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PSYCHOLOGICAL EXPLORATION

Key Issues to Consider in Therapy with Muslim Families

Stephen Weatherhead · Anna Daiches

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Abstract We present the key issues to consider in therapy with Muslim families. Following a brief introduction, five themes are presented: self, family dynamics, causation, and coping strategies. The section on "self" includes a discussion of three terms which link the four Islamic models of "self" identified through the review. The family dynamics section pays particular attention to interconnectedness, family roles, and gender. Causation is discussed with reference to supernatural and spiritual causes. On the theme of coping strategies, religious responses are discussed as are the roles of religious leaders, and professional mental health services. Clinical implications from the key themes are also discussed in addition to limitations of the published literature in this area. This includes a discussion of the epistemological and paradigmatic issues related to the research. The review concludes by summarising these issues and presenting areas for further research.

Keywords Muslim · Islam · Family · Systemic · Therapy

Introduction

Theorists and researchers considering cultural issues within therapy have highlighted the challenge of engagement with people whose perspective is not consistent with the dominant "Western Academic Scientific Psychology" (for an overview, see Matsumoto 2001). The Muslim population has been a particularly "under-represented population" (Carolan et al. 2000, p. 68). This review aims to synthesise some of the key issues to consider when working with Muslim families, according to published literature on the topic.

The health science databases of MetaLib were searched, followed by a hand search of reference lists. The search terms used were "Islam" or "Muslim" and "therapy". Articles were excluded if they were not available in the English language due to having no access to

S. Weatherhead (✉) · A. Daiches
Department of Clinical Psychology, C16 Furness College, Lancaster University, Lancaster LA1 4YG, UK
e-mail: s.weatherhead@lancaster.ac.uk

a translation service. Quotes from the Qur'an and hadiths[1] have not been included, and where possible, religious terminology has been kept to a minimum. The organisational themes for this review are self, family dynamics, causation, coping strategies, conclusions, and directions for future research.

Before considering the themes identified from the literature, it is important to note two things: the diversity of the Muslim population, and the context of much of the available literature. There is a vast amount of diversity within people of Muslim faith (Rasool 2000; Al-Mateen and Afzal 2004; Hedayat 2006), with somewhere in the region of 1.5 billion followers of Islam worldwide, spanning many countries (Al-Mateen and Afzal 2004). There are approximately 1.6 million followers of the religion in the UK, about 40 % of who were born outside the UK (Census 2001). This diversity is reflected not only in nationality, but also the cultural variations in beliefs, values, and practices.

Much of the available literature on the subject is theoretical and written from the perspective of Muslim scholars and clinicians, which makes the following statement paramount when considering their work, this review, and any connected research:

> (In Islam) There are scholars, acknowledged as experts in matters of law and ethics, whose opinions may be sought for contentious or contemporary issues. Scholars have divergent opinions on new issues and it is important to approach each patient or family as unique…
> (Hedayet 2006, p. 1283)

Whilst this heterogeneity is unequivocal, followers of Islam are connected by faith and membership of the Ummah (Muslim community). However, cultural and individual differences are inherent, and the available literature and research should be used as a guide for developing hypotheses, not as templates for universal rules.

Self

The focus of this review is Muslim families; however, before looking specifically at families, it is also worth noting there is an emerging focus on the self amongst Muslim psychologists. According to some Muslim counsellors and therapists, there are particular features of an Islamic concept of self that may be important to consider when working with Muslim clients. Four specific models were identified through the course of this review (Khalid 2006; Yaqoob 2003; Inayat 2005a, b; Skinner 2006), all of which incorporated language from Islamic texts, and psychological theory. Three terms in particular appear to provide a thread which runs through and between the models: Nafs, Ruh, and Qalb. The use of these terms within models of self is summarised below:

Nafs (*psyche*)

Nafs are described in the Qur'an as the states of self (Yaqoob 2003); whilst only three forms of Nafs are referred to directly, they may be viewed as a continuum (Inayat 2005a, b), encompassing both positive and negative drives (Yaqoob 2003; Khalid 2006). The three primary forms broadly map onto psychoanalytic descriptions of the ego, superego, and id (see Table 1).

