious coping (finding meaning in life or expressions of a less secure relationship with Allah) and non-religious means of coping (reaching out to others) with stressful events (for example, post-9/11) related to their Muslim identity, such as anti-Muslim comments, special airport security checks and discrimination (Abu-Raiya *et al.*, 2011; Abu-Ras and Abu-Bader, 2008).

Types of coping strategies

A growing body of literature suggests that people often turn to religion when coping with stressful events. The findings from a meta-analysis of 49 relevant studies (Ano and Vasconcelles, 2005) showed that positive and negative forms of religious coping are related to positive and negative psychological adjustment to stress, respectively. There are two main coping strategies: problem-focused and emotion-focused (Gurung, 2006; Lazarus, 1991). Five coping strategies were identified by Aymanns *et al.* (1995): seeking social integration, rumination, threat minimisation, turning to religion and seeking information.

Problem-focused coping is a strategy that takes direct action on the causes of stress and subsequently directly lessens the stress. The aim of problem-focused strategies is either to remove or reduce the cause of the stressor. However, the problem-focused approach will be rather limited in situations where it is beyond the individual's control to remove the stressor(s). Problem-focused strategies include, first, analysis of the situation and the source of stress. Once the source of stress is identified, the next stage is for the individual to take control by changing the relationship between him- or herself and the source of stress (McLeod, 2010). This is a fight (removing the stress) or flight (avoidance) reaction. Information seeking is the next strategy, putting into place cognitive strategies to avoid the stressor in the future and evaluating the pros and cons of different options for dealing with the stressor (McLeod, 2010). In a study by Carver (2011), the findings showed that problem-focused coping had a biological effect on stress, lowering cortisol levels and promoting recovery from the stress. However, problem-focused coping is ineffective when an individual cannot exert control over a circumstance or stressor, or cannot make an adjustment to the stressor (Carver, 2011). This strategy is not possible when dealing with emotion-based stressors. For example, feelings of grief, loss or bereavement cannot be adjusted or modified. Here, the use of emotion-focused coping will be more effective.

Emotion-focused coping is aimed at changing the negative feelings associated with stress. The option to use an emotion-focused coping strategy is when the source of stress is beyond the individual's control. Emotion-focused coping strategies are

effective in the management of unchangeable stressors (DeGraff and Schaffer, 2008). Emotion-focused coping includes a wide range of responses, ranging from self-relief or de-stressing (for example, relaxation or seeking emotional support), to expression of negative emotion (for example, screaming or crying), to a focus on negative thoughts (for example, reflection), to attempts to escape stressful situations (for example, avoidance, denial or wishful thinking). The strength of emotion-focused coping is that the approach enables an individual to deal with both emotions and solutions and provides an opportunity for self-reflection on potential solutions. These coping mechanisms involve a cognitive reappraisal process that includes self-reflection and taking control over one's emotions (Carver, 2011). Seeking professional help, social support and using spiritual or religious interventions would be part of the solution.

Religious coping in an Islamic context

The strategy of religious coping to deal with life's difficulties and give individuals a meaningful interpretation of difficult events is derived mainly from the Qur'aan and the Prophet's (ﷺ) teachings. Muslim clients are encouraged to heal themselves through prayers, supplications or *Du'as*, meditation, reading the Qur'aan and trusting God. The Qur'aan emphasises clearly that the difficulties in this world are to test believers and also asks people to have patience in facing their problems. Allah tests our sincerity and our faith by giving us favours or difficulties on different occasions. Allah reminds us (interpretation of the meaning):

> *Every soul will taste death. And We test you with evil and with good as trial; and to Us you will be returned.*
>
> *(Al-'Anbyā' (The Prophets) 21:35)*

> *And We will surely test you with something of fear and hunger and a loss of wealth and lives and fruits, but give good tidings to the patient.*
>
> *(Al-Baqarah (The Cow) 2:155)*

These trials and tribulations have a 'perception of significance' for Muslims and they are required to be patient to achieve spiritual growth and development. Despite the trials and tribulations, Allah does not give any burden more than one can bear (interpretation of the meaning):

> *Allah does not charge a soul except [with that within] its capacity. It will have [the consequence of] what [good] it has gained, and it will bear [the consequence of] what [evil] it has earned.*
>
> *(Al-Baqarah (The Cow) 2:156)*

There are many verses of the Qur'aan asking Muslims to bear these trials, despair and sadness with 'patient perseverance and prayer'. For example, Allah says (interpretation of the meaning):

> *O you who have believed, seek help through patience and prayer. Indeed, Allah is with the patient.*
>
> *(Al-Baqarah (The Cow) 2:153)*

That is, patience combined with prayer, as patience is needed in all activities, including prayer. In another verse, Allah says (interpretation of the meaning):

> *And seek help through patience and prayer, and indeed, it is difficult except for the humbly submissive [to Allah].*
>
> *(Al-Baqarah (The Cow) 2:45)*

Other verses include (interpretation of the meaning):

> *O you who have believed, persevere and endure and remain stationed and fear Allah that you may be successful.*
>
> *('āli 'Imrān (The Family of Imran) 3:200)*

> *And be patient, [O Muhammad], and your patience is not but through Allah.*
>
> *(An-Naĥl (The Bee) 16:127)*

The exercising of patience is also emphasised in the following verses: Hūd (Hud) 11:115; Ghāfir (The Forgiver) 40:55; Fuṣṣilat (Explained in Detail) 41:35; and Al-'Aṣr (The Declining Day) 103:2–3.

Since Allah is the decision maker, believers must be dependent on Allah and have trust in Him (*Tawakkul*). Below are verses that express this trust in Allah (interpretation of the meaning):

> *Put your trust in Allah. Allah loves those that trust [in Him].*
>
> *('āli 'Imrān (The Family of Imran) 3:159)*

> *Say, 'Never will we be struck except by what Allah has decreed for us; He is our protector.' And upon Allah let the believers rely.*
>
> *(At-Tawbah (The Repentance) 9:51)*

> *And will provide for him from where he does not expect. And whoever relies upon Allah – then He is sufficient for him. Indeed, Allah will accomplish His purpose. Allah has already set for everything a [decreed] extent.*
>
> *(Aṭ-ṭalāq (The Divorce) 65:3)*

> *And why should we not rely upon Allah while He has guided us to our [good] ways. And we will surely be patient against whatever harm you should cause us. And upon Allah let those who would rely [indeed] rely.*
>
> *('Ibrāhīm (Abraham) 14:12)*

There is also a saying of Prophet Muhammad (ﷺ):

> If you had all relied on Allah as you should rely on Him, then He would have provided for you as He provides for the birds, who wake up hungry in the morning and return with full stomachs at dusk.
>
> *(Tirmidhî, cited in Thameenah, 2009)*

Remembrance of Allah

The concept of remembrance of Allah (*dhikr*) is central to Islamic practices and Allah and His Prophet (ﷺ) have praised the blessings of *dhikr* in numerous verses and sayings. The remembrance of Allah, in the form of glorifying, exalting and praising, is a powerful remedy related to feeling better and coping with difficulties. For example, Allah says in the Qur'aan (interpretation of the meaning):

> *So remember Me; I will remember you. And be grateful to Me, and do not deny Me.*
>
> *(Al-Baqarah (The Cow) 2:152)*

> *Those who have believed and whose hearts are assured by the remembrance of Allah Unquestionably, by the remembrance of Allah hearts are assured.*
>
> *(Ar-Ra'd (The Thunder) 13:12)*

> *And remember the name of your Lord and devote yourself to Him with [complete] devotion.*
>
> *(Al-Muzzammil (The Enshrouded One) 73:8)*

It is stated that:

> All scholars of Islam have agreed on the acceptance and permissibility of the remembrance of Allah by heart and by tongue, for the adult men and women, for children, for the one who has ablution, and for the one without ablution; even for the woman during her menses. Moreover, *dhikr* is allowed by all scholars in the form of *tasbih* (glorifying), *tahmid* (praising), *takbir* (exalting), and praising for the Prophet(s).
>
> *(Imam Nawawi, n.d.)*

The Prophet (ﷺ) said: 'The example of the one who remembers his Lord (God) in comparison with the one who does not remember his Lord is that of the living and the dead' (Bukhârî and Muslim, cited in Qadhi, 2009). That is:

> [the difference] between life and death is the same difference between the one who does *dhikr* versus the one who does not do *dhikr*. A sign of true life, a sign of spiritual life, a sign of real life is that you need the Giver of life. You need the mercy of the One who gives you this life and that is Allah. If you truly have spirituality, if your heart is alive, it will be manifested in *dhikr*.
>
> *(Qadhi, 2009)*

One of the blessings of *dhikr* is that it purifies the heart and makes it alive. Allah says in the Qur'aan (interpretation of the meaning):

> *No! Rather, the stain has covered their hearts.*
>
> *(Al-Muṭaffifīn (The Defrauding) 83:14)*

That is, 'The only thing that blocked their hearts from believing in it is the dark covering cast over it from the many sins and wrong they committed that has covered up their hearts' (Ibn Kathir, n.d.). And that is why one of the great scholars of medieval Islam, Sheik Islam Ibn Taymiyah, said that the example of *dhikr* to the heart is that of fish to water; and if you don't do *dhikr*, your heart will die (cited in Qadhi, 2009). Qadhi (2009) recommended that, in order to do *dhikr* perfectly, one needs to be sincere and ask Allah 'O Allah make me amongst those who do dhikr perfectly.' It was the Prophet (ﷺ) who told Mu'adh Ibn Jabal, the famous companion, never to forget to say *dhikr* after the prayer (*Salaat*). Furthermore, there are other religious interventions that involve specific prayers, fasting, pilgrimage and reciting verses of the Qur'aan.

Prayer as a coping strategy

Prayer has been defined as 'thoughts, attitudes, and actions designed to express or experience connection to the sacred' (McCullough and Larson, 1999, p. 86). Praying and having faith in God are the strategies that are the most frequently used to cope with personal problems (Bade and Cook, 2008; Koenig *et al.*, 1988). The formal prayer, a direct communication or conversation with the divine, is a very significant element in helping people cope with their difficulties. According to Richards and Bergin (1997), prayer is an expression of relatedness to the divine rooted in most religions. Four types of prayer have been identified: petitionary, conversational, ritual and meditative (Poloma and Gallup, 1991). In a cross-sectional, descriptive study, Dunn and Horgas (2000) reported that the most frequently reported alternative treatment modality use by elders (84 per cent) was prayer. In a study of caregivers, Stolley *et al.* (1999) concluded that prayer may be the most profound religious coping behaviour used and can support the use of other positive coping methods.

For Muslims, prayer (*Salah*) is the second pillar of Islam. The main purpose of prayer is the remembrance of God as stated in the Qur'aan (interpretation of the meaning):

> *Indeed, I am Allah. There is no deity except Me, so worship Me and establish prayer for My remembrance.*
>
> *(ṭāhā (Ta-Ha) 20:14)*

> *Maintain with care the [obligatory] prayers and [in particular] the middle prayer and stand before Allah, devoutly obedient.*
>
> *(Al-Baqarah (The Cow) 2:238)*

Through prayer, there is also direct communication with Allah. That is, the nearest a person is to the Lord is when he or she is the state of prostration (*Sajdah*). *Sajdah* is an action that exhibits the highest degree of humility of a creature before the Creator. When a person performs prostration he or she is basically acknowledging the fact that he or she is completely inferior to Allah (islamic-dictionary.tumblr.com, n.d.). Furthermore, the way to success lies in the prayer: the Prophet (ﷺ) said:

> The first thing among their deeds for which the people will be brought to account on the Day of Resurrection will be prayer. Our Lord will say to His angels, although He knows best, 'Look at My slave's prayer, is it complete or lacking?' If it is complete, it will be recorded as complete, but if it is lacking, He will say, 'Look and see whether my slave did any voluntary (*Nawâfil*) prayers.' If he had done voluntary prayers, He will say, 'Complete the obligatory prayers of My slave from his voluntary prayers.' Then the rest of his deeds will be examined in a similar manner.
>
> *(Abu Dawud, cited in islamqa [e], n.d.)*

Another function of prayer is acting as a shield or protection against evil. Allah says (interpretation of the meaning):

> *Indeed, prayer prohibits immorality and wrongdoing, and the remembrance of Allah is greater. And Allah knows that which you do.*
>
> *(Al-'Ankabūt (The Spider) 29:45)*

In addition, prayers wipe out the sins or evil deeds. Allah says (interpretation of the meaning):

> *Indeed, good deeds do away with misdeeds.*
>
> *(Hūd (Hud) 11:114)*

Prayer is a form of meditation that gives your soul peace and contentment. Allah says (interpretation of the meaning):

> *Those who have believed and whose hearts are assured by the remembrance of Allah. Unquestionably, by the remembrance of Allah hearts are assured.*
>
> *(Ar-Ra'd (The Thunder) 13:28)*

Accordingly, the characters that prayer builds include God fearing, good speaking and good acting (Philips, 2007, p. 80). The Prophet (ﷺ), whenever he was afflicted with hardship, would say: 'O Bilal! Give us comfort and call for the Salaat!' (Bilal was chosen by the Prophet (ﷺ) to lead the call to daily prayers at the mosque). Gubi (2008) demonstrates the benefits of prayer and spirituality as well as methods of integrating prayer into counselling. He suggested that prayer can be

part of the counselling session and can be said at the beginning or end of the session. So the daily prayers are a source of comfort and tranquillity.

Spiritual interventions in counselling may include the prayer of repentance (*Salaat al-Tawbah*) prescribed in Islamic jurisprudence (*Shari'ah*). That is, clients can perform this act of worship where sinners can draw close to their Lord with the hope of their repentance being accepted. It is narrated that the Messenger of Allah (ﷺ) said:

> There is no one who commits a sin then purifies himself well and stands and prays two rak'ahs (units of prayer), then asks Allah for forgiveness, but Allah will forgive him. Then he recited this verse: 'And those who, when they have committed Faahishah (illegal sexual intercourse) or wronged themselves with evil, remember Allah and ask forgiveness for their sins; – and none can forgive sins but Allah.'
>
> *(Abu Dawud, cited in islamqa [f], n.d.)*

Making supplications (*Du'as*)

Allah says in the Qur'aan (interpretation of the meaning):

> *So remember Me; I will remember you. And be grateful to Me and do not deny Me.*
> *(Al-Baqarah (The Cow) 2:152)*

Supplications have enormous potential to help us ask for forgiveness and other things. The following are some of the Prophet's (ﷺ) sayings about making *Du'as* to Allah. The Prophet (ﷺ) said: 'The du'aa' of any one of you will be answered so long as he does not seek to hasten it, and does not say, "I made du'aa' but I had no answer"' (Bukhârî and Muslim, cited in islamqa [i], n.d.). Abu Hurayrah reported:

> The Messenger of Allah (ﷺ) said: 'There is no man who prays to Allah and makes *Du'as* to Him, and does not receive a response. Either it will be hastened for him in this world, or it will be stored up for him in the Hereafter, so long as he does not pray for something sinful, or to cut the ties of kinship, or seek a speedy response.' They said, 'O Messenger of Allah, what does seeking a speedy response mean?' He said, 'Saying, "I prayed to my Lord and He did not answer me."'
>
> *(Tirmidhî [a], n.d.)*

The Prophet (ﷺ) said:

> If a person who is afflicted by anxiety or sorrow says: *'Allaahumma inni 'abduka wa ibnu 'abdika wa ibn ammatika naasiyati bi yadika maadin fiyya hukmuka 'adlun fiyya qadaa'uka as'aluka bi kulli ismin huwa laka sammayta bihi nafsaka aw 'allamtahu ahadan min khalqika aw anzaltahu fi kitaabika aw asta'tharta bihi fi 'ilm il-ghaybi*

> *'indaka an taj'al al-Qur'aana rabee'a qalbi wa noora sadri wa jalaa'a huzni wa dhahaaba hammi* (O Allah, I am Your slave, son of Your slave, son of Your female slave, my forelock is in Your hand, Your command over me is forever executed and Your decree over me is just. I ask You by every name belonging to You with which You have named Yourself, or You have taught to any of Your creation, or You have revealed in Your Book, or You have preserved in the knowledge of the Unseen with You, that You make the Qur'aan the life of my heart and the light of my breast, and a departure for my sorrow and a release for my anxiety)', then Allah will take away his anxiety and sorrow, and will replace it with joy.
>
> *(Ahmad, cited in islamqa [g], n.d.)*

Healing from the Qur'aan

The Qur'aan is not a textbook of medicine; rather, it contains rules of guidance that, if followed, will promote good health and healing (Athar, 2012). Allah says in the Qur'aan (interpretation of the meaning):

> *O mankind, there has to come to you instruction from your Lord and healing for what is in the breasts and guidance and mercy for the believers.*
>
> *(Yūnus (Jonah) 10:57)*

Another verse on the same theme is:

> *And We send down of the Qur'aan that which is healing and mercy for the believers, but it does not increase the wrongdoers except in loss.*
>
> *(Al-'Isrā' (The Night Journey) 17:82)*

According to Athar (2012):

> Healing from the Quran is of three types: (a) Legislative effect: This includes faith (Iman) in God as not only the Creator but the Sustainer and the Protector. This also includes the medical benefits of the obligatory prayers, fasting, charity and pilgrimage; (b) Health Guidelines: Health-promoting items from the Quran and the tradition of the Prophet Mohammed (ﷺ) including the use of honey, olives, fruit, lean meat, avoiding excessive eating, and the prohibition of alcohol, pork, homosexuality, sexual promiscuity and sex during menstruation; (c) The direct healing effect of the Quran: Recitation of Quran by the ill or for the ill (*ruqya*) has shown to have a direct healing effect . . . Listening to the recitation of the Holy Quran has been shown, in a study conducted by . . . Kadi and his associates, to lower blood pressure and heart rate, and to cause smooth muscle relaxation in Muslim Arabs, non-Arab Muslims and even in non-Muslims.

Furthermore, 'It is permissible for you to recite Qur'aan over water and to drink some of it and wash yourself with it' (islamqa [a], n.d.).