[1] Sayings and stories from the life of The Prophet Mohammed.

Table 1 Islamic and psychoanalytic parallels of drives (adapted from Yaqoob 2003)

Naf	Description	Psychoanalytic parallel
Nafs Ammara	Negative drives and lower aspects of self	Id
Nafs Lawwama	Self-reproaching aspect of self, initiated by an awareness of wrongdoing	Superego
Nafs Mutmainnah	State of spiritual harmony and peace	Ego

In a further similarity, both understandings suggest that the struggle between lower drives and the reproaching aspect of self is ongoing and is located internally. However, from an Islamic perspective, humans are believed to have an inherent "good" state. Nafs Ammara is rooted in "uncleanliness and contamination" and presents a constant struggle to overcome negative drives, in receiving the mercy of God (Ali Rizivi 1994, p. 70). According to this view, the goal is not to eliminate Nafs Ammara, but to control it and balance boundaries of suppression and over-indulgence (Yaqoob 2003).

Ruh (*Soul*)

The idea of people having a soul may also be an important consideration for therapy. There are, however, variations in how this is presented in available literature. For example, the term Nafs may be used as a descriptive label for soul, but elsewhere it is labelled as Ruh. It appears that this may simply be a linguistic difference due to translation, or interpretation. The main commonality is that Islam teaches that only Allah, as creator, holds knowledge about each person's soul. The soul characterises the fluid state of self, travelling through four worlds: from the womb (where it joins the body); followed by a relatively brief time in the living world; the grave; and onto everlasting state in the afterlife. Therefore, if therapy is focussed only on the present, living world, it is missing a significant portion of the soul's journey.

Qalb (*heart*)

Hussain (2001) describes the heart as having a physical and spiritual role for followers of Islam, and as the location for emotional pain. Inayat (2005a, b) states that for Muslims, the heart functions as a container of spiritual intelligence and wisdom, suggesting that this connection with God makes the heart the most important part of a human being.

This metaphysical understanding of the heart may be important from a therapeutic perspective. For example, it has been suggested that people of Muslim faith often present with somatic complaints relating to the heart or upper body as a description of psychological distress, which may be viewed as an incongruent heart (Hussain 2001) or a heart that is "wounded" or "worried" (Khalid 2006, p. 6). The inference is that this distress is the result of spiritual disharmony or a distance from God and may be rectified by prayer and good deeds (Al-Krenawi and Graham 2000a, b).

Clinical Implications

According to Islamic perspectives on self, one has a natural instinct for what is right and wrong. Distress occurs through disharmony with this natural state, which distances us from

God, and resolution results from reinstating closeness to God. For example, Hussain (2001) suggests that the aim of therapeutic interventions should, therefore, be to restore the heart's spiritual congruence (Hussain 2001). Perhaps the most productive starting point with reference to concepts of self would be to enhance the current literature base through empirical research. For example, one could conduct interviews with members of the general Muslim population about their own concepts of self and what influences it. This could then have the ultimate goal of defining self within the language of the lay Muslim, rather than academics.

Family Dynamics

Key Themes

Balancing a presentation of key issues when working with Muslim families with the understanding that followers of Islam are not a homogenous group is a theme that runs throughout this review. Each family is of course unique; however, there are a number of themes that literature in this area suggests may be pertinent to Muslim families. These systemic considerations are discussed here in the context of cultural and religious practices, family dynamics, and gender roles. This is followed by a brief discussion of the usefulness of gender demarcation within the available literature, and a summary of the clinical implications of the themes presented here.