The Qur'aan contains innumerable benefits, so everyone who seeks happiness in this world and in the Hereafter must refer to it for judgement and follow its commands. Imam Ibn Hazm said:

> Because the proof and the miracles indicate that the Qur'aan is the covenant of Allah with us, we must believe in it and act in accordance with it. It has come down to us through generations of Muslims narrating it to those who came after them, which leaves no room for doubt that the Qur'aan is the one which is written in the *Mus-hafs* [codex or collection of sheets – Qur'aan] which we find everywhere. We have to follow its teachings, for it is our reference-point, because we read in it the words (interpretation of the meaning): '*There is not a moving (living) creature on earth, nor a bird that flies with its two wings, but are communities like you. We have neglected nothing in the Book, then unto their Lord they (all) shall be gathered*' [Al-An'ām (The Cattle) 6:38]. Whatever commands and prohibitions are in the Qur'aan, we must adhere to them.
>
> *(Cited in islamqa [b], n.d.)*

Ruqyah

Ruqyah in Islam is the recitation of the Qur'aan, seeking refuge in Allah, remembrance and supplications that are used as a means of treating sicknesses and other problems as the Qur'aan is a source of healing (al-Hakeem, n.d.). The main purpose of *Ruqyah* is to treat and cure evil eye, possession of *Jinn*, envy and black magic. The essence behind this approach is to have sincerity and placed one's full trust, reliance and dependence only on Allah, the source of all healing and cure. It is stated that 'There is nothing wrong with the Muslim reciting *Ruqyah* for himself. That is permissible; indeed it is a good Sunnah, for the Messenger (ﷺ) recited *Ruqyah* for himself, and some of his companions recited *Ruqyah* for themselves' (islamqa [c], n.d.). It was narrated that: 'When the Messenger of Allah (ﷺ) was ill, he would recite *al-Mi'wadhatayn* over himself and spit drily. When his pain grew intense, I recited over him and wiped him with his own hand, seeking its *barakah* (blessing).' (Bukhârî and Muslim, cited in www.missionislam.com [b], n.d.). With regard to the supplications that are prescribed for Muslims to say if they want to recite *Ruqyah* for themselves or for someone else, there are many such supplications, the greatest of which are *al-Fātiĥah* and *al-Mi'wadhatayn*.

Sheikh Assim al-Hakeem (n.d.) stated that the way to perform *Ruqyah* on oneself is:

> recite *Ruqyah* on yourself by gathering the palms of your hands and reciting in them the *Ruqyah* and then blow in your hands and wipe the area that is ill and hurting you. You can also bring Zam Zam water preferably and recite 3, 5 or 7 times the following over it and blow every time you recite it: *Al Fātiĥah*, *Ayatul Kursi*, the last 2 verses of Suratul *Baqarah* and the last 3 Surah of the Qur'aan. You can add to that any Prophetic *Du'as* and blow on it. Drink from this water in the morning, in the afternoon and before going to bed and also you can wipe with it over the places that hurt you.

The *Du'as* that have been narrated in the Sunnah include the following: Muslim (cited in www.missionislam.com [a], n.d.) narrated from 'Uthmaan Ibn Abi'l-Aas that he complained to the Messenger of Allah (ﷺ) about the pain that he had felt in his body from the time he had become Muslim. The Messenger of Allah (ﷺ) said to him: 'Put your hand on the part of your body where you feel pain and say *'Bismillah* (in the name of Allah) three times, then say seven times, *'A'oodhu bi 'izzat-illaah wa qudratihi min sharri ma ajid wa uhaadhir* (I seek refuge in the glory and power of Allah from the evil of what I feel and worry about).' Tirmidhî [b] (n.d.) added: 'He said, I did that, and Allah took away what I had been suffering, and I kept on enjoining my family and others to do that.' The Prophet (ﷺ) would say: 'Your father [meaning Ibrāhīm] used to seek refuge with Allah for Isma'il and Isaac with these words: *A'oodhu bi kalimaat Allah al-taammah min kulli shaytaanin wa haammah wa min kulli 'aynin laammah* (I seek refuge in the perfect words of Allah, from every devil and every poisonous reptile, and from every evil eye)' (Bukhârî, cited in www.missionislam.com [b], n.d.). In addition:

> It was narrated from Abu Sa'eed al-Khudri (may Allah be pleased with him) that Angel Jibreel (ﷺ) came to the Prophet (ﷺ) and said: 'O Muhammad, are you sick?' He said: 'Yes.' He said: 'In the name of Allah, I perform *Ruqyah* for you, from everything that is harming you, from the evil of every soul or envious eye may Allah heal you, in the name of Allah I perform *Ruqyah* for you.'
>
> *(Muslim, cited in islamqa [h], n.d.)*

The scholars advise one Muslim who is sick:

> whether that is spiritual (mental) illness such as anxiety and depression, or physical illness such as various kinds of pain – to hasten first of all to treat the problem with *Ruqyah* as prescribed in Shari'ah . . . Then we advise treating it with natural materials which Allah has created, such as honey and plants, for Allah has created special properties in them which may treat many kinds of diseases . . . We think that you should not take artificial chemical remedies for anxiety. For this disease a person needs a spiritual remedy rather than a chemical one. So he needs to increase his faith and his trust in his Lord; he needs to make more *Du'as* and pray more. If he does that, his anxiety will be removed. Seeking to relax by means of doing acts of worship has a great effect on the soul, dispelling many kinds of psychological disease. Hence we do not see any benefit in going to a psychologist whose beliefs are corrupt, let alone one who is a kaffar. The more the doctor knows about Allah and His religion, the better advice he will give to his patient.
>
> *(islamqa [d], n.d.)*

Sheikh Muhammad Ibn al-'Uthaymin was asked: 'Can a believer become mentally ill? What is the treatment for that according to Shari'ah?' He replied:

> Undoubtedly a person may suffer from psychological or mental diseases, such as anxiety about the future and regret for the past. Psychological diseases affect the body more than physical diseases affect it. Treating these diseases by means of the things prescribed in Shari'ah – for example, *Ruqyah* – is more effective than treating them with physical medicines, as is well known.
>
> *(Cited in islamqa [d], n.d.)*

We need to remind ourselves of the words of Allah (interpretation of the meaning):

> *Verily, with every difficulty there is relief.*
>
> *(Ash-Sharĥ (The Relief) 94:5–6)*

Dealing with anger: spiritual interventions

The Prophet (ﷺ) advised his followers to control their anger at all costs: 'In a saying about advice, the Prophet (ﷺ) said: "Advise me." He [the Prophet (ﷺ)] said, "Do not become angry." The Prophet (ﷺ) repeated [his request] several times and he [the Prophet (ﷺ)] said, "Do not become angry"' (Bukhârî, cited in Zarabozo, 2008). Sheikh Muhammad Ibn al-'Uthyamin suggested that:

> if a person feels angry he should try to counteract this anger in the ways prescribed by the Prophet (ﷺ) when a man asked him, 'O Messenger of Allah, advise me.' He said: 'Do not get angry,' and he repeated it several times, saying, 'Do not get angry.' So he must exercise self-control and seek refuge with Allah from the accursed Shaytan. If he is standing, he should sit down; if he is sitting, he should lie down. If his anger grows too intense, he should do Wudu (ablution).
>
> *(Cited in islamqa [j], n.d.)*

In another saying, the Messenger of Allah (ﷺ) said: 'A strong person is not the person who throws his adversaries to the ground. A strong person is the person who contains himself when he is angry' (Bukhârî, n.d.).

Zarabozo (2008) stated that a Muslim must think before acting or speaking and when the feeling of anger appears it is important to think of why it appears and whether it is necessary to be angry. Furthermore, while asking these questions, the person must remember Allah and the Hereafter (*Akhirah*). This will cause the person to calm down and not get angry. The person needs to be aware of her or his behaviour and the Prophet (ﷺ) has advised us to pay attention to the physical signs of anger (muscle tension, increased pulse, etc.). He said: 'Beware of anger, for it is a live coal on the heart of the son of Adam. Do you not notice the swelling of the veins of his neck and the redness of his eyes?' (Tirmidhî, cited in islamweb, n.d.). The Prophet (ﷺ) described the nature of anger in an individual, saying:

> Some are swift to anger and swift to cool down, the one characteristic making up for the other; some are slow to anger and slow to cool down, the one characteristic making up for the other; but the best of you are those who are slow to anger and swift to cool down, and the worst of you are those who are swift to anger and slow to cool down.
>
> *(Tirmidhî, cited in islamweb, n.d.)*

In various sayings, the Prophet (ﷺ) teaches us different methods of how to control our anger. He emphasised the importance of relaxing one's muscles. He suggested the following: 'When one of you becomes angry while standing, he should sit down. If the anger leaves him, well and good; otherwise he should lie down' (Abu Dawud, cited in islamweb, n.d.). He also stated that one of the ways to control anger is to seek refuge in Allah. The Prophet (ﷺ) said: 'I know a word, the saying of which will cause him to relax, if he does say it. If he says: "I seek Refuge with Allah from Satan" then all his anger will go away' (Bukhârî, cited in islamweb, n.d.); and, 'I know a phrase which, if he repeated, he could get rid of this angry feeling.' They asked: 'What is it, Apostle of Allah?' He replied: 'He should say: "I seek refuge in Allah from the accursed devil"' (Abu Dawud, cited in islamweb, n.d.).

Conclusion

A growing body of literature suggests that people often turn to religion when coping with stressful events. There is evidence to suggest that people from Muslim backgrounds are more likely to use religious coping techniques than individuals from other religious groups in the UK (Barron, 2007). The Islamic approach to psychological and spiritual illnesses is to discover the best possible therapeutic methods by using a combination of traditional psychotherapeutic approaches and spiritual interventions. Spiritual interventions are recommended for all physical, psychological disorders and spiritual problems. Ibn al-Qayyim al-Jawziyyah (2004) stated that once a person abandons the Qur'aan, he or she abandons all means of healing the sick through it as well. The Islamic counsellor should use both traditional congruent therapy in line with Islamic principles and spiritual interventions. Ameen (2005) suggested that Muslim medical practitioners (or counsellors) should conduct *Ruqyah* upon Muslim patients regardless of the specificities of their psychological illness. Spiritual interventions, including *Ruqyah*, may become a therapeutic tool in a counsellor's repertoire of treatment modalities. Indeed, a recent study has found that religious therapy, in addition to traditional therapy, can be quite beneficial to the treatment (Hook *et al.*, 2010). The challenges to incorporate spiritual interventions in traditional therapies are for both non-Muslim and Islamic counsellors.

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15

TOWARDS AN ISLAMIC COUNSELLING PRACTICE MODEL

Introduction

Counsellors use 'models' or theoretical representations to help them understand human problems and how to enable clients to achieve more accomplished and fulfilling lives. In the previous chapters, it was acknowledged that the application of some elements of the mainstream counselling approaches to therapeutic intervention is often incompatible with Muslim clients (al-Abdul-Jabbar and al-Issa, 2000; Azhar and Varma (2000); Banawi and Stockton, 1993; Carter and el-Hindi, 1999; Haque, 2008, 2010). However, with the emergence of Islamic psychology and as more literature on Islamic counselling becomes available, there is now more critical examination of the theoretical bases and approaches necessary to constitute a framework model of intervention for Islamic counselling. This has led to several models of Islamic counselling based on different ideologies and approaches. Therefore, the best approach to Islamic counselling is the inclusion of the good aspects of mainstream counselling and incorporating the Qur'aan and the Sunnah. This chapter aims to examine the different models or approaches to Islamic counselling and outlines a framework for Islamic counselling practice.

Models of Islamic counselling

From a historical perspective, the traditional model of Islamic counselling was provided in various forms, the most common of which were giving advice and sharing wisdom. Islam underscores the value of sincerity and sincere advice in Muslim relations: 'The Prophet (ﷺ) said (three times), "The Religion is sincerity and sincere advice (*Naseeha*)." We said, "To whom?" He said, "To Allah, His Book, His Messenger, and to the leaders of the Muslims and the general people"' (Muslim, n.d.). Tribal chiefs, elders or religious leaders offer important support networks and resources to assist with individual and family problems.

Abdullah (2007) has identified three approaches to counselling: traditional healing (cultural model), Muslim personal law (MPL) and Sufism. Traditional healing in Muslim communities is widely practised by local healers, Sheiks or Imams for understanding psychological or spiritual problems that are caused by the evil eye or spirit (*Jinn*) possession. This type of healing practice has been shown to hold the same therapeutic value as mainstream counselling approaches (al-Krenawi and Graham, 1997) and many still access this service in the Muslim world (al-Rawi *et al.*, 2011; Azaizeh *et al.*, 2010; Edwards, 2011; Ypinazar and Margolis, 2006, p. 780). However, many of the rituals of the traditional healers will include sorcery and black magic, which are not acceptable within the Islamic framework as they are not in accordance with the teachings in the Qur'aan and Sunnah, and are even banned in certain Muslim countries (al-Issa, 2000).

Abdullah (2007) has identified another model of Islamic counselling based on MPL: 'Since Imams typically deal with marital and family problems, Muslim personal law (MPL) provides the legal framework for regulating family life in Islam, [and] is the basis of their intervention' (p. 45). The focus of this type of therapy is related to matters including divorce, maintenance, child custody and inheritance based on the Islamic law (*Shari'ah*). Another approach in the model of Islamic counselling is based on Sufism (Badri, 1979; Jafari, 1993). It has been suggested that Sufism can have therapeutic outcomes and aspects of its practice, especially *dhikr*, are part of counsel in MPL and Islamic traditional healing (Abdullah, 2007). The Sufi principles of counselling are sometimes amalgamated with cosmology, numerology and astrology (Bakhtiar, 1994) and the use of devotional practices, music, poetry and mystical experience, including Rumi's divine love (Ozelsel, 2007; van Bruinessen and Howell, 2007). The Sufi Sheikh's multiple roles include those of a psychologist/counsellor/social worker/psychiatrist (Spiegelman *et al.*, 1991). The concept of 'transnational Sufism from below' as a form of religious counselling has been proposed by Rytter (2014). This concept is characterised when migrant families are experiencing a period of radical social change and turn towards Sufi Sheikhs in their country of origin for religious counselling in dealing with the contingencies of everyday life.

Another model of Islamic counselling is that developed by Stephen Maynard & Associates (Dharamsi and Maynard, 2010). The authors maintained that their model is based on the Qur'aan, the Sunnah and the Islamic Science of the Self (*Tassawuf*). According to Maynard and Dharamsi (n.d.), Islamic counselling is based on the study or science of the self and on the relationships between people, their world and the reason for existence itself. Within this framework, mental health is considered to be a dynamic balanced state between the inner and outer aspects of a person's being. Within this holistic approach, presenting problems are therefore a means for self-development and it is through self-reflection that clients are able to heal themselves. They added that Islamic counselling is not 'about judging people or giving them advice on *Fiqh* (Islamic jurisprudence), but rather working with people to facilitate them in reaching their highest potential (Islamic counselling)'. Some of the characteristics of the model of Islamic counselling as advocated by

Stephen Maynard & Associates (www.islamiccounselling.info/index.htm) are: self-knowledge; seeing people in light of their true potential; the goodness in people; transformative processes; and the relationship of oppositions. The model is assumed to be based on the concept of *Tawheed*, and Islamic counsellors take on a multi-faceted role in that they provide advice, information, advocacy, consultancy and counselling – body, mind and soul working with the interpersonal at a social and/or political level.

Keshavarzi and Haque (2013) have proposed a model of counselling/psychotherapy for enhancing mental health within an Islamic context. The model takes as one of its components the view that Islamic culture is generally collectivist. The framework of this model is based on the use of al-Ghazali's conceptualisation of the human soul, into four aspects of a person that signify his or her spiritual identity. These are the *Nafs*, *Aql*, *Ruh* and *Qalb* (heart). The *Nafs*, similar to Freud's conception of the id, is the acquired automatic tendencies of the human being (see Chapter 4). The *Aql* is related to logic, reason and acquired intellectual beliefs. The *Ruh* is the spirit and the *Qalb* is the heart, sometimes used synonymously with 'self' and 'soul'. However, Muslims are also governed by three disciplines in which they are required to actively engage, both intellectually and experientially, in order to live life as complete Muslims. These disciplines include the Islamic creed (*Aqeedah*), jurisprudence (*Fiqh*) and the science devoted to the nourishment of the soul (*Tazikiyyah* or *Tassawuf*). According to Keshavarzi and Haque (2013), in order to remove sicknesses of the heart, 'one must work toward modifying the inclinations of the *Nafs* toward good, restructuring and acquiring positive/moral thoughts in the *Aql*, and feeding the spirit through remembrance of God' (p. 239). The goal of the practitioner in this model would focus on intervening on one of these levels (*Nafs*, *Ruh* or *Aql*) or on all three levels of the self towards a healthy heart and towards self-actualisation. The components of the model include: the therapeutic alliance, using curiosity to gather information for assessment; use of a directive approach; and advice-giving. In addition, psychoeducation, integrated cognitive behavioural therapies and spiritual healing practices are part of the treatment interventions.

Limitations and strengths of existing models of Islamic counselling

Some of the theoretical models of Islamic counselling examined above are limited in the description of the underlying philosophy, assumptions, basic principles and elements, concepts, strategies and techniques. In relation to the core theoretical model, some of these models provided limited information or failed to meet the criteria based on the following questions:

- What assumptions are made about the nature and development of human beings?
- How do psychological problems develop?

- How does the model account for the perpetuation of psychological problems?
- How does the model explain the process of therapeutic change?
- What is the range of therapeutic intervention strategies expounded in the core model?
- How does the model deal with any apparent discrepancies between theoretical and practical aspects?
- What are the comparisons with other counselling/psychotherapy approaches?

Some models are esoteric in nature and scope and are heavily influenced by Sufi ideologies and practices. The spiritual healing practices of Sufism, including the supplementary and supererogatory rituals, are regarded as innovations (*bid'a*). The mainstream Islamic scholars have regarded as particularly objectionable 'the Sufis' repetitive *dhikr* litanies, which can facilitate ecstatic experiences, especially in extended group performances where people may punctuate their utterances with emphatic bodily movements or accompany them with dance' (van Bruinessen and Howell, 2007, p. 7). These spiritual interventions are not consistent with Islamic norms and practices and the creed of *Ahlus Sunnah Wal Jamaah*.

Keshavarzi and Haque's (2013) model is currently the most comprehensive and robust model for enhancing Muslim mental health within an Islamic context. This model is not a concise or technique-driven theory. However, the model fulfils most of the criteria in relation to its philosophy, assumptions, concepts, strategies and techniques. One particular strength of Keshavarzi and Haque's model is that it is not tied to any particular therapeutic technique, but does promote the collaborative therapeutic counselling relationship. This approach promotes clients' personal growth and development, and helps clients resolve the ultimate struggle in their spiritual development. The model is psychosocial in its orientation and is more closely aligned with practical interventions that are consistent with the Islamic views of the varying elements of the human being. The model provides the counsellor with a set of principles and constructs that serve as a guide to the foundation of Islamic counselling practice.

In Keshavarzi and Haque's (2013) model of Islamic counselling, the authors identified some of its limitations. They stated:

> this model is not postulated to be comprehensive enough as a manual for the treatment of the disorder with Muslim populations, nor does it offer a sufficient discussion of the various presentations of clinical pathologies that would necessitate accommodations or adjustments in the application of the model.
>
> *(p. 246)*

As Rogers noted, every theory, including his own, contains 'an unknown (and perhaps at that time unknowable) amount of error and mistaken inference'. He believed that a theory should serve as a stimulus to further creative thinking (cited in www.person-centered-counseling.com, n.d.). Moreover, Keshavarzi

and Haque (2013) claimed that their model is also 'heavily contingent upon the religious investment and motivation of the client. Thus, if an individual does not identify as a Muslim at all, then much of this model may be inapplicable, unless the approach is preserved, but secularized' (p. 246). It is argued that, despite the lack of motivation of the client, it would be valuable to enable or 'nudge' the client from a pre-contemplation stage to a contemplation stage (Prochaska and Velicer, 1997; Prochaska *et al*., 1992) in relation to readiness to change. In addition, this model would be inappropriate for non-Muslims who would probably benefit from Western-oriented counselling. Besides, how do you secularise an approach that is Islamic-oriented and which has spiritual development as its core dimension in the counselling process? What is not clear with this model is its application, in practice, to those with dual diagnosis and with personality disorders. Further, evidence suggests that Islamic traditional healing works mainly for treating neurotic symptoms, as opposed to severe mental or physical illness where it will fail (Razali, 1999). In addition, the model assumes a level of verbal ability and thus needs to be adapted for use with clients with limited verbal skills. Further refinement needs to be undertaken to make its application viable in different settings with a diversity of psychosocial and spiritual problems.

Towards an Islamic counselling practice model

A counselling practice model is a collection of ideas, knowledge, values and practical application concerning counselling that determines the way counsellors use the structure to work with their clients. The Islamic counselling practice model is an adaptation based on Barise's (2005) social work practice model, which integrates social work processes, the conceptual framework of helping, problem solving and change with an Islamic worldview. It is important to view the Islamic counselling practice model as a tool for the counselling process rather than as a rigid template for counselling practice. The Islamic counselling practice model is presented in Figure 15.1. This eleven-stage model has been conceptualised for a variety of problem behaviours and intervention strategies. The proposed model consists of selected concepts (Ibn al-Qayyim al-Jawziyyah, n.d.) and is based on the following stages: awakening (*Qawmah*) and intention (*Niyyah*); consultation (*Istisharah*); contemplation (*Tafakkur*); guidance-seeking (*Istikhara*); wilful decision (*'Azm*); goal-and-route vision (*Basirah*); absolute trust in God (*Al-Tawakkul-Allah*); action (*'Amal*); help-seeking (*Isti'aanah*); self-monitoring (*Muraqabah*); and self-evaluation (*Muhasabah*).

The Islamic counselling practice model is a circular (or spiral) rather than a linear model. Generally, it is assumed that, when one stage is completed, clients would move on to the next stage. While that is a possibility, it is more likely that clients may go through several cycles of awakening (*Qawnah*) contemplation (*Tafakkur*) and goal and route vision (*Basirah*) before either reaching the action (*'Amal*) or exiting the system without the attainment of the desired and permissible goals The stages are not clearly delineated, and many stages must be re-experienced

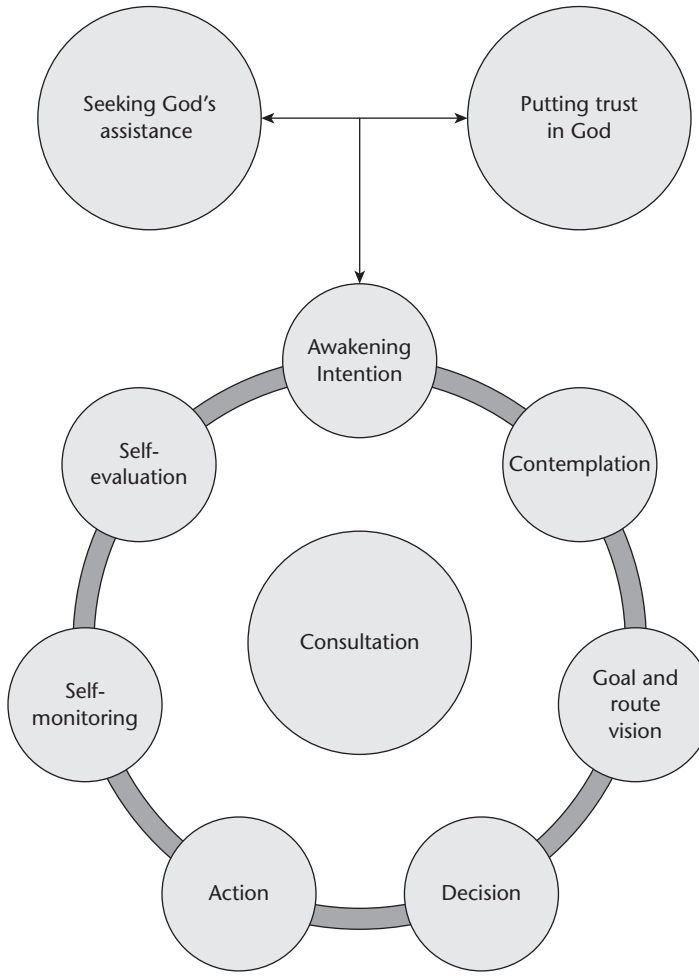

FIGURE 15.1 Islamic counselling practice model

Source: Adapted from Barise, A. (2005) 'Social work with Muslims: insights from the teachings of Islam', *Critical Social Work*, 6(2)

or readjusted, partly or completely, and the client passes through the counselling process and enters and exits at any stage and often recycles several times.

One of the Islamic counselling practice model's major benefits is that it is flexible enough to enable counsellors to meet the diversity of Muslim cultures. However, the practice model is based on the assumption that the client is a Muslim, as this model is slanted towards an Islamic theological perspective and practice model orientation. Barise (2005) maintained that counsellors must be aware of, and respect the different levels of, religiosity within the Muslim community, and clients must be allowed to choose the extent to which they want to adhere to this model. In this context, counsellors could help clients who are working on religious issues to feel as though their religious values are an accepted part of the counselling process

and therefore an important part of the solution to the problems as well (Podikunju-Hussain, 2006). The proposed practice model is also appropriate for those clients who are not motivated to change, because it is adaptable to each client's set of psychosocial and spiritual needs. The proposed model allows the involvement of family members as it is also critically important for counsellors to become familiar with the cultural expectations of the broader family (Springer *et al.*, 2009). The involvement of the family in the counselling process would enable the family member(s) to understand what the client is experiencing, resulting in better psychosocial and spiritual support for the client.

A concept selected for inclusion in the Islamic counselling practice model is the contract (*Musharata*) (al-Ghazali, 1853/1986). This contract, in the context of the proposed model, is twofold. A personal contract is made towards the meeting of identified goals. The identified goals, the target of therapy, are negotiated between the counsellor and the client during the stage of contemplation (*Tafakkur*) of the counselling process (see below). In addition, a professional contract or mutual agreement is also negotiated between the counsellor and the client. The professional contract articulates the responsibilities of the counsellor and client in the context of the therapeutic relationship and counselling process. The contract may include issues of codes of ethics, confidentiality, boundaries, duration of counselling sessions, fees (if appropriate), cancellation of sessions, freely given consent to this contract, records and termination of contract. This contract is endorsed by both the client and the counsellor.

*Stage of awakening (*Qawmah*) and intention (*Niyyah*)*

Qawmah, which means awakening or becoming conscious, is part of the first stage of the Islamic counselling practice model. *Qawmah* is often what brings the client to seek professional help. Initially, it is important for the counsellor to assess the client's readiness to change. The transtheoretical model (Prochaska and Velicer, 1997; Prochaska *et al.*, 1992) is an integrative model where behavioural change is viewed as a process with individuals at various levels of motivation or stages for 'readiness' to change (precontemplation, contemplation, preparation, action and maintenance). Various interventions may be used to facilitate the transition from the different stages of change. These include support, counselling, motivational interviewing (Miller and Rollnick, 2002, and cognitive behavioural therapies.

According to Barise (2005), *Qawmah* refers to the client becoming aware of the need for change and the problem that must be solved. Applying the stages of change model, the client in the *Qawmah* stage is in the contemplation, preparation and action phase. Clients in the pre-*Qawmah* stage (pre-contemplation) may deny or fail to recognise that they have a problem through lack of knowledge or inertia and do not want to consider a change. For the clients, the impact of the problem has not become fully conscious, or they have given up hope about the possibility of change. In fact, some clients may not change because they believe they cannot change. It is the role of the counsellor to facilitate or 'nudge' the client from a pre-*Qawmah* stage to a *Qawmah* stage (from pre-contemplation to contemplation). Ibn

al-Qayyim al-Jawziyyah (n.d.) stated that one of the signs of *Qawmah* 'is sensitivity to the passage of time as the person realises that there is no time to waste anymore. A resolution to change habits or negative environment is the result of *Qawmah* and the client starts his transformation journey.'

Behavioural intention (*Niyyah*) is a central component of the Islamic counselling practice model. It works in close collaboration with *Qawmah*. The meaning of intention (*Niyyah*) and its derivatives is found in the Qur'aan. These words are volition (*al-iraada*), purpose (*al-qasd*) and determination (*al-azm*). These words all suggest 'they want to do or not to do something specific' and indicate both knowledge and action (Zarabozo, 2008, p. 98). The concept of intention (*Niyyah*) in Islam is an important and essential component influencing both deeds and actions. The base of every action of human beings lies in their intention. Muslims believe in the great importance of intention and its importance for the reminder of their deeds, both in this world and the Hereafter on which the authenticity and acceptance of deeds depends. Ibn al-Qayyim al-Jawziyyah (n.d.) defined intention as 'the knowledge of a doer of what he is doing and what is the purpose behind [this action]'. He stated that the intelligent, voluntary actor does not do anything without first conceiving it and wanting it. 'This is the reality of intention which is not something external to the conceptualization of the person and his purpose to do it' (Ibn al-Qayyim al-Jawziyyah, n.d.). Al-Suyooti stated: 'Intention describes the driving force in the heart towards when the person seems to be in conformity with what he wants, of either bringing about good or putting off harm, both present and future' (cited in Zarabozo, 2008, p. 104). An important saying of the Prophet Muhammad (ﷺ) is 'Surely, all actions are but driven by intentions'. That is, the deeds are the external aspect and the intention behind them is the internal aspect (Imam al-Shafi'ee, cited in Zarabozo, 2008, p. 91). Zarabozo explained this as follows:

> First, there must be knowledge of the act that one wants to fulfil. Then the action must follow, as long as there are no preventative factors. In fact, no action will be completed unless it has three components: knowledge of the act, want[ing] to do the act and ability to do the act.
>
> *(2008, pp. 106–7)*

Stage of consultation (Istisharah)

Istisharah (consultation) is the process of collecting relevant information about the client's past and presenting problems. The counsellor consults all appropriate sources of information, starting with the client, the family or significant others. This form of consultation includes the process of assessment. Counselling assessment focuses on gathering information on the bio-psychosocial and spiritual needs of the client. The assessment should include a statement of the presenting problem, development and educational history, family history, a mental health assessment and a risk assessment (if appropriate). The mental/psychological examination

is focused on cognitive, affective and behavioural factors (appearance, thoughts, feelings, insight, etc.) and observation over a period of time. The process of assessment can be enhanced by the style of interaction, which should be non-confrontational, empathic and respectful of the client's subjective experiences. Attempts to have a confrontational and judgemental approach may exacerbate the potential for clients to disengage with the assessment and consultation process.

Stage of contemplation (Tafakkur)

The next stage of engagement with the client is the stage of *Tafakkur*, which is often translated as contemplation (Badri, 2000) or reflection. According to Barise (2005), the concept of *Tafakkur*, in this context, means broader thinking processes that entail both contemplation and reflection. The contemplation, reflection and planning phase of the client's needs involves the development of a plan and is a key component of the structured counselling process. The counsellor and the client are both engaged in analysing the 'issues or problems', set realistic goals and tentatively identify appropriate intervention strategies. However, the effectiveness of the plan is based on the engagement of the client throughout the assessment and counselling process and being actively involved in the formulation of identified goals. Barise (2005) also suggested that, if the identifying problems are primary and secondary problems of a psychological, cognitive, social or biological nature, the original problem is often of a spiritual nature. In addition to the analysis and planning aspects of this stage, the client should 'reflect upon God's creation and uncountable bounties to sharpen his vision and spiritually strengthen his motivation' (Barise, 2005). Islamic contemplation, in addition to achieving the relaxing benefits of meditation, differs fundamentally from Eastern meditative procedures in that its main objective is more cognitive and intellectual. Islamic contemplation is derived from Qur'aanic injunctions and aims to seek insightful knowledge of God as the Creator and Sustainer of the universe (Badri, 2000). Badri (2000) stated that there are individual levels of contemplation that vary in degrees determined by personal, social, cultural and environmental factors. He argues that the determining factor in the depth of contemplation is one's level of faith, that is, deep faith and consciousness of God are the backbone of contemplation.

Stage of guidance-seeking (Istikhara)

Following reflection and contemplation initiated by the counsellor, the next stage is guidance-seeking from the Almighty God. Ibn Hijr said: '*Istikhaarah* is a word which means asking Allah to help one make a choice, meaning choosing the best of two things where one needs to choose one of them' (cited in islamqa [a], n.d.). That is, whenever a Muslim wishes to make an important decision, he or she should seek Allah's guidance and wisdom and perform a specific prayer for guidance (*Salaat-l-Istikhara*). However, it is recommended to consult others (a counsellor/Imam) before praying *Istikhara*. Al-Nawawi said: It is recommended, before

praying *Istikhara*, to consult someone whom you know is sincere, caring and has experience, and who is trustworthy with regard to his religious commitment and knowledge' (cited in Zarabozo, 2008). Allah says (interpretation of the meaning):

> *and consult them in the affairs.*
>
> *('āli 'Imrān (The Family of Imran) 3:159)*

The Prophet Muhammad (ﷺ) said:

> If any one of you is concerned about a decision he has to make, then let him pray two cycles (*rak'ahs*) of non-obligatory prayer, then say: 'O Allah, I seek Your guidance [in making a choice] by virtue of Your knowledge, and I seek ability by virtue of Your power, and I ask You of Your great bounty. You have power, I have none. And You know, I know not. You are the Knower of hidden things. O Allah, if in Your knowledge, this matter (then it should be mentioned by name) is good for me both in this world and in the Hereafter (or: in my religion, my livelihood and my affairs), then ordain it for me, make it easy for me, and bless it for me. And if in Your knowledge, it is bad for me and for my religion, my livelihood and my affairs (or: for me both in this world and the next), then turn me away from it, [and turn it away from me], and ordain for me the good wherever it may be and make me pleased with it.'
>
> *(Bukhârî, cited in islamqa [a], n.d.)*

The transliteration is:

> *Allaahumma inni astakheeruka bi 'ilmika wa astaqdiruka bi qudratika wa as'aluka min fadlika, fa innaka taqdiru wa laa aqdir, wa ta'lamu wa laa a'lam, wa anta 'allaam al-ghuyoob. Allaahumma fa in kunta ta'lamu haadha'l-amra* (then the matter should be mentioned by name) *khayran li fi 'aajil amri wa aajilihi* (or: *fi deeni wa ma'aashi wa 'aaqibati amri) faqdurhu li wa yassirhu li thumma baarik li fihi. Allaahumma wa in kunta ta'lamu annahu sharrun li fi deeni wa ma'aashi wa 'aaqibati amri* (or: *fi 'aajili amri wa aajilihi) fasrifni 'anhu [wasraflhu 'anni] waqdur li al-khayr haythu kaana thumma radini bihi.*

The issue of *Istikhara* is confined to matters that are allowed, liked or encouraged when there is a decision to be made as to which one should be given priority. The wisdom behind prescribing it is that it is:

> submission to the command of Allah and a practical demonstration that one has no power and no strength of one's own. It means turning to Allah and seeking to combine the goodness of this world and of the Hereafter. In order to achieve that, one has to knock at the door of the King, Allah, may He be glorified, and there is nothing more beneficial in this regard than prayer and supplication, because they involve venerating Allah, praising Him and expressing one's need for Him. Then after praying *istikhaarah* one should do that which one feels is best.
>
> *(islamqa [b], n.d.)*

The scholars are unanimously agreed that for Muslims seeking guidance to the right decision from God is a Sunnah and that it is obligatory to believe in what the Prophet (ﷺ) has told us, and to obey his instructions. The Qur'aan speaks of the importance of the Sunnah, for example: Allah says (interpretation of the meaning):

> *He who obeys the Messenger has indeed obeyed Allah.*
> *(An-Nisā' (The Women) 4:80)*

> *O you who believe! Obey Allah and obey the Messenger.*
> *(An-Nisā' (The Women) 4:59)*

All the four schools of Islamic jurisprudence agreed that the guidance prayer is prescribed in cases where a person does not know the right decision to make in case of conflict and where ambivalence has not been resolved. The person who wants to pray *Istikhara* should have an open mind, and not have decided on a specific course of action.

Stage of goal-and-route vision (Basirah)

After the guidance prayers, the client adheres to the goals and action strategies that become crystallised and he or she feels comfortable with (Barise, 2005). This involves the clarification of the goals and actions of the road map and sticking with those change strategies. In this process, the client achieves *Basirah* or goal-and-route vision. Barise (2005) maintained that:

> through contemplation, the client envisions the spiritual merits he would accumulate and the pleasures that this would bring about both in this life and in the hereafter. In other words, he imagines the benefits of the problem having been solved and how this would add to the ultimate goal of life, which is to worship God in order to achieve the utmost pleasures and well-being in this world and in the hereafter.