The first theme to consider is the connection that members of the Muslim community may have with each other. It is likely that a connection with the wider Muslim community in the UK is partly due to patterns of migration. However, there is also a religious rationale to consider. Muslims are believed to be part of Ummah Wahida (one community), regardless of nationality. This cohesion is deemed more important than the needs of any individual member (Daneshpour 1998; Al-Krenawi and Graham 2000a, b; Al-Mateen and Afzal 2004).

Research has also suggested that the extended family may be particularly important within Muslim culture (Messent 1992; Shah and Sonouga-Barke 1995; Carolan et al. 2000). It is suggested that the needs of the family and extended family may be prioritised over individual autonomy within Islam (Al-Mateen and Afzal 2004). This appears to be stable across Muslims regardless of ethno-cultural background, but research in this area is limited.

A restricted differentiation of self has traditionally been considered by Western psychological literature to have a negative impact on self (see Bowen's family systems theory, for example). However, recent empirical evidence has suggested a more complex interplay (Johnson et al. 2001; Jenkins et al. 2005). Jenkins et al. (2005) suggest that whilst a lack of differentiation may lead to reduced self-confidence, this "Fusion" may encourage a stable identity and more intimacy.

In terms of family roles, it has been suggested that many Muslim families may be demarcated by gender, females generally being responsible for the emotional aspects of family functioning, including childcare, and males taking responsibility for finance and decision-making (Daneshpour 1998; Al-Krenawi and Graham 2000a, b; McGoldrick et al. 2005). However, there is a distinct lack of research investigating how stable these constructs are outside the traditional Muslim family, or whether they are applicable beyond first-generation migrants.

It has been shown that traditional tri-generational households can have a negative impact on the psychological well-being of mothers, but a positive impact on children, with particular reference to greater incidence of depression (in mothers) and reduced incidence

of behavioural problems (in children) (Shah and Sonouga-Barke 1995). However, Shah and Sonouga-Barke (1995) focussed on Pakistani Muslim families and had only 35 participants. Therefore, the results may be linked to culture, or sampling flaws rather than family structure. Furthermore, no discussion was offered on the cultural relevance of the questionnaires used. However, Sonouga-Barke had a larger sample and compared Pakistani Hindu families with Pakistani Muslim families. Again, the study found better mental health in children and grandmothers than in mothers, regardless of religion. However, the question of the validity of the tools used remains outstanding, as does the generalisability of these findings to the more common dual-generation households, where the extended family is still important.

Gender demarcation is also apparent in the literature on Muslim mental health. For example, in Carter and Rashidi's (2004) critique of Western psychotherapy approaches, they suggest that therapy with Muslim women requires therapists to be cognisant of etiquette with regards to eye contact, rules of male–female social interaction, and the involvement of members of the wider family in decision-making processes. They conclude with an argument for a specific model of psychotherapy for working with Muslim women.

However, many of the points presented by Carter and Rashidi within their model are also relevant to Muslim men, such as the incorporation of spirituality into therapy, through "connecting to the higher power" (Carter and Rashidi 2003, p. 410), and collaboration with other family members. This relevance is particularly pertinent to the authors' argument for a holistic approach to therapy, which draws on many of the concepts introduced earlier such as the integration of spirit, soul, body, and emotion.

There may be a political explanation for gender demarcation within the literature. In a strong critical appraisal of feminism in Islam, Majid (1998) argues that Islamic literature has a history of being interpreted and dominated by males. She dissects the social-, sexual-, emotional-, and economic-based struggles that are reflected in the literature and theory in this field, arguing that there needs to be a re-evaluation of the history of Islamic theory, and its relationship with Western perspectives.

Perhaps the best way to acknowledge the difficulties associated with the literature presenting a gender divide, from a therapeutic perspective, is to consider all difficulties on an individual rather than gender-specific level, as recommended by Valiante (2003) when discussing the application of a solution-focussed approach to family therapy with Muslim families:

> …Each individual has the ultimate responsibility of discerning free will and actions, and of seeking solutions and setting goals that will not be impaired because of gender (Valiante 2003, p. 3)

Consequently, whilst there may be particular considerations to take into account when working with Muslim individuals and families, empirical research and scholarly advice should not be assumed to be applicable to everyone who falls into a particular category, be it defined by religion, nationality, or gender.