Stage of wilful decision ('Azm)

This is the stage during the counselling process where the counsellor facilitates or enables the client to make a decision for action (*'Azm*). This corresponds with the preparation stage (intentions to change behaviour) of the model of change (Prochaska *et al.*, 1992). This is the readiness to change period, which is the final step in the action planning stage, where the client works towards the desired goals and intervention. During this stage, some clients may experiment with small changes as their determination to change increases. The stage combines intention and determination and the clients appear to be ready and committed to action. Commitment to change without appropriate skills and activities can create a fragile and incomplete action plan. Intervention of the counsellor, by coming up with concrete solutions and promoting the client's self-esteem and self-efficacy, is

important. In some cases, the client has no choice but needs to change, from his or her baseline undesirable behaviours, to more acceptable, permissible and desirable behaviours. As the client is highly motivated and has the readiness to change, resistance is less likely to occur. It is maintained that *'Azm* does not rule out the flexibility in goal and action strategies, which is necessary as circumstances change or new needs emerge (Barise, 2005).

*Stage of absolute trust in God (*Al-Tawakkul-Allah*)*

Once the final decision making has taken place, the client needs to have belief in the absolute trust in God. *Tawakkul* is a fundamental part of the Islamic creed and is translated as either trust or being dependent. Putting our trust in God is a matter of belief and contributes to our view regarding this life. To make this point clear, Allah says in the Qur'aan (interpretation of the meaning):

> *Then, when you have taken a decision put your trust in God. For God loves those who put their trust (in Him).*
>
> *('āli 'Imrān (The Family of Imran) 3:159)*

There are other verses of the Noble Qur'aan that explicitly enjoin Muslims to have reliance and trust in God in their lives (65:3; 3:160; 9:51; 26:21). By having absolute trust in God, the individual needs to be aware of the fact that it is only God who controls the universe and both good and bad are His decree. Therefore, our actions and the material resources available to us do not guarantee the outcome of any of our undertakings (www.islam21c.com, 2012). The psycho-spiritual benefits of *Tawakkul* are that the client feels relieved and empowered because whatever trials or tribulations the client is going through, God has decreed it. However, there is a misconception that, because of our trust in and reliance on God, there is no need to make an effort to change our attitudes and behaviours. The following illustrates this point:

> One day the Messenger of God (ﷺ) noticed a 'bedouin' (desert Arab) leaving his camel without tying it and he asked the 'bedouin': 'Why don't you tie down your camel?' The 'bedouin' answered, 'I put my trust in God.' The Prophet (ﷺ) then said, 'Tie your camel first, then put your trust in Allah.'
>
> *(Tirmidhî, cited in islamhelpline, n.d.)*

Barise (2005) indicated that, although absolute trust in God is emphasised after decision making, it is continuously used throughout the different stages of the counselling process.

Stage of action ('Amal)

During this stage of change, clients begin taking direct action in order to accomplish their desired goals.This process involves intention and execution of the

action plan. The accomplishment of their desired goals cannot be realised unless it results in change in inward self-improvement and outward improvement. That necessitates appropriate action in conformity with what is intended and understood from the previous stages. Frequently, the actions fail because the previous steps have not been given enough thought or time. The attainment of small goals should be rewarded or reinforced. Reinforcement and social support are extremely important in helping maintain positive steps towards change. Support would be provided by the family and the counsellor. At this stage, the client must be self-reliant after putting his or her trust in God. Allah says in the Qur'aan (interpretation of the meaning):

> *Whoever does good, it is to the benefit of his soul, and whoever does evil, it is against it; and your Lord is not in the least unjust to the servants.*
>
> *(Fuṣṣilat (Explained in Detail) 41:46)*

Stage of help-seeking (Isti'aanah)

Help-seeking or *Isti'aanah* is one of main processes employed throughout all of the stages of the Islamic counselling practice model. According to Barise (2005), *Isti'aanah* refers to seeking God's help in the problem-solving process. During times of trials and tribulations, for most Muslims God is the ultimate source of help. Muslims seek comfort and guidance in the words of Allah in the Qur'aan. Allah reminds us that all people will be tried and tested in life, and calls upon Muslims to bear these trials with 'patient perseverance and prayer'. Allah says in the Qur'aan (interpretation of the meaning):

> *And seek help through patience and prayer, and indeed, it is difficult except for the humbly submissive [to Allah].*
>
> *(Al-Baqarah (The Cow) 2:45)*

> *O you who have believed, seek help through patience and prayer. Indeed, Allah is with the patient.*
>
> *(Al-Baqarah (The Cow) 2:153)*

From an Islamic perspective, Muslims are called to put their trust in their Lord, and not to fall into despair or hopelessness. However, seeking help from God does not mean that the client cannot seek help from counsellors or Imams for family problems and personal issues. In case of necessity, seeking help from others is encouraged to the extent that the client would see helpers as a means only and God as the ultimate help provider. Consulting others is part of the Islamic practice as emphasised in the Sunnah of the Prophet (ﷺ). God mentions consulting others in one's affairs as a positive trait of righteous believers in the Qur'aan (interpretation of the meaning):

> *And those who have responded to their Lord and established prayer and whose affair is [determined by] consultation among themselves, and from what We have provided them, they spend.*
>
> *(Ash-Shūraá (The Consultation) 42:38)*

Believers call on God and make supplications during prayers at least 17 times a day. They say:

> *It is You we worship and You we ask for help.*
>
> *(Al-Fātiĥah (The Opener) 1:5)*

Stage of self-monitoring (Muraqabah)

Muraqabah or self-monitoring is another main all-encompassing process used throughout all of the stages of the Islamic counselling practice model. Baskett (1985) defined self- monitoring as 'the ability to be aware of and correctly label one's own behaviour' (p. 107). Self-monitoring has been used in the counselling process both as an intervention strategy and as a way to collect data to evaluate the effectiveness of the intervention. Self-monitoring allows the client to observe his or her behaviour from the initial awakening stage to the implementation of action plans. It consists of self-observation (for example, self-reflection and assessing one's behaviour) and self-recording (for example, recording assessment on paper) (Moore *et al.*, 2001). As an intervention level of self-monitoring, it is believed that the act of observing and recording one's behaviours, thoughts and feelings may lead to behaviour change (Mahoney, 2013). From an Islamic perspective, the client is also aware that God is watching and monitoring him or her and this is possibly the single most important mechanism in changing any thought or behaviour. Allah says in the Qur'aan (interpretation of the meaning):

> *Is not Allah, most knowing of what is within the breasts of all creatures?*
>
> *(Al-'Ankabūt (The Spider) 29:10)*

> *Allah knows what you conceal and what you declare.*
>
> *(An-Nahl (The Bee) 16:19)*

> *He knows what is within the heavens and earth and knows what you conceal and what you declare. And Allah is Knowing of that within the breasts.*
>
> *(At-Taghābun (The Mutual Disillusion) 64:4)*

> *And your Lord knows what their breasts conceal and what they declare.*
>
> *(Al-Qaṣaṣ (The Stories) 28:69)*

The awareness of God results in clients being honest with themselves and consistent between their internal and external processes (Barise, 2005). This is the

Muraqabah an-Nafs, watching ourselves in order to prevent us from doing undesirable things and to maintain behavioural changes.

*Stage of evaluation (*Muhasabah*)*

Muhasabah, or evaluation, is the last process in the Islamic counselling practice work model. Evaluation in counselling is essential in order to assess whether the counselling was helpful, whether there was a decrease in symptoms in clients, whether clients have improved or gained coping skills and the realisation of the desired changes. The reduction of symptoms and the realisation of desired changes in clients are part of the change process that often occurs for clients over the duration of counselling. It is, therefore, important to evaluate the counselling process and outcomes since this offers a chance for clients' continued psychosocial and spiritual development. Evaluation should be an ongoing process. Barise (2005) affirmed:

> like all other processes in the Islamic model, there is no distinction between the 'material' and the 'spiritual' aspects. Muslims believe that God will evaluate all of their actions in this world and they will be rewarded accordingly both in this world and in the next world.

Conclusion

This chapter has provided a broad overview of the existing approaches and models of Islamic counselling. Most of the models and approaches are limited in their theoretical and practical constructs, but they provided the historical development of the emergence and validity of Islamic counselling. The proposed model differs from mainstream counselling in that it is based on a psychosocial and spiritual orientation of counselling. The main differences between mainstream models and the Islamic counselling practice model include the dominant role of spiritual over psychosocial needs, God as the source of help, the process of seeking help and decision making, and problem solving. In this model, both non-directive and directive counselling techniques and approaches that are accepted from an Islamic perspective are operational. Finally, the proposed model is not claimed to be comprehensive, but provides an outline for further development and refinement. In addition, specific appropriate techniques and examples may be included at each stage within the model. The proposed practice model should be perceived as a preliminary mapping exploration and as agenda setting. Muslim scholars, psychologists and clinicians should share in this development.

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16

COUNSELLING AND ADDICTION

Introduction

Addiction is now regarded as a public health problem. Addictive culture is now part of the social fabric of most societies. Our constant exposure to, and accessibility of, both addictive substances and addictive activities has created new social and cultural norms that have influenced and made people more susceptible to addictions (Rassool, 2011). In contemporary society, the range of addictive behaviours covers both pharmacological and non-pharmacological addictions, including eating, drinking, drug use, gambling, work, exercise, internet use and sexuality. Addictive behaviour problems can affect every one of us, regardless of age, sex, race, marital status, place of residence, income level or lifestyle. The consequences of addiction do not only affect the individual user, but also their families, communities and the entire society and economy. From an Islamic perspective, the 'war' on drugs and other addictive behaviours began fourteen centuries ago (Philips, n.d.). This chapter will focus on counselling those with addictive behaviours related to drug misuse and gambling. For a more comprehensive account of addictive behaviours, such as drug and alcohol addiction, internet addiction, eating disorders and sexual addiction, see Rassool (2011).

Drugs and gambling: nature and extent

Cannabis is the world's most widely used illicit substance, followed by amphetamine-type stimulants, cocaine and opiates. There has been an increase in opioid and cannabis use, whereas the use of opiates, cocaine and amphetamine-type stimulants (excluding 'ecstasy') has either remained stable or followed a decreasing trend (UNODC, 2014). An emerging phenomenon among opioid-dependent drug users is that drugs are being gradually replaced or substituted by other drugs

(due to access, availability or fashion). For example, formulations include 'spice', which mimics the effects of cannabis, and *Salvia divinorum*, a hallucinogenic plant (UNODC, 2012, 2013); heroin is being substituted by oxycodone, desomorphine or other opioids, and 'ecstasy' is being substituted by mephedrone and MDPV (often sold as 'bath salts' or 'plant food') or some other new synthetic psychoactive substance (UNODC, 2014). However, it is opiates and opioids that top the list of problem drugs that cause the most disease and drug-related deaths worldwide. Drug overdose is the primary contributor to the global number of drug-related deaths, and opioids (heroin and the non-medical use of prescription opioids) are the main drug type implicated in those deaths. In addition to the sequelae resulting from drug misuse, unsafely injecting drugs can have very serious health implications due to the high risks of the transmission of blood-borne infections such as HIV and hepatitis B and C, contracted by sharing contaminated injecting equipment. In addition, the tobacco epidemic is one of the biggest public health threats the world has ever faced, killing nearly six million people a year (WHO, 2014). Tobacco is the leading global cause of preventable deaths and can cause cancer, cardiovascular disease, diabetes and chronic respiratory diseases.

Limited data exist on illicit drug use, tobacco use and gambling among Muslims; all are prohibited in Islam. Some studies of illicit drug use and tobacco use, including cigarettes and water-pipes, among Muslim religious minorities living in Western countries have been undertaken with high school students (Abu-Ras *et al.*, 2012; Ahmed *et al.*, 2014; Bradby and Williams, 2006). In England, the pattern of illicit drug use among South Asians appears little different from that of the general population in terms of the drugs used and the ages of users, but this is seen to result from the communities becoming more Westernised (Fountain, 2009). The main drugs of choice for Muslims depend on the geographical location, ranging from hashish or cannabis to opiates, amphetamine-type stimulants (ATSs), ecstasy, Khat and Captagon. Regardless of their gender, age, economic and social status or ethnicity, Muslim youth are not immune to the dangerous world of drugs (www.islam-today.org, n.d.). Over the last decade drug use has been gradually increasing within the Muslim community. In some areas it has reached crisis point and some are still under the impression that it is not an issue within the community (www.muslimhealthnetwork.org, n.d.).

Gambling, now recognised as a psychiatric disorder, has emerged as a significant public health issue as there has been a rapid increase in the proliferation and accessibility of legalised gambling in many parts of the world. While most efforts target adult pathological gamblers, there is growing concern that women and the older generation are playing more games, games are becoming more mobile and Asia is still the hotbed for gaming (Galarneau, 2014). With the increased use of the internet, one of the most serious problems affecting people is the rise of online gambling. This includes lottery tickets, casino games, draws, scratch cards, football pools, bingo, slot machines, horse and dog races, betting with a bookmaker, online betting on any event or sport, online gambling, private betting (for example, with friends or colleagues) and stock market speculation. According to Sheikh Muhammed Salih al-Munajjid (n.d.), a modern form of gambling is insurance,

including life insurance, car insurance, product insurance and comprehensive insurance. Despite the strong prohibitions against gambling, in some countries where Muslims are in large majorities casino-style gaming has been introduced, for example in Northern Cyprus, Malaysia, Egypt, Lebanon and Morocco (Dien, 2004).

Islamic rulings on drugs (non-alcoholic intoxicants) and gambling

The prohibition of drug use and gambling is based on the Qur'aan and the Sunnah. Allah says in the Qur'aan (interpretation of the meaning):

> *O you who have believed, indeed, intoxicants, gambling, [sacrificing on] stone altars [to other than Allah], and divining arrows are but defilement from the work of Satan, so avoid it that you may be successful. Satan only wants to cause between you animosity and hatred through intoxicants and gambling and to avert you from the remembrance of Allah and from prayer. So will you not desist?*
>
> *(Al-Mā'idah (The Table Spread) 5:90–1)*

In the above verse, Allah has described intoxicants and gambling among other things as being appalling, despicable and hateful acts of Satan, and he has commanded us to abstain from them because intoxicants, apart from sowing the seeds of enmity, also stop you in the remembrance of Allah (Islam and Drugs, n.d.). Within the Islamic context, the term 'intoxicant' encompasses narcotics, hashish, cannabis, cocaine, morphine, alcohol and tobacco. Islam forbids both drugs and gambling. There is no doubt that taking drugs is forbidden (*Haram*) because of their effects on mood and behaviour. The Prophet (ﷺ) said: '*Khamr* is whatever befogs the mind' (Bukhârî and Muslim, cited in islamqa [a], n.d.), and 'Every intoxicant is liquor (*Khamr*), and every intoxicant is *Haram*. Whoever drinks *Khamr* in this world and dies persisting in that and without having repented, will not drink it in the Hereafter' (Muslim, cited in islamqa [a], n.d.). Prophet Muhammad (ﷺ) described intoxicants as 'The key to all evils; the head of all errors and lapses; the most terrible of major sins; the mother of all atrocities; and the mother of all evils' (www.islamweb.net, n.d.). Intoxicating substances are placed in the same category as gambling, where most people lose their savings, become addicted and destroy their lives. Muslim scholars are unanimous on the prohibition of contemporary drugs. The scholars have used principles of Islamic jurisprudence (*Fiqh*) to derive judgments regarding many of the illicit drugs available today that were unknown at the time of the revelation of the Qur'aan. According to Sheikh Yusuf al-Qaradawi (2007), drugs such as cannabis, heroin, cocaine, opium and the like 'are taken as a means of escape from the inner reality of one's feelings and the outer realities of life and religion into the realm of fantasy and imagination'.

Sheikh Bilal Philips (2007) stated that 'by classifying drugs on a par with games of chance, idolatrous practices and the fortune-telling, all of which have been pronounced as absolutely forbidden, the prohibition of drugs is further emphasised'.

In short, the four legal schools agree that all intoxicants are unlawful, and they include plants that intoxicate under this category of prohibited substances. It is stated that:

> There is a misconception among Muslim users that although drugs are unlawful, smoking hashish is not so serious. Or they say that at least we don't drink! They seem to divide drugs into hard and soft drugs: a division that is quite baseless according to Divine law. All drugs are Class A according to our religion.
>
> *(Birt, 2001)*

Gambling, from an Islamic perspective, is a great evil of society and immensely harmful to the well-being of the human social order. The Messenger of Allah (ﷺ) emphasised the prohibition of gambling to such an extent that even considering taking part in gambling was regarded to be blameworthy. The Messenger of Allah (ﷺ) said: 'Whosoever says to another: "come let's gamble" should give in charity (m: as a form of expiation for intending to gamble)' (Bukhârî, cited in islamqa [b], n.d.).

Problems and issues

The issues and problems caused by addiction affect not only the individual drug user or gambler, but the extended family, mother, father, children or spouse. Generally, most Muslim families are ashamed to ask for help when they think everyone will find out about their family problem. The result is that families often employ strategies that focus not on seeking professional help for the addict, but on hiding and denying the situation for the extended family and the rest of their community (Fountain, 2009). Consequently, the family is always pretending, covering up for and bailing the addict out of trouble. Some families become co-dependent, that is, they are part of the process of enabling the addict to continue using drugs or gambling. This co-dependence is counterproductive for both the family and the individual addict or gambler. Family members who are affected by addiction face a form of chronic stress that impacts upon them at a number of different levels, which includes daily hassles of an unpleasant kind, as well as relationships that deteriorate over what may be a very long time span (Orford, 2012). It has been suggested that family members should learn to modify their own behaviour (*Sadaqah*) and become an important part of recovery programmes (Garrett *et al.*, 1998).

For the drug user, going public about drug use in Islam can be tantamount to denouncing one's faith. It is not the religious prohibition per se that is the concern, but more the stigma within the community. The stigma that surrounds addiction is much stronger in the case of the Muslim client. Feelings of guilt, shame and fear of being stigmatised and rejected by the family or community are among the reasons why many Muslims fail to seek help. By the time the addicts show up at the treatment centre, they have lost their support system and have to deal with severe physical and social problems. In addition, the reality is that there are no

culturally sensitive places offering help for Muslims struggling with drug addiction. It is reported that there are encouraging signs that Muslims are accessing treatment and this is seen as being very positive, given that a decade ago the stigma associated with drug misuse meant Muslims remaining 'treatment naive'. In contrast to the denial of previous decades, the community in general acknowledges the problem. 'This is where the Muslim community needs to accelerate its work. The level of education within the family and discussion in religious institutions about the perils of drugs do not reflect the drug usage trend' (Ahmed, n.d).

The importance of counselling in addiction treatment

Addiction to substances like heroin is more than a physical dependence on drugs. Individuals can develop tolerance to a variety of psychoactive substances, but the drug must be taken on a regular basis and in adequate quantities for tolerance to occur. In physical dependence, there is a need to take the drug to avoid withdrawal symptoms following cessation of use. The severity of the withdrawal symptoms depends on the type or category of psychoactive substances. For example, the withdrawal from alcohol, for instance, can cause hallucinations or epileptic fits and may be life-threatening, while the physiological withdrawal symptoms from nicotine abstinence may be relatively slight. With other dependence-inducing psychoactive substances such as opiates and depressants, the withdrawal experience can range from mild to severe. Psychological dependence is accepted as the most widespread and the most important. However, it is not only attributed to the use of psychoactive drugs, but also to food, sex, gambling, relationships or physical activities.

There is a wide range of psychosocial and pharmacological interventions for the treatment of alcohol and drug misuse. Pharmacological interventions are categorised as detoxification, medications for relapse prevention and nutritional supplements. Even after detoxification, when physical dependence is treated, addicts are at high risk of relapse. Psychological and social factors are often powerful stimuli for prescription drug misuse relapse. Psychosocial interventions encompass a wide range of treatment strategies, such as brief interventions, counselling, cognitive behavioural therapy (CBT), family therapy, social skills training, supportive work and complementary therapy. There is evidence to suggest that drug misuse treatment is effective in terms of reduced substance misuse; improvements in personal and social functioning; reduced public health and safety risks; and reduced criminal behaviours. Counselling is an essential part of drug misuse treatment for many people and CBT, family counselling and other therapy approaches can help people recovering from drug addiction to remain drug free.

The counselling process usually starts with an assessment of the alcohol or drug user's needs or problems. The purposes of assessment are for the taking of an alcohol or drug history, to intervene in urgent medical and psychological problems, to provide feedback for clients on their level of substance misuse and to build a rapport with clients (Rassool, 2011; Rassool *et al.*, 2006). The maintenance of

rapport, empathy, genuineness and being non-judgemental is critical in the process of assessment. A drug or alcohol history is a detailed assessment of the current presentation of an individual's drug- or alcohol-taking patterns of use. One of the initial tasks of the assessment is to discern the individual's views of their drug and/or alcohol consumption. The assessment should then focus on the current pattern of substance misuse, the type of drug used, quantities of substances use, level of dependence, risk behaviours, associated problems, source of help, source of access to psychoactive substance(s) and periods of abstinence and relapse. In order to ascertain the level of dependency, it is important to ask about experiences of withdrawal symptoms or any medical complications. The inclusion of an assessment of the positive aspects of the individual regarding substance misuse may highlight and enhance the person's self-efficacy and self-esteem. This positive approach may enable the individual to engage with the service with less resistance and also influence his or her coping strategies and treatment outcomes (Rassool *et al.*, 2006). The position of strength should focus on strategies that the client has 'successfully' used in previous attempts to manage substance misuse and psychiatric symptoms, for example previous coping strategies used to remain drug free.

There is a number of screening and diagnostic tools for use in the assessment of problem gamblers. These include the short CAMH Gambling Screen, the Problem Gambling Severity Index (PGSI), GA (Gamblers Anonymous) 20 Questions and the South Oaks Gambling Screen (SOGS). However, these tools have not been tested for their psychometric properties with a Muslim population, given that cultural norms, values and attitudes can predispose populations to disordered gambling, and that the prevalence of disordered gambling varies between cultures (Binde, 2005; Parhami *et al.*, 2012; Raylu and Oei, 2004). Velleman (2011) has developed an approach to counselling substance misusers that highlights the processes irrespective of the theoretical persuasion of the counsellor. He describes six stages, namely developing trust, exploring the problem, helping clients to set goals, empowering clients to take action, helping them to maintain changes and agreeing with them when the time comes to end the counselling relationship.

Counselling the addict: motivational interviewing

Motivational interviewing (Miller and Rollnick, 2002) is a counselling approach that has been employed extensively and successfully among people with alcohol and other drug problems in order to enhance involvement and reduce substance use (Miller and Rollnick, 2002). Rollnick and Miller (1995) defined motivational interviewing as 'a directive, client-centered counseling style for eliciting behavior change by helping clients to explore and resolve ambivalence'. They described it as more focused and goal-directed than non-directive counselling, and said the counsellor takes a directive approach to the examination and resolution of ambivalence, which is its central purpose. Motivational interviewing has been found to increase the effectiveness of more extensive psychosocial treatment for alcohol problems and has improved outcomes for drug-related problems (Raistrick *et al.*, 2006).

Many problem drug users or gamblers have ambivalence about making changes in their behaviour. Consider the client who is expected to attend a substance misuse service or a counsellor. The client may start thinking about going, but finds more excuses for not attending. For example, the client may say: 'I would be wasting a good chance if I don't attend the appointment, and besides I will be bored if I stay here. I want to do something about my drug problem. But, I have seen many people attending the treatment centre who have been going for months and they do not seem to be drug-free.' This is normal ambivalence as the client wants to attend the appointment and at the same time wants to stay home. In addition, the client has some doubts about whether it really will help to go to a counsellor.

Motivational interviewing is an approach that accepts ambivalence and enables the client to explore and resolve it. One way of helping someone express this ambivalence is to complete a 'decisional balance' matrix (see Table 16.1). Examining the pros and cons (costs and benefits) gives a lot of information about the worldview of the client concerning the addiction or problem issue. There are two ways of examining pros/cons: looking at the current behaviour and looking at change. The counsellor will discuss with the client what would go in each of the boxes and how important each item is for them. For example, the pro question might be: 'What are some of the good things about becoming drug free?' The con question might be: 'What are the not so good things about giving up cannabis or gambling?' By mapping out the ambivalence, the client can evaluate what is most important to him or her and begin to focus on the solutions.

The four principles of motivational interviewing are: express empathy, develop discrepancy, roll with resistance and support self-efficacy. Various tools and strategies have been developed to help apply these principles and these include pencil and paper exercises, structured questions and focused reflections (Mason, 2006). The concept of empathy is one of principles that are critical to the motivation interviewing approach. Empathy is 'understanding another's meaning through the use of reflective listening and requires sharp attention to each new client statement, and the continual generation of hypotheses as to the underlying meaning' (Miller and Rollnick, 1991, p. 20). The counsellor tries to understand the experience of the client at a deeper level, acknowledge and value the other person's perspective and convey this understanding to him or her. It is through empathy that the client

TABLE 16.1 A decisional balance matrix: pros/cons of current behaviour and pros/cons of change

Pros of current behaviour	*Cons of current behaviour*
Pros of change	*Cons of change*

becomes more receptive about lifestyle issues and beliefs about substance use. The key components of expressing empathy are open questions and reflective listening. Examples of the expression of empathy are:

- 'So you really want to change your gambling habits, but it is overwhelming because you're not sure where to start.'
- 'Most clients I know would feel anxious in that situation.'

Developing discrepancy is a principle that is related to the concept of cognitive dissonance. 'Motivation for change occurs when people perceive a discrepancy between where they are and where they want to be' (Miller *et al.*, 1992, p. 8). In this context, counsellors seek to encourage clients to explore the conflicts between their beliefs and their behaviours. The discrepancy is emphasised 'by raising the clients' awareness of the negative personal, familial, or community consequences of a problem behaviour and helping them confront the substance use that contributed to the consequences' (CSAT, 1999). When clients recognise and accept that their current behaviours are not leading towards some positive outcomes, they develop more readiness to make important life changes. The role of the counsellor is to enable the client to perceive discrepancy. The 'Columbo approach' (Kanfer and Schefft, 1988) can be used to enable a client to perceive discrepancy. The goal is to have a client help the therapist make sense of the client's discrepant information (Sobell and Sobell, 2008). The rationale of this approach is that a position of uncertainty or confusion can motivate the client to take control of the situation by offering a solution to the clinician (Van Bilsen, 1991). This approach is intended to be non-judgemental or non-blaming and allows for the contrasting, in a non-confrontational manner, of information that is contradictory (Sobell and Sobell, 2008). An example of developing discrepancy might be:

> 'Help me understand – on the one hand, I hear you saying you want to return to your religious practices. Yet, on the other hand, you are telling me that you are using heroin occasionally with your workmate. I am wondering how using heroin might affect the ability to practise your religion.'

In motivational interviewing, the counsellor does not fight client resistance, but 'rolls with it'; that is, using the metaphor of 'dancing' rather than 'wrestling' with the client (www.motivationalinterview.org, n.d.). Resistance, in the context of counselling:

> occurs when the client experiences a conflict between their view of the 'problem' or the 'solution' and that of the clinician, or when they experience their freedom or autonomy being impinged upon. These experiences are often based in the client's ambivalence about change.
>
> *(www.motivationalinterview.org, n.d.)*

The resistance behaviours may include making excuses, blaming others, minimising importance or significance, challenging, hostile language (verbal and non-verbal) and ignoring (www.motivationalinterview.org, n.d.). Clients who remain resistant during the counselling process are not ready for change. During resistance, which is a signal to change direction, the counsellor needs to express empathy by remaining non-judgemental and to refocus the direction of the communication without being confrontational. The core skills used in dealing with resistance include simple reflection, amplified reflection, double-sided reflection, shifting focus, agreement with a twist, reframing and siding with the negative (CSAT, 1999).

Motivational interviewing is a strength-based approach that believes that clients have the potential within themselves to change. However, many clients do not believe that they can achieve the behavioural change and question whether there will be a beneficial outcome if change occurs. It is stated that improving efficacy requires 'eliciting and supporting hope, optimism, and the feasibility of accomplishing change' (CSAT, 1999). The counsellor needs to identify clients' strengths, highlighting skills, and encouraging them to talk about past successes and strengths and the support they can solicit. For example:

- 'What is the longest you have been drug free recently? What sorts of things have you found help you cope when you haven't taken the drug?'
- 'You say you used to cope better than you do at the moment. What were you like at that time? What sort of things did you do to help yourself then? Could you do any of them now if you were to give up gambling?'

One way to help people to understand their own position regarding their self-efficacy or level of confidence is to ask scaling questions similar to those used in solution-focused therapy (de Shazer *et al.*, 1986) (see also Chapter 12). Clients have the readiness to change when both importance and confidence are high. Prochaska and DiClemente (1986) have developed a model that explains readiness to change in terms of stages through which people move. From pre-contemplation, when the person is not interested in change, there is a move through contemplation, determination (or preparation), action and maintenance. Motivational interviewing can be seen as a counselling approach that 'nudges' the client through these processes of change. Self-efficacy can be enhanced if the client believes in the possibility of change and positive outcomes are achieved based on small, realistic goals. The strategies that counsellors may adopt in motivational interviewing include:

- *Asking open-ended questions*: Open-ended questions invite elaboration and thinking more deeply about an issue or problem.
- *Reflective listening*: The most crucial skills are expressing empathy and making reflective responses, supporting the goal-directed aspect of motivational interviewing.
- *Summarising*: Summaries communicate interest and understanding and call attention to important elements of the discussion.

- *Affirmation*: This includes statements that recognise client strengths, assist in building rapport and help clients feel that change is possible.
- *Eliciting self-motivational statements*: This is a critical skill for clients who are not committed to change. There are four areas of questioning that can help elicit these concerns: problem recognition; expression of concerns; intention to change; and optimism about change.

Lapse and relapse is a process that is part of the addict's treatment journey. Clients need help to identify relapse indicators, so bringing these to clients' notice and helping them strengthen their coping mechanisms is important. Relapse prevention utilises a cognitive behavioural framework to help individuals maintain the goals they may have achieved in relation to changing their substance use. The techniques used to teach coping skills include identification of specific situations where coping inadequacies occur, and the use of instruction, modelling, role-plays and behavioural rehearsal. Exposure to stressful situations is gradually increased as adaptive mastery occurs. Clients may need support to identify risks associated with their substance misuse and a relapse prevention plan is based on the identified risk factors. An important part of any plan should include assertiveness work and social inclusion. Relapse prevention skills training is typically offered in the following areas: exploring the positive and negative consequences of continued use; self-monitoring to recognise drug cravings; development of strategies for coping with craving; identifying high-risk situations for use; developing strategies for coping with and avoiding high-risk situations; and homework assignments. Including the family, partners, carers or significant others who care for, and who are close to, clients in the relapse prevention programme can strengthen the programme. Family engagement in the targeted treatment plays an important part in helping people with dual-diagnosis disorders (Clark, 2001). There is good evidence of the effectiveness of specific relapse prevention in the treatment of drug problems and psychosocial functioning (Raistrick *et al.*, 2006).

The role of the Muslim family in drug addiction

The family should be part of the treatment journey of the Muslim drug addict or gambler. The Muslim family can play a significant role in the care and treatment of the drug user during the stages of detoxification, rehabilitation and aftercare. However, family members may also be as dysfunctional as the client or may be co-dependent. This would involve having counselling or family therapy. Some Muslim clients may be reluctant to involve their families due to the fear of rejection and shame. Attempts to reintegrate clients with their families may not be easy. Families should remind themselves that addicts are responsible for their own choices and actions, and their own deviant behaviours. Families should not remind addicts of past mistakes or negative incidents, but should focus on the positive aspects of addicts' behaviours, that is, highlighting their strengths or positive behaviours. Families should avoid confrontation or being drawn into

arguments with addicts. Rather, they should challenge their unacceptable behaviours. Families should have clear boundaries, such as not tolerating addicts using drugs in their homes. Explain to addicts that their addiction is their own problem and if they choose to disobey Allah by using drugs or gambling, then they can do it without your help. Families can be informed that there are places they could go for help; perhaps offer them some literature to read. They should always have hope that Allah will help them out of difficulties. Allah says in the Qur'aan (interpretation of the meaning):

> *and whoever fears Allah, He will make for him a way out.*
>
> *(Aṭ-ṭalāq (The Divorce) 65:1–5)*

The principles of Islamic interventions

- Dealing with the Muslim problem drug user is to empower the soul of the individual to fulfil the Divine mission and strengthens the human soul in the approaches that Islam has prescribed.
- The client needs to be reminded that, in testing times, Muslims remember that for every hardship Allah provides an ease. In fact, through the Mercy of Allah, when a Muslim faces any kind of difficulty, Allah removes his or her sins. Allah says (interpretation of the meaning):

> *So, verily, with every difficulty, there is relief.*
>
> *(Ash-Sharĥ (The Relief) 94:5)*

- Treatment for Muslim drug users or gamblers should be based on bio-psycho-social and spiritual interventions. However, the core of the treatment package is spiritual guidance and interventions.
- No single treatment is appropriate for everyone. The intervention strategies vary:

> depending on the type of drug and the characteristics of the clients. Matching treatment settings, interventions, and services to an individual's particular problems and needs is critical to his or her ultimate success in returning to productive functioning in the family, workplace, and society.
>
> *(National Institute on Drug Abuse, 2012)*

- Problem drug users or gamblers have complex needs. Effective spiritual, physical and psychological interventions should attend to the multiple needs of the client, not just his or her problem drug misuse or gambling behaviour.
- Overcoming problem drug use and gambling is a long-term process because of lapse and relapse. 'Research indicates that most addicted individuals need at least 3 months of treatment to significantly reduce or stop their drug use and that the best outcomes occur with longer durations of treatment' (National Institute on Drug Abuse, 2012).

- Detoxification is only the first stage of addiction treatment. This stage manages the acute physical symptoms of withdrawal. For Muslims, in order to achieve long-term abstinence, the client needs to have intensive spiritual interventions The client needs support from the family, community and Imam and to keep company with other Muslims who are practising their Islamic way of life correctly.
- Pharmacological interventions are an important element of treatment for many clients, especially when combined with counselling and cognitive behavioural therapies. 'For example, methadone, buprenorphine, and naltrexone (including a new long-acting formulation) are effective in helping individuals addicted to heroin or other opioids stabilize their lives and reduce their illicit drug use' (National Institute on Drug Abuse, 2012).
- Harm reduction should be part of the treatment package, if appropriate:

> Harm reduction can therefore be accepted as a necessity in order to preserve [these things], which are threatened by the twin epidemics of drug use and HIV/AIDS. In Islam, life and good health must be protected and promoted in all circumstances and this includes prevention and treatment of any illness and disease. In this regard, the numerous harms associated with drug addiction, a chronic medical condition, should be prevented through measures that have been scientifically proven.
>
> *(Kamarulzaman, 2005)*

- Clients need to adhere to the Islamic version of the Alcoholics Anonymous (AA) twelve-step programme (see below).
- Cognitive behavioural therapies, including individual, family or group counselling, are the most commonly used forms of drug misuse treatment. These need to be adapted to include spiritual interventions in the therapeutic process.
- Many problem drug users have co-morbidity, that is, they also have other psychological disorders. Clients presenting with one condition should be assessed for any others.
- Assessment is a continuous process and continuous spiritual detoxification and interventions may be needed, as lapses do occur. Monitoring clients' drug use can be a powerful incentive for clients and can help them withstand urges to use drugs. Monitoring also provides an early indication of a return to drug use, signalling a possible need to adjust an individual treatment plan to better meet a client's needs (National Institute on Drug Abuse, 2012).

Islamic perspective in dealing with problem drug users

The Islamic approach towards drug misuse is a combination of spiritual, psychological and physical interventions. It is worth pointing out that Islam does not 'shame' its believers when they come for treatment for addiction. All Muslims have the responsibility to support and assist in the recovery of those who have been addicted. The importance first is to treat the soul, then the mind and then the

body. Initially, the client needs to be sincere about giving up drugs or gambling and making repentance (*Tawbah*) (the Doors of *Tawbah* are open until you die or until the run rises from the West). The conditions attached to repentance include: leaving the sins immediately; feeling guilt or remorse at having committed the sins; and resolving never to repeat the sins. Addicts must remember Allah's favours and mercy with gratitude and humbleness and put their trust in, and rely on, Allah with sincerity, as He has the power to do anything. The client needs to have hope in the treatment, but remember to accept Allah's predestination (*Qadar*).

The Muslim problem drug user or gambler should be treated with gentleness, but needs to take responsibility for his or her behaviour. Making mistakes and committing sins are part of human nature. The Prophet (ﷺ) said: 'Every son of Adam makes mistakes, and the best of those who make mistakes are those who repent' (Ibn Majah, cited in Daily Hadith Online, n.d.). This Hadith clearly states that making *Tawbah* or repenting sincerely to make up for mistakes and sins is important, since humans are not perfect. The Islamic counsellor has a responsibility to 'enjoin what is good and forbid what is evil'. According to Sheik 'Abd al-'Azeez ibn Baaz:

> The believing men and women enjoin what is good and forbid what is evil, and the believer does not keep quiet. If he sees his brother committing an evil, he denounces him. Similarly, if he sees his sister, paternal aunt, maternal aunt or anyone else committing an evil action, he tells them not to do that. If he sees his brother in faith or his sister in faith falling short in some duty, he denounces him for that, and enjoins him to do what is good. All of that is to be done with kindness and wisdom, and good manners. If the believer sees one of his brothers in faith . . . smoking or drinking, . . . he denounces him in kind words and with good manners, not with hateful words and harshness, and he explains to him that it is not permissible for him to do this thing.
>
> *(Cited in islamqa [c], n.d.)*

The role of the Islamic counsellor is to provide spiritual guidance and counselling. The aim of spiritual guidance includes faith revival, repentance and helping the addict to incorporate both the cognitive aspects (beliefs) and behavioural component (practices) and disciplined lifestyles (Ali *et al.*, 2005). To develop a good character, Prophet Muhammad (ﷺ) emphasised that the individual should engage in constant practice of prayer, meditation, remembrance of God and other activities, as these actions change the heart and thereby bring one closer to God (Zortzis, 2010). Spiritual interventions include supplications, prayers, fasting and reading the Qur'aan. The psycho-spiritual programme adopted at Al-Amal Hospital, Saudi Arabia, is an excellent example of the interface between religion as a cultural construct and psychiatric practice (Salem and Ali, 2008). The programme includes a variety of individual and group interventions as part of the treatment package. The individual interventions include: spiritual guidance; religious bibliotherapy; spiritual meditation and prayer; religious journal writing; scripture memorisation;

acupuncture and relaxation; individual eclectic psychotherapy; and group interventions (community meetings, recovery groups, religious group activities). Night prayer is particularly helpful for patients with insomnia as part of the residual withdrawal syndrome (Salem and Ali, 2008).The findings of a study on the effect of religious spirituality and biofeedback devices in drug addiction treatment among teenagers indicate that, for recovering individuals, religious spirituality is connected to several optimistic mental health outcomes. Religious spirituality was closely associated with better coping, reduction of stress, positive life orientation and lesser levels of anxiety (Salam and Wahab, 2014).

Alcoholics Anonymous (AA) runs a twelve-step recovery programme that has helped many people stop the use of alcohol. The original programme focused on spirituality, religion and God having an impact on changing a person's life. A modified twelve-step programme related to drugs and conforming to Islamic teachings is presented below (adapted from Salem and Ali, 2008):

1 We admit that we are powerless over drugs and that our lives have become unmanageable.
2 We have come to believe that Allah can restore us to sanity.
3 We have made a decision to turn our wills and our lives over to the care of Allah.
4 We have made a searching and fearless moral inventory of ourselves in the light of the Islamic doctrines (*Shari'ah*).
5 We admit to Allah and to ourselves the exact nature of our wrongs.
6 We are entirely ready to pray to Allah to remove all these defects of character.
7 We have humbly asked Him to remove our shortcomings.
8 We have made a list of all persons we have harmed, and we have become willing to make amends to all.
9 We have made direct amends to such people wherever possible, except when to do so would injure them or others.
10 We continue to take personal inventory and, when we do wrong, we promptly admit it.
11 We seek through prayer and other religious commitments and activities to improve our conscious contact with Allah, praying only for knowledge of His will for us and the power to carry that out.
12 We have had a spiritual awakening as the result of these steps. We try to carry this message to problem drug users and practise these principles in all our affairs.

Conclusion

Many Muslim addicts are reluctant to go to non-Muslim agencies for help and advice, fearing a lack of confidentiality and a lack of cultural competence of service providers. In addition, there is the perception that mainstream service providers will not meet their cultural and religious needs or provide advice or therapies

that are compatible with Islamic practices. The findings of a study indicated that the majority of the drug users who had accessed mainstream drug treatment services rated them poorly, not only because their expectations were unmet, but also because of the perceived lack of cultural and religious competence in the services (Fountain, 2009). Families are fundamental in the recovery process and they should receive help and support from Muslim doctors, Imams, Islamic counsellors or Islamic organisations. It is important to note that there is no one approach that is appropriate for every client with addiction. The right addiction treatment plan is tailored to a person's addiction and individual needs. Motivational interviewing has been found to be a useful approach to counselling clients with addictive behaviours. It provides a way of engaging with clients who do not share the counsellor's view of what their problems are or who are reluctant to engage in treatment.

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17

COUNSELLING FOR ALCOHOL PROBLEMS

Introduction

Alcohol is part of the social and cultural fabric of Judaeo-Christian societies and is actively promoted in many cultural, social and religious circumstances. It has become a 'staple diet' among an increasing number of people in countries of the Northern hemisphere. Groups from all walks of life and ages celebrate intoxication as a rite of passage, applauded by their peers, while at the same time the effects of intoxication are negatively moralised and marginalised (Room, 2005). Public-health problems associated with alcohol consumption have reached alarming proportions, and alcohol has become one of the most important risks to health globally (WHO, 2004, 2011). The harmful use of alcohol is a serious health burden, and is one of four common risk factors, along with tobacco use, poor diet and physical inactivity, for the four main groups of non-communicable diseases (NCDs) – cardiovascular diseases, cancer, chronic lung diseases and diabetes (WHO, 2011).

Alcohol is often used as a way of coping with emotional problems, such as depression, anger, anxiety, boredom, frustration or marital problems. However, prolonged drinking leads to memory loss, hangovers and blackouts. Long-term physical problems associated with heavy drinking include stomach ailments, heart problems, cancer, brain damage and liver cirrhosis. There is also the risk of accidents, homicide and suicide. Drinking problems also have a very negative impact on mental health and can worsen existing conditions such as depression or induce new problems such as serious memory loss, depression or anxiety, suicidal thoughts, anger, disruptive behaviour, risk taking, aggression or violence, accidents and arguments. These altered behaviours have emotional consequences, both directly on the individual (such as guilt), then indirectly on that person's relationships with significant others. For a comprehensive account of alcohol and its problems see Rassool (2009). In relation to the use of non-pharmacological therapies, cognitive

behavioural strategies such as motivational interviewing, goal setting, problem solving and relapse prevention have been found to be helpful for addiction problems and should be incorporated into any theoretical approach when working with addicted clients (Kaskutas *et al.*, 2009; Magill and Ray, 2009; Marsh *et al.*, 2007; Spirito *et al.*, 2011). The Islamic prohibition on alcohol was a logical final step of a well-organised plan executed over a period of three years, communicated by the Qur'aan and put into practice by the Prophet (ﷺ), and this approach has some resemblance to the present-day systematic desensitisation approach in behavioural therapy (Mufti, 2001).

Alcohol consumption in Muslim communities

Alcohol consumption remained relatively stable in Western regions, while the least drinking seems to take place in Muslim countries of North Africa and South Asia (WHO, 2014). In the United Kingdom, alcohol consumption and related problems appear to be comparatively lower in Muslim communities, and among most Pakistani and Bengali men and women, than in the population at large (Alcohol Concern, 2003; The Information Centre, 2004). It has been reported that, in France, one-third of Muslims (originally from Algeria, Morocco, Tunisia and sub-Saharan Africa) drink alcohol (IFOP, 2011). Alcohol consumption appears to be more frequent among Albanian men (Burazeri and Kark, 2010), but lower among Muslim immigrants (Turkey and Pakistan) except for the Iranians (Amundsen, 2012). In the United States, there is a low rate of alcohol misuse for adherent Muslim populations (Hanolt, 2006, cited in Ali *et al.*, 2009), but Muslim students had a higher rate of alcohol consumption compared to their counterparts in predominantly Muslim countries (Abu-Ras *et al.*, 2010).

Alcohol and the Islamic perspective

Linguistically, *Khamr*, Arabic for 'wine', is alcohol derived from grapes. The prohibition of consumption of alcohol and intoxicants is one of the 'distinctive' marks of the Islamic world. In Islam, intoxicants or psychoactive substances are those that make one forgetful of God and prayer, whether it be wine, beer, gin, whisky or other alcoholic beverages. Intoxicants are forbidden in the Qur'aan through several separate verses revealed at different times over a period of years. The first Qur'aanic verse (chronologically) to deal with alcohol was revealed in Makkah (interpretation of the meaning):

> *And from the fruits of date-palms and grapes, you derive strong drink (this was before the order of the prohibition of the alcoholic drinks) and a goodly provision. Verily, therein is indeed a sign for people who have wisdom.*
>
> *(An-Naĥl (The Bee) 16:67)*

This verse is made in reference to the drinks that people make from the fruits of the date palm and grapevine. This also alludes to the fact that there are both evil

and good possibilities in certain drinks. The next step in turning people away from consumption of alcohol is shown in the next verse (interpretation of the meaning):

> *They ask you (O Muhammad) concerning alcoholic drink and gambling: 'In them is a great sin and (some) benefit for men, but the sin of them is greater than their benefit.'*
>
> *(Al Baqarah (The Cow) 2:219)*

The third mention of alcohol in the Qur'aan appeared as follows (interpretation of the meaning):

> *O you who believe! Approach not As-Salaat (the prayer) when you are in a drunken state until you know (the meaning) of what you utter.*
>
> *(An-Nisā' (The Women) 4:43)*

This was one of the stages in turning people away from the consumption of alcoholic beverages. Finally, the focus of the rulings was on total abstinence as alcohol is intended to turn people away from God and forget about prayer, and Muslims were ordered to abstain. The following verse was revealed (interpretation of the meaning):

> *O you who believe! Intoxicants (all kinds of alcoholic drinks), gambling, arrows for seeking luck or decision are an abomination of Satan's handiwork. So avoid (strictly all) that (abomination) in order that you may be successful.*
>
> *(Al-Mā'idah (The Table Spread) 5:90–1)*

The Prophet Muhammad (ﷺ) also instructed people to avoid any intoxicating substances, whether in large amounts or even when taking in a small amount: 'Whatever intoxicates in large quantities, a little of it is haram' (Tirmidhî, cited in islamqa [a], n.d.). For this reason, most observant Muslims avoid alcohol in any form, even small amounts that are sometimes used in cooking. In fact, all activities associated with its production, transportation and consumption have been condemned (Abu Dawud and Ibn Majah, cited in islamqa [b], n.d.)

Muslims who drink alcohol feel the need to hide and lie about what they are doing lest they be condemned by their religious communities. Those who consume alcohol, no matter what the amount, are breaking the rule and are going against the decree set by God (Allah) and what the individual is doing is unlawful (*Haram*).The Prophet Muhammad (ﷺ) issued a warning of the punishment in Islam for alcohol drinkers. Allah has promised that whoever drinks *Khamr* and becomes intoxicated, his prayers will not be accepted for forty days, and if he dies he will enter Hell, and if he repents Allah will accept his repentance. He will make him drink the mud of *khibaal*. The people asked, 'O Messenger of Allaah, what is the mud of *khibaal*?' He said, 'The sweat of the people of Hell, or the juice of the people of Hell' (Muslim, cited in islamqa [b], n.d.).

Alcohol and counselling

Addiction counselling often involves addressing addictions through combining the bio-medical model, conditioning theory, social learning theory, family systems and a lens of spirituality (Chapman, 1996). Given that many problem alcohol users are in fact ambivalent about wanting to stop, may be lacking in trust, or may just be in denial, the support of a counsellor becomes essential. Prochaska *et al.* (1992) have proposed a model or theory of change that may be used to explain the different decision-making stages the client may go through when attempting to make a significant lifestyle change:

- *Pre-contemplation stage*: This is a state where the problem alcohol user does not even consider changing and is in denial; that is, where people who have a long history of alcohol or drug use insist they can handle it.
- *Contemplation stage*: This is the stage where individuals become aware that there are problems associated with their alcohol use and have begun to think about the issue, but are not yet ready to deal with it. During this stage, patients assess barriers (for example, time, expense, hassle, fear, 'I know I need to, doc, but . . . ') as well as the benefits of change.
- *Preparation stage*: This is the stage where clients are beginning to try things such as going to AA (Alcoholics Anonymous), looking at the options and making a plan to stop or cut down. During the preparation stage, patients prepare to make a specific change.
- *Action stage*: This is the stage where individuals have detoxification, actively attend counselling or AA or both, and have committed to change their behaviour.
- *Maintenance stage*: This is the stage where clients use 'relapse prevention' strategies to ensure new behaviours are maintained. Few people are able to get on top of alcohol problem without a 'slip', where they start drinking again. However, some of the best learning comes from having a slip that is brought under control before the user relapses completely.

Motivational interviewing (see Chapter 16) is an effective counselling approach that helps clients to change specific health behaviours such as alcohol use.

The first step towards recovering from an alcohol problem is to admit to the problem. Muslim alcoholics, like their counterparts, are sometimes not ready to face up to problems, and they are sometimes said to be in a state of denial. Denial is used as a psychological defence mechanism where individuals either reject or distort the consequences associated with their drinking in spite of evidence to the contrary. Muslim clients tend to deny their drinking to their families because of their guilt and shame. Sometimes the power of the problem alcohol user's denial may be so strong that it carries over to the alcoholic's family, that is, convincing the family the problem is trivial and temporary, or the family colluding with the client because of stigma. In psychological terms, a problem alcohol user with little insight into the impact of his or her alcohol use may be called pre-contemplative.

There are several techniques that can be used to help clients to believe that they can change, including raising self-awareness about their problems and restructuring the way the clients think about their behaviour. Sometimes clients only come to the realisation that they need to address their problem drinking when there is a crisis, such as the break-up of a relationship or the possibility of imprisonment because of a legal offence such as a drink-driving conviction. Sometimes clients will take this step just to appease a partner or family member who may be expressing concern about the problem. However, the level of motivation involved in addressing alcohol issues in order to please family members or friends is not likely to be sufficient in the long run for a change in behaviour.

In the initial stages of addressing an alcohol problem, most people are ambivalent about stopping completely, but the compulsion to continue may also be very strong. Clients have ambivalent feelings and expectations concerning two things. According to Velleman (2011), the first is the extent to which they want to give up or reduce their drinking, and the second concern is whether they can change their behaviour. This is particularly so when someone is either psychologically or physically dependent on alcohol:

> [By] acknowledging the conflicting feelings that most people in this situation experience, a good alcohol counsellor can assist the 'user' to clarify their intentions and move through their ambivalence. The point is that having conflicting feelings about wanting to stop is a normal part of the process.
>
> *(www.selfassess.info, n.d.)*

In expressing empathy, the counsellor tries to understand clients' positions as well as possible and to convey this understanding to them. Core counselling skills such as open questioning and reflection are essential. In particular, the counsellor expresses empathy with clients' ambivalence, being willing to listen to and understand why they are reluctant to change as well as why they are keen to do so. When clients are ambivalent about something they are, in effect, in conflict with themselves. For example, 'I want to do it and I don't want to do it.' In motivational interviewing, counsellors seek to encourage clients to explore the conflicts between their beliefs and their behaviours. Counsellors aim to support what self-efficacy clients have, encouraging them to talk about past successes, their strengths and the support they can enlist. The use of cognitive behavioural therapy (CBT) (see Chapter 11) teaches patients why they crave alcohol and how to cope with this craving; how to avoid the people, places and things connected to alcohol; how to cope with difficult feelings that can trigger relapse; and how to prevent a minor slip or 'lapse' from becoming a major relapse. Changing friends, habits and lifestyles is a difficult process as alcohol recovery takes time. In order to change the problem alcohol user's environment, the support of a culturally competent alcohol counsellor, and/or the support of a group such as AA, is generally what makes the difference.

Muslims generally have a lack of trust and engagement with alcohol abuse services, in part due to mainstream services not meeting the holistic needs of Muslim

clients. Many alcohol counselling services still have a one-size-fits-all approach, with little understanding of an individual's cultural and family pressures. Other barriers include a lack of confidentiality, systems that are not responsive to the needs of Muslim clients, restrictions on access, and a lack of cultural competence from those proving the services. Giving accurate health information about alcohol is important, so clients can make informed decisions. In the first session, giving health information has been found to lead to a change of behaviour and enable problem drinkers to stop drinking (Orford and Edwards, 1977).

The counsellor's role is to help clients work through their ambivalence, and motivate them towards gaining control of their alcohol use. Aspects of the role include:

- *Assessment*: assessing the extent of a person's alcohol use by taking an alcohol and drug history and making a comprehensive assessment.
- *Identifying mental health issues*: assessing whether there is an underlying mental health problem or co-morbidity (alcohol and mental health problems); a referral may need to be made to a specialist service.
- *Identifying triggers*: helping identify the situations, thoughts and feelings that trigger clients' drinking or drug taking.
- *Enabling lifestyle changes*: helping clients make appropriate lifestyle changes – paying particular attention to the people they mix or socialise with who may draw them into substance use.
- *Identifying socially acceptable activities*: helping clients find distractions or activities to cope with cravings.
- *Suggesting treatment options*: making referrals to residential treatment programmes when this is appropriate.
- *Providing support*: helping, supporting and motivating those who want to change, but are finding it hard. In addition to the importance of ensuring that clients' basic needs are met, counsellors also need to learn to place substance use in the context of people's lives. This includes an understanding of the meaning and functionality of clients' alcohol use.

Spiritual interventions

For Muslims, the ultimate salvation from alcohol is to turn to Allah (God), read the Noble Qur'aan, and seek Allah's forgiveness and help. Muslims are required to seek such treatment and the method of treatment is clearly prescribed. Spiritual intervention mainly comprises prayers, supplications, recitation of the Qur'aan, remembrance of Allah, fasting, giving charity, and the use of Prophetic medicine. It is stated that religion may inhibit alcohol use through at least three possible mechanisms: positive peer groups, moral values and increased coping skills. More specifically, participation in religious communities may reduce the likelihood of choosing friends who use alcohol (Koenig *et al.*, 2001). It is the process of acculturation into peer groups characterised by non-alcohol-using norms that serves to instil moral values that discourage alcohol use (Hodge, 2011).

For Muslims there are purpose and benefits in using spiritual interventions (Mardiyono *et al.*, 2011). Supplications are usually performed by Muslim clients for wishing the blessing of God. The Qur'aan has positive effects when clients are faced with disease and psychological or spiritual problems. *Dhikr* means remembrance of Allah, and is beneficial for patients to elicit a relaxation response of calmness, mindfulness and peacefulness. Fasting clearly has benefits to clients' health by resting and balancing body metabolism. Charity (*Sadaqah*) can develop positive psychological feelings, happiness and inner beauty that positively affect body metabolism. Spiritual interventions may be used during and after the process of detoxification. The use of relaxation therapy, in the form of *dhikr* therapy, results in peaceful body, mind and spirit. This promotes one's optimal harmonisation, which enhances psychological, social, spiritual and physical health (Abdel-Khalek and Lester, 2007; Syed, 2003). *Dhikr* therapy is the remembrance of Allah, and requires one to sit or lie comfortably, with eyes closed, and practise remembrance of Allah through recitation of: 'Glorious is Allah, praise to Allah, Allah is the greatest' for 20 to 30 minutes (Damarhuda, 2005; Mardiyono and Sulistyowati, 2007; Purwanto and Zulaekah, 2007; Sitepu, 2009).

Ito and Donovan (1986) suggested that a well-planned programme for continued assistance will increase the problem drinker's chances of a successful long-term outcome. A twelve-step recovery programme based upon Islamic principles, for persons who experience problems associated with addiction, has been established at the Millati Islami (www.millatiislami.org, n.d.). Millati Islami is a 'fellowship of men and women . . . [who] look to Allah (God) to guide us on Millati Islami (the Path of Peace). While recovering, we strive to become rightly guided Muslims, submitt[ing] our will and services to Allah.' This recovery support group has adapted the twelve steps to incorporate Islamic principles (www.millatiislami.org, n.d.):

1. We admitted that we were neglectful of our higher selves and that our lives have become unmanageable.
2. We came to believe that Allah could and would restore us to sanity.
3. We made a decision to submit our will to the will of Allah.
4. We made a searching and fearless moral inventory of ourselves.
5. We admitted to Allah and to ourselves the exact nature of our wrongs.
6. Asking Allah for right guidance, we became willing and open for change, ready to have Allah remove our defects of character.
7. We humbly ask Allah to remove our shortcomings.
8. We made a list of persons we have harmed and became willing to make amends to them all.
9. We made direct amends to such people wherever possible, except when to do so would injure them or others.
10. We continued to take personal inventory and when we were wrong promptly admitted it.
11. We sought through *Salaat* [prayer service in Islam] *Iqraa* [reading and studying the Qur'aan] to improve our understanding of *Taqwa*

[God-consciousness; proper Love and respect for Allah] and *Ihsan* [though we cannot see Allah, He does see us].

12 Having increased our level of *Iman* (faith) and *Taqwa*, as a result of applying these steps, we carried this message to humanity and began practicing these principles in all our affairs.

(www.millatiislami.org, n.d.)

For Muslim clients, the Millati programme is a process of spiritual renewal:

- *Step 1: We admitted that we were neglectful of our higher selves and that our lives have become unmanageable*. This means that we are powerless and totally reliant and dependent upon Allah for our total sustenance. Only Allah (*Ahad*) can bring us to the awakening to change and can arrest this addiction. It is this belief that is the first step in solving the alcohol problem.
- *Step 2: We came to believe that Allah could and would restore us to sanity*. That is, it reaffirms the first step and 'if one is to stay sane and sober, it is our belief that following the prescription, following the cure as given to us by Allah, is THE assured method for remaining so, and this on a daily basis' (www.millatiislami.org, n.d.).
- *Step 3: We made a decision to submit our will to the will of Allah*. That is, we have complete submission to Allah.
- *Step 4: We made a searching and fearless moral inventory of ourselves*. This means having self-awareness, striving for excellence in all of our affairs, identifying personal resources and seeking guidance from Allah.
- *Step 5: We admitted to Allah and to ourselves the exact nature of our wrongs*. In contrast with AA, in the Millati Islami programme Muslims are not advertising their faults to other people. 'In Islam, there is no equivalent to the confessional of other faiths and that we confess our wrongs to and beg for forgiveness from Allah alone, who already knows our defects' (www.millatiislami.org, n.d.). It is stated that 'God does not forgive the one who discloses his sins (*mujahir*) that He has concealed from people's eyes' (Bukhârî, n.d.). Seeking repentance and doing good deeds are part of the process.
- *Step 6: Asking Allah for right guidance, we became willing and open for change, ready to have Allah remove our defects of character.* This is the opportunity to seek guidance from Allah to put us on the right path. We ask Allah for guidance at least seventeen times a day (minimum) in our obligatory prayers by reciting the opening chapter of the Qur'aan (Al-Fātiĥah (the Opening)). This is following the command of Allah as stated in many verses of the Qur'aan (29:45; 11:114; 17:78; 4:103; 2:238; 107:4–7).
- *Step 7: We humbly ask Allah to remove our shortcomings*. The tried and proven method of having Allah remove our shortcomings is through fasting during and outside *Ramadhan*.
- *Step 8: We made a list of persons we have harmed and became willing to make amends to them all* is closely related to *Step 9: We made direct amends to such people wherever*

possible, except when to do so would injure them or others. Generally, those who are addicted are 'economical with the truth' and cheat in order to use alcohol. Relationships get damaged or broken and others get hurt by the behaviour of the problem drinker. The first step in making amends is to identify who we have hurt and what exactly we said or did that hurt those individuals. We need to manage our hurt and we set out to amend the 'unfinished business' of sincerely apologising for each specific mistake we have made that has hurt others. This is a way to make direct amends to such people, wherever practical, and start healing the past with others. The problem drinker needs to restore justice. This process will also enable us to feel more connected to Allah. Allah said in the Qur'aan (interpretation of the meaning):

> *But whoever pardons and makes reconciliation – his reward is [due] from Allah. Indeed, He does not like wrongdoers.*
>
> *(Ash-Shūraá (The Consultation) 42:40)*

- *Steps 10, 11* and *12* are sometimes called the maintenance steps and they reinforce the previous steps. The maintenance period is a period of self-reflection, taking the personal inventory. This is a form of spiritual cleansing and action (*Steps 11* and *12*).

The Millati model is a deeply rooted in Islamic teachings. It is a culturally sensitive and sensible programme for those who take their religious beliefs seriously, even though they have fallen into a temporary lapse of judgement (Ali, 2014).

Conclusion

The treatments for alcohol disorders have been subjected to criticism by Muslim scholars (Badri, 1976; Suliman, 1983). Badri (1976) criticises Western alcoholism treatments, such as chemically induced aversion, defends Islamic remedies, which he says have been mischaracterised, and concludes that Muslim therapists should use 'the potential power of Islam as a force of persuasion and aversion' (pp. 1, 50, 55). Suliman (1983) advocates that a remedy for alcoholism is to return to 'the therapeutic village and the mosque' (p. 65). It is argued that the deeper integration of Muslims into their communities can be both prevention and cure for alcoholism; at the same time, there may be non-religious therapies for alcoholism that could be combined with Islamic therapies (Michalak and Trocki, 2006). However, in order for any modern psychological treatments to be effective, it has been suggested that there needs to be education about the correct interpretation of belief (*Aqeedah*), devotion (*Ibadah*) and the practice of virtue, morality and manners (*Akhlaq*) (Alias and Majid, 2005). However, owing to the difficulty of identifying and treating alcohol use disorders in Muslim patients, services need to develop an outreach approach through the local Imam and mosque. Multidimensional pharmacological and psychosocial interventions and a multiprofessional approach, coupled with

culturally sensitive care, are required to provide better and more effective outcomes for those with alcohol-related problems.

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18

THE ROLE OF THE IMAM IN COUNSELLING

Introduction

The word 'Imam' itself means 'to stand in front of' in Arabic, referring to placement of the Imam in front of the worshippers during prayer. In principle, every Muslim can act as an Imam, but the most worthy to lead people in prayer is the one who is most versed in the Qur'aan. The Prophet Muhammad (ﷺ) stated that, 'If you are three in number, then one of you should be the Imam. The one who has the most right to it is the one who is the most versed in the Qur'âan' (Muslim, n.d.). An Imam can be defined as 'the man who leads the prayers, gives the sermon, and advises the congregation on spiritual matters. His community-based role is analogous to that of a priest, a minister, or a rabbi' (Padela *et al.*, 2011a, p. 16). The word Imam can also be used in a broader sense, referring to any person who leads prayer; or the local, national or international Muslim scholars. However, the word Imam is regarded to be too restrictive. It is stated that 'to focus only on imams would be to miss the important leadership roles exercised by many others. The term *Muslim faith leaders* is substantially more inclusive' (Communities and Local Government, 2010, p. 10).

Thus, these faith leaders not only exercised at mosques (Imams) but also at schools, universities, courses and conferences, and in youth settings, and with a wide range of religious scholars (*Alims* and *Alimahs*). In recent years, there has been a new development in the creation of Muslim chaplains to provide services to hospitals, prisons, universities and the armed services. Besides taking the role of the Imam, these chaplains are involved in other activities, such as giving advice and medical decision making, and serve as religious 'translators' and cultural brokers (DeVries *et al.*, 2008). This chapter examines the traditional and extended role of

the Imam in relation to the provision of counselling to those with psychosocial and marital problems.

Traditional and extended roles of the Imam

All Imams are men and lead the prayer for groups of men, or mixed groups of men and women. The term Imam is fluid. Imams are not like the clergy in Christianity and often have more diffuse, varied and informal roles (Institute for Strategic Dialogue, 2000). The core duties of the Imam are leading the five daily prayers, conducting marriage and funeral services, preaching and teaching. Traditionally, an Imam leads the congregational prayers and gives the Friday sermon (*Khutbah*); teaches in madrassas (Islamic schools); conducts ceremonies in relation to births, marriages and deaths; provides advice on matters of *Fiqh* (Islamic jurisprudence); and promotes spiritual growth and development. Imams are involved in visiting the sick, engaging in inter-faith service programmes and organising educational gatherings in the mosque. In contemporary times, the Imam is increasingly in a position to be involved in youth education and development, in community cohesion work and in the provision of counselling. A taxonomy of Imams includes: Imam – a prayer leader; Sermon-Giver-Imam and/or Khatib (more senior role in mosque affairs and in particular responsible for delivering the Friday sermon); Spiritual Guide as Imam and/or Sheikh; Islamic Law Expert-Imam and/or Sheikh; and Director of Mosque as Imam and/or Sheikh (Padela *et al.*, 2011a). Four categories of Imams have been identified (Institute for Strategic Dialogue, 2000): the traditional Mosque Imam; Imam as community development worker/social welfare practitioner, specialising in public preaching/evangelism, chaplaincy, counselling and the Sharia council; Imam as leader of an institute, organisation and community network; and Imam as scholar, intellectual and thought leader.

In the American context, the role of the Imam in the mosque is multifaceted and different in its nature from the official job of the Imam within the Muslim nations (Abuelezz, 2011). In contrast, the American Imam plays a wide variety of roles. He 'is often encouraged to assume responsibilities that more closely resemble those of the American pastor or rabbi' (Haddad and Lummis, 1987). The multiplicity of the Imam's tasks and responsibilities is one of the biggest challenges. Imam Shakeel Begg (2014), in London, discussed his life as an Imam and his extended role, which includes *Dawah* (calling people to Islam), social work, community cohesion, education, matrimonial services, funeral services and dealing with Islamophobia. The social work focused on issues pertaining to matrimony, bereavement and general counselling; gang mediation; solving drug and alcohol problems; business-related disputes; and financial disputes. Imams also play key roles in their community's health, as they are perceived as counsellors and a source of spiritual cures (Abu-Ras *et al.*, 2008; Padela *et al.*, 2011b), and in community social activities (Baru *et al.*, 2011).

One area, though limited in its scope, is the involvement of the Imam in client–provider–family healthcare discussions (DeVries *et al.*, 2008). The findings of a

study (Padela *et al.*, 2011b) showed that four central healthcare-related roles for Imams were identified: encouraging healthy behaviours through scripture-based messages in sermons; performing religious rituals around life events and illnesses; advocating for Muslim patients and delivering cultural sensitivity training in hospitals; and helping Muslims make healthcare decisions. In the context of this chapter, the focus will be directed towards the role of counselling for Imams. In addition, outside the United States, Imams even help resolve disputes that in the United States would be reserved for legal courts (Ali *et al.*, 2004; al-Issa, 2000).

Imams and counselling

The Imam's counselling may be sought for personal or religious issues. Imams are asked to address counselling issues in their communities that reach beyond religious and spiritual concerns and include family problems, social needs and psychiatric symptoms (Ali *et al.*, 2005). In modern times, Imams have an extended role and are in the front line as mental healthcare providers and counsellors. Although Imams have little formal training in counselling, they are asked to help congregants who come to them with mental health and social service issues (Ali *et al.*, 2005) and to screen Muslims with *Jinn* and possession problems. Inadequate assessment and inappropriate treatment are often the result of seeking assistance from religious leaders alone (Budman *et al.*, 1992). The findings from a study showed that Imams can recognise the severity of a serious mental health problem (Ali and Milstein, 2012). In the study, Imams reported a broad range of attitudes towards mental illness in terms of aetiology and helpful interventions, but few reported actually utilising professional healthcare resources. The findings of another study showed that, despite Imams having limited practice in Islamic counselling and psychotherapy, they played a major role in the promotion of Muslims' health (Isgandarova, 2011a).

During the counselling process, the Imam's role is to help the client go through the re-examination of the basic tenets of Islam and behaviours compatible with the Qur'aan and Sunnah. Isgandarova (2014) maintained that:

> [the] Muslim spiritual and religious caregivers' role is to help the client go through the re-examination process without feeling guilt and achieve good mental and spiritual health of the individual through natural balance within the individual and the practice of social and religious obligation.
>
> *(p. 2)*

One of the new psychotherapeutic approaches, based on the study of the Qur'aan, Sunnah and the works of early Muslim scholars, is Iman Restoration Therapy (IRT) (Abdul Razak *et al.*, 2011). A study in the use of IRT by Abdul Razak *et al.* (2011) revealed that maintaining one's faith in Allah can bring about a positive functioning in an individual's cognitive, emotional, behavioural and motivational components and attain spiritual intuition that fosters religious faith and meaningful living. Other spiritual interventions can also be used by the Imam during the counselling process,

including supplications, prayers, *dhikr* therapy, *Ruqyah* (if appropriate) and the use of Qur'aanic verses as sources of healing. The key skills required are pastoral and counselling skills – the capacity to 'listen with moral attentiveness while not being judgmental' (Communities and Local Government, 2010, p. 31).

Dual relationships

The Imam may have a dual role (theological and counselling) with the same client and this raises a number of issues. A dual relationship exists when an Imam serves in the capacity of both therapist and at least one other role with the same client. Problems arising from 'blurred, dual, or conflictual relationships' were the second most frequent ethical dilemma (Pope and Vasquez, 1998, p. 27). The ethical concern about dual relationships is that they:

> can erode and distort the professional nature of the therapeutic relationship and may create conflicts of interest that compromise professional judgment or create situations where the therapist is engaged in meeting his or her own social, financial, or other personal needs, rather than putting the welfare of the client foremost.
>
> *(Friedman, n.d)*

The power relationship between the client and the Imam may result in the exploitation of the vulnerable and harm can occur. There is also the concern that the therapist may be held legally liable and may be called to testify in court regarding the patient's diagnosis, treatment or prognosis (Pope and Vasquez, 1998). The Imam has multiple roles that are fluid and are unavoidable. However, it is important to take steps to minimise harm when multiple relationships do occur by utilising informed consent, negotiation and professional consultation. Pearson and Piazza (1997) classify dual relationships into five categories in order to aid the decision-making process of whether or not a dual relationship will cause harm: circumstantial roles, structured multiple professional roles, shifts in professional roles, personal and professional role conflicts, and the predatory professional. The intent of counselling, the intent of spiritual guidance, the intent of conciliation and the intent of giving advice need to be clearly defined. A framework on the ethical principles have been developed for Imams to follow when counselling community members (Siddiqui, 2014).

Conclusion

In summary, Imams are de facto counsellors and mental healthcare providers. Collaboration and communication should be strengthened between mental healthcare professionals and Imams or faith leaders to facilitate proper referrals and improve access to culturally appropriate mental health services. However, Imams and faith leaders are not adequately prepared in counselling psychology to fulfil

that role (Ali *et al.*, 2005). According to Morgan's (2010) study, three-quarters (75 per cent) of Imams have never received any kind of training in counselling. Nonetheless, the literature on Islamic spiritual care and counselling points out that many Muslim spiritual care professionals usually rely on folklore or common sense in working with clients with psychological problems (Isgandarova, 2011b; Isgandarova and O'Connor, 2012). There is an urgent need to have counselling psychology and Islamic counselling in the curriculum of undergraduate courses for Imams and faith leaders.

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19

CHALLENGES, STRATEGIES AND COMPETENCE

Introduction

There has been a growth in the provision of counselling for Muslim clients, but this has not been matched with the adequate educational preparation of counsellors. Professional organisations and accrediting bodies have integrated multicultural counselling competence into the ethical standards and mandated programmes to infuse multicultural issues into their counselling and psychology training programmes. The development of multicultural counselling competence is not an 'optional endeavor, but is foundational for effective and ethical professional practice' (Arthur and Collins, 2005, p. 51). Multicultural counselling competence refers to counsellors' attitudes/beliefs, knowledge and skills in working with individuals from different cultural (for example, racial, ethnic, gender, social class and sexual orientation) groups (Arredondo *et al.*, 1996; Sue *et al.*, 1982, 1992, 1998). Counsellors who do not have sufficient training in cross-cultural counselling may lack the requisite skills to work with culturally diverse clients (D'Andrea and Daniels, 1996). Multicultural counselling training, which has become an integral part of counsellor education, needs to be multifaceted and infused and supported in all areas of training programmes (Olfer, 2006).

Although counselling and psychology programmes for undergraduate and postgraduate levels have infused multicultural issues into their philosophies and curriculums, there is limited development for the provision of Islamic counselling, that is, to make counsellors and psychotherapists culturally competent to work with Muslim clients. Cultural competence is often developed through education, formal training programmes and clinical supervision, which makes it vital that 'these training opportunities accurately reflect the proposed competencies that are being taught' (Constantine and Ladany, 2001, p. 494). There is evidence to suggest that certain training variables (for example, completing academic coursework,

attending workshops, receiving multicultural supervision) are significantly related to counsellors' perceived competence in working with diverse populations (Olfer, 2006; Pope-Davis *et al.*, 1995; Sodowsky *et al.*, 1998). This chapter focuses on the challenges facing counsellors in the provision of culturally competent counselling for Muslim clients and the educational preparation of counsellors in Islamic counselling.

Cultural competence: challenges and solutions

There are major challenges facing counsellors in the provision of culturally competent counselling for Muslim clients. The diversity of ethnic and linguistic groups of Muslim clients, with each having its own cultural characteristics and worldview of health and illness, presents constant challenges to Islamic and non-Muslim counsellors. Understanding these perspectives of counsellors should inform efforts designed to achieve cultural competence and the delivery of culturally sensitive counselling. However, culturally sensitive counselling needs to be delivered clearly and effectively. This is achieved by creating awareness of the different cultural backgrounds, in order to plan individualised courses of intervention strategies. The findings of a study indicate that 'cultural competency efforts will lead to a greater understanding of Islam and Islamic culture, thereby improving the patient–provider relationship, and improve Muslim experiences within the healthcare system, resulting in reduced challenges and increased accommodations' (Padela *et al.*, 2011, p. 14).

The major challenges faced by counsellors in working with Muslim clients include: Islamophobia, ethical issues, the therapeutic alliance and trust, communication styles and recognition of clinical differences in Muslim clients. Inayat (2007) suggested that, in the counselling arena, four distinct aspects of the counselling relationship are affected: the therapeutic alliance, the socio-political context in which counselling occurs, the awareness of personal characteristics and competencies that facilitate multicultural counselling and, finally, the training requirements of multicultural counsellors.

Islamophobia or anti-Muslim discrimination refers to the 'Irrational hostility, fear and hatred of Islam, Muslims and Islamic culture, and active discrimination towards this group as individuals or collectively' (Open Society Institute, 2009, p. 18). It is a stereotype, bias or acts of hostility towards individual Muslims and includes institutional discrimination against a person because he or she is a Muslim, physical assault and verbal abuse in speech or in writing. The danger of Islamophobia is that it can be both latent and overt. If the counsellor has a frame of reference that holds a 'closed' view of Islam (Runnymede Trust, 1997), the danger of Islamophobia is inherent in the counselling nature and responses. Moreover, White counsellors are victims of a cultural conditioning process that imbues within them biases and prejudices and are not immune from inheriting racial biases and prejudices (Abelson *et al.*, 1998; Burkard and Knox, 2004; Sue, 2005). Non-Muslim counsellors must be conscious of their own biases and stereotypes about Muslims, and how these

stereotypes may unintentionally manifest in the counselling process; for example, if a non-Muslim counsellor assumes that wearing a hijab or burka is a form of subjugation and a symbol of female oppression. The counsellor, instead of understanding the significance, would go against the worldview and values of the client and try to impose a set of Western-oriented values. That is, the critique of Muslim women's dress 'becomes a critique of Islamic injunctions that forcibly conceal the Muslim female, masking her identity and sexuality, setting Islamic traditions apart from the norms of gender equality that prevail in western societies' (ENGAGE, 2010). In fact, according to Benn and Jawad (2004), 'anti-Muslim discourse is increasingly seen as respectable, providing examples on how hostility towards Islam and Muslims is accepted as normal, even among those who may actively challenge other prevalent forms of discrimination' (p. 165).

There are some exchanges that may be perceived as Islamophobia and these behavioural and communication styles are known as microaggressions. The term 'microaggressions' has been described as 'subtle insults (verbal, non-verbal and/or visual) directed toward people of colour, often automatically or unconsciously' (Solorzano *et al.*, 2000, p. 60). The dangers for counsellors, consciously or unconsciously, are that they may endorse these microaggressions in the form of 'religious stereotypes'; they make the assumption that their own 'religious identity' is the norm; and the 'denial of religious prejudice' (Nadal, 2010). That is, although counsellors assume that they are not religiously biased, their communication styles may indicate otherwise. Counsellors must recognise the types of microaggressions that their Muslim clients may experience in their everyday lives, as well as potential microaggressions that may occur during therapy (Nadal *et al.*, 2012). It has been suggested that counsellors should make a concerted effort to identify and monitor microaggressions within the therapeutic context (Sue *et al.*, 2007, p. 280).

It is also important to note when working with Muslim clients that it often creates internal conflict within the non-Muslim counsellor with regard to professional and personal values. In working with Muslim clients (or other diverse clients), it is often essential that counsellors do not impose their personal values or beliefs upon their clients, so that they are able to meet the needs of their clients in the context of their clients' value systems. Counsellors may not realise that their professional and personal values can create internal conflict and have an impact on the decisions they make with clients, because they can become blind-sighted by their own cultural beliefs (Holaday *et al.*, 1994). An example of a lack of cultural understanding is the role and importance of the family in the client's life. Sometimes, Muslim clients feel the need to discuss or examine the 'unfinished business' of family issues, such as excessive family demands or other commitments. In this context, clients may be encouraged by therapists 'to speak out against their families or to make decisions regardless of family support or expectations. Therapists may be unaware that they may be directly invalidating cultural respect for authority and imposing an individualistic view over a collectivist one' (Sue *et al.*, 2007, p. 281). This devaluates the worldview of the Muslim client and imposes the values and worldview of the counsellor. The intrapsychic conflict experienced by the counsellor is

the outcome of attempting to help resolve problems within the client's frame of reference or worldview. It is suggested that, as counsellors become more proficient in multicultural counselling and more able to promote decision making from another's point of view, feelings of internal conflict will decrease (Holaday *et al.*, 1994). However, it is important that counsellors do not totally disregard their personal values; rather, they should work out many personal conflicts that they may have relative to Muslim clients and use them as a cultural frames of reference in the counselling process. For a more comprehensive account of examples of racial microaggressions in therapeutic practice see Sue *et al.* (2007).

Within the socio-political context, it is stated that 'the aetiology of a client's distress is not simply an intrapsychic phenomenon but oftentimes a socio-cultural and environmental one' (Arredondo *et al.*, 2008, p. 266). That is, there is a recognition of the impact of political, socio-economic and cultural factors on psychological health. In view of the promotion of collectivist values rather than individualism in Muslim communities, Islamic counsellors have a responsibility for both social justice and advocacy. Counselling within a social justice framework includes case and cause advocacy. Case advocacy takes place when counsellors enable the empowerment of individuals and families to act on their own behalf to fulfil their needs (Lee *et al.*, 2013). Cause advocacy requires counsellors to stand with or act on behalf of individuals and communities to achieve a more just and equitable position within society (Crethar and Winterowd, 2012; McNutt, 2011). The Islamic counsellor has a good fit in fulfilling the role of advocate for his or her clients.

Models of cultural competence

One of the multicultural models is the one developed by Sue *et al.* (1982, p. 72), proposing eleven cross-cultural counselling competencies, which were organised along three dimensions: beliefs and attitudes (and beliefs about racial and ethnic minorities); knowledge (knowledge and understanding of cultural groups and counsellors' awareness of their clients' worldviews); and skills (interventions, techniques and strategies). These characteristics are described as the counsellor's ability to 'use intervention strategies that are sensitive to the cultural and contextual factors of the client, such as the client's spiritual beliefs and cultural traditions' (Fuertes *et al.*, 2001, p. 4). Two other models are the Multidimensional Model of Cultural Competence (MMCD) (Sue, 2001) and the Framework for Culture-infused Counselling Competence (Arthur and Collins, 2005). In the MMCD, the three primary dimensions connected with effective multicultural counselling are: '(a) specific racial/cultural group perspective, (b) components of cultural competence, and (c) foci of cultural competence' (Sue, 2001, p. 791). According to Sue (2001), the MMCD enables the identification of culture-specific and culture-universal domains of competence; highlights the neglected area of skill development; shows that cultural competence for one group is the same for another group; and indicates that counsellors need to have an extended role to achieve cultural competence. Culture-infused counselling (Arthur and Collins, 2005) focuses on the core construct of culture in the understanding of human nature and goes

beyond race and ethnicity to encompass elements such as age, gender and sexual orientation. Three main competency domains that form the foundation of their conceptual model are:

> Cultural awareness of self – active awareness of personal assumptions, values, and biases; Cultural awareness of others – understanding the worldview of the client; and Cultural-infused working alliance – agreement on goals, agreement on tasks, in the context of a trusting relationship.
>
> *(Arthur and Collins, 2005, p. 58)*

Within this framework, the theoretical conceptualisations of multicultural counselling competencies, focusing on the specific attitudes, knowledge and skills required for multicultural competence, provide a foundation for counsellors' education and continuing professional development (Collins and Arthur, 2010).

There are several criticisms and limitations of the multicultural counselling models, including: differences over defining cultural competence (Ridley *et al.*, 2000); the lack of a conceptual framework for organising its multifaceted dimensions (Atkinson *et al.*, 1998); the underlying theoretical and practical models may be interpreted as applying only to certain groups in our society (Arthur and Collins, 2005); and the focus on set groups and not fully addressing diversity means that the model fails when an individual does not fit into a set category (Mollen *et al.*, 2003). In addition, some of the standards of competencies are often supported by conceptual or theoretical writings rather than empirical evidence and the integration of multicultural counselling into actual practice (Arthur and Achenbach, 2002; Constantine and Ladany, 2001).

Models of training in multicultural counselling

The terms cross-cultural, intercultural and multicultural are often used interchangeably by trainers (Ptak *et al.*, 1995). In order to make counselling meaningful and culturally relevant, it is very important for educational and training programmes to have workable counselling models that are context-specific. A variety of educational approaches have evolved to teach counsellors' skills, from early methods where counsellors learned by being clients, to having counsellor trainees observe experienced practitioners demonstrating and describing skills (Crews *et al.*, 2005). In cross-cultural, mental health and multicultural counselling training, four basic curriculum models have been identified '(a) separate course, (b) area of concentration, (c) interdisciplinary, and (d) integration' (Yutrzenka, 1995, p. 200; see also LaFromboise and Foster, 1992). The separate course model involves a separate course in multicultural counselling. The area of concentration model relates to formal coursework or exposure to one specific ethnic group. The interdisciplinary model involves courses outside a counsellor's discipline or a number of joint programmes between disciplines. The integration model means that cross-cultural content is integrated into every course. The Skilled-Counsellor Training Model (SCTM) is a skills-based learning programme that promotes the acquisition of skills

through the use of modelling, mastery, persuasion, arousal and supervisory feedback (Smaby *et al.*, 1999.) This model incorporates the training of both basic and advanced-level counselling skills through having trainees learn about, observe and perform skills, and then self-assess as well as receive peer and instructor feedback (Urbani *et al.*, 2002).

There is evidence to suggest that an SCTM approach reliably improved trainee counselling skills (Smaby *et al.*, 1999), led to skill transfer into work with actual clients (Schaefle *et al.*, 2005) and enhanced counsellor self-efficacy (Urbani *et al.*, 2002). Counsellor trainees who completed the SCTM had better counselling skills and higher levels of cognitive complexity than did counsellor trainees who did not receive the training (Little *et al.*, 2005). The findings suggest that skills-based training may improve counselling skills and cognitive complexity in counsellor trainees. Recent meta-research has illuminated that culturally sensitive counsellor training programmes deepen trainees' understanding of difference, which has proven to have a positive impact on how Black people/people of colour experience ethnically different counsellors (Cooper, 2008). In addition, the author highlighted that counsellor training that includes diversity training does improve a counsellor's ability to work transracially/culturally. The findings of a study suggest that experiential diversity training had a positive impact on counsellors' personal and professional development, and in relation to increasing their confidence in offering effective transracial/cultural clinical practice (Agambi *et al.*, 2010). Bezrukova *et al.* (2012), in a review of aspects of diversity training programmes on campuses and in the workplace, reported that some programmes (for example, integrated training) were relatively rare, but were viewed more positively than other programmes (for example, stand-alone training).

Within the different multicultural education models there are many different teaching methods that attempt to enhance the infusion of multicultural competency into the educational and training programmes of counsellors. One such methodology is Experiential Diversity Training. This is defined as:

> A specific and imbedded aspect of counsellor training which focuses on the intra and interpersonal experiential exploration of the obvious/known and/or the latent or 'unconscious' fears, prejudices, stereotypical views and beliefs we hold in relation to human diversity; which participating individuals (including tutors) may have inherited or absorbed from significant others, society itself or from any other distorted life experience. This training also explores the impact of belonging to either an 'oppressed' or an 'oppressor group' and how we can minimise the impact of such 'isms' within our psychotherapeutic practice through the development of conscious awareness and personal and interpersonal honesty and open discourse.
>
> *(Brown, 2009, cited in Agambi et al., 2010)*

This experiential diversity training, in conjunction with multicultural coursework, is most effective when promoting multicultural competence and awareness. In addition, counselling programmes need to implement other opportunities (for

example, dialogue groups with diverse members) to support and advance the knowledge of multicultural issues.

Educational development and professional competence

With the increase in psychosocial and spiritual problems faced by Muslims in the Western world, there is a pressing need for Islamic counsellors to develop their knowledge and clinical expertise in order to respond effectively to the needs of the Muslim communities. Counsellors who have limited preparation in multicultural approaches to counselling, or on diversity issues within the counselling process, have produced outcomes of conflict (Coleman, 1997; Robinson and Morris, 2000). In addition, those lacking the knowledge, skills and attitudes in cultural competence may unintentionally engage in unethical prejudicial and discriminatory practices.

Currently the preparations of Islamic counsellors are rather limited and these do not facilitate the development of knowledge, skills and attitudes necessary for counselling Muslim clients. However, there are now a few accredited Islamic courses in the United Kingdom (UK). Stephen Maynard & Associates have been providing Islamic counselling training and one-to-one counselling in the UK since 1996. They have pioneered Islamic Counselling as a field of psychotherapy, including the development of the first accredited training programme in Islamic Counselling in the UK (www.islamiccounselling.info, n.d.). This course is based on extensive theoretical and philosophical underpinnings and is claimed by the course organisers to be "the most or one of the most developed models in the field" (personal communication). The course includes a placement of a minimum of 100 hours and supervision and personal therapy with qualified Islamic counsellors. The progression route in Islamic Counselling comprises three accredited qualifications of increasing advancement. Muslim Family Matters (MFM) (www.muslimfamilymatters.com, n.d.), a faith-centric mediation service and family consultancy, provides different levels of courses in Islamic Counselling: Level 1 – Understanding Islamic counselling; Level 2 – Understanding your heart, mind and soul; and Level 3 – Understanding the world of *Jinns* (and Satanic illnesses & remedies). The Islamic Online University, Faculty of Psychology, has also developed an Islamic Counselling module as part of their BA (Psychology) programme.

The preparation of Islamic counsellors should not be ad hoc, but based upon systematic planning. Initially, educational establishments should develop an educational strategy with local authorities and providers of services to identify the target needs and to plan an educational programme. It is acknowledged that, although this process is complex and time-consuming, it is invaluable in delivering high-quality training and is service-driven. This analysis should focus on the mapping of skills, experience and attitudes, which would provide adequate theoretical content and skills development. The goals of an Islamic counselling educational programme would be:

- To provide an increased awareness and recognition of the psychosocial and spiritual needs of Muslim clients.
- To understand the components that contribute to psychopathology and health.
- To improve the evidence-based intervention strategies required in dealing with such complex problems.

- To develop skills in the use of spiritual interventions based on the Qur'aan and Sunnah.
- To introduce Western theories of counselling, while distilling this information through an Islamic filter to facilitate an enhanced integrative learning process.

Islamic counsellors, like mainstream counsellors, are envisaged to be autonomous practitioners with professional competence in the delivery of counselling and accountable to the clients and the profession. In its simplest form, clinical supervision refers to a process of practising, experiencing and reflecting upon clinical practice. Clinical supervision can be seen as a formal process whereby a worker and an experienced practitioner meet to examine and reflect on the management of clients and the refinement of therapeutic skills.

Conclusion: the way forward

Islamic counselling should actually be seen from a broader perspective so that it covers the provision of health information, advice, therapy, guidance and counselling, advocacy and spiritual interventions. Counselling is facing a daunting challenge in the provision of culturally appropriate services to meet the holistic needs of Muslim clients. For counsellors, the provision of culturally competent counselling is both a professional and an ethical requirement. The questions arise: How does one become culturally competent? Does having more knowledge about Islam make counsellors more competent? No, having knowledge about Islamic beliefs and practices does not make counsellors more competent. According to Lieberman (1990):

> cultural sensitivity does not entail an encyclopaedic knowledge about different practices, but a genuine attempt to understand the other's beliefs, the role that they play, not only in their understanding of adequate parenting, but also in the ways they intend to raise a child who will embody and perpetuate those traits they consider necessary in a well-adjusted adult.
>
> *(p. 117)*

What is fundamental in culturally competent counselling is being responsive to the health beliefs and practices of Muslim clients, and to their religio-cultural needs. If education and training in Islamic counselling are to become a reality, Muslim scholars and clinicians need to focus on an effective strategy in order to meet the needs of Muslim patients in a multicultural society. This is a major challenge.

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