Clinical Implications

There are a number of clinical implications of the themes outlined above; for example, in "Ethnicity & Family Therapy", McGoldrick et al. (1997, 2005) have commented that traditional family therapy has focussed too much on the nuclear family, when a broader perspective may be more helpful with some Muslim families. They suggest that the literature on the role of the extended family may make it necessary to offer more

consideration to the extended family when constructing psychological genograms and formulations. Additionally, there may be potential for damage to the therapeutic relationship being incurred by misconstruing interconnectedness for enmeshment, due to cultural naivety. This may threaten the therapeutic alliance, by encouraging a culturally inappropriate goal of differentiation of self.

The themes presented above may be taken as prompts for investigating certain issues and developing hypotheses, which can be investigated on an individual client/family level, as concluded by Benawi and Stockton (1993) with reference to group therapy:

> The assumption is that increased information about Muslim religious and cultural values will allow group leaders to become sensitised and thus more therapeutic in their interventions with Muslims
> (Benawi and Stockton 1993, p. 159)

A number of theorists have specifically considered the appropriateness of family therapy for Muslim families (Messent 1992; Rubin and Nassar 1993; Daneshpour 1998; Valiante 2003). Daneshpour (1998) asserts that family interventions are unlikely to succeed without consideration of the contextual differences detailed above. The author primarily focuses on the circumplex model, but specifically considers the concepts she claims are common to most models, "cohesion/togetherness; flexibility/adaptability; and communication". She also raises the importance of a "joining process" in facilitating a sense of cohesion for the family with the therapist. This may mean that the connectedness with the community and extended family is also applicable to the therapeutic relationship.

Valiante (2003) presents a solution-focussed model of family therapy and its use with Muslim families in Turkey. She reports her reflections on the application of the approach with Muslim families, citing eight key features in applying the model in a religiously sensitive way. Some of these techniques are fundamental to the generic application of the approach such as focussing on individual behaviour and strengths, goal-setting, and focus on action rather than pathology. Other aspects are adapted, such as relating Qur'anic concepts to the therapy, and using the miracle question literally rather than metaphorically. The conclusion is that therapy with Muslim families needs to incorporate the "religious, cultural, social and personal experiences of these families" (Valiante 2003).

Finally, Messent (1992) suggests taking an integrative approach to the different schools of family therapy. As an example, he details case studies where a structural approach was useful for hierarchical Muslim families where the emphasis is on the "behavioural and concrete" (p. 301), and then, strategic approaches were useful for reframing anger. However, these adapted models of working have not been subjected to empirical research and are currently limited to clinical commentaries and case studies.

Causation

It has been suggested by many researchers into Muslim mental health, illness, and distress that illness and suffering can be considered as a test from Allah (Husain 1998; Al-Krenawi and Graham 2000a, b; Rasool 2000; Hussain 2001; Al-Mateen and Afzal 2004; Salas and Jadhav 2004, Hanley 2007). This section also discusses jinn as a second spiritual perspective on the cause of mental health difficulties.

The perception of a spiritual understanding of illness and mental health difficulties appears to cross the boundaries of nationality and research focus within published

literature. A typical example, being Hanley's (2007) study of the emotional well-being of Bangladeshi mothers, in which one of the main findings was that:

> All expressed the view that whatever fate should befall them, however painful or distressing, was ordained by the will of Allah and was not to be questioned or doubted. It was meant to happen
> (Hanley 2007, p. 36)

She goes on to explore the concept of the role of Jinn (evil angels) within the participants' understanding of postnatal depression, and the role of belief and custom in overcoming these difficulties.

Hanley does not examine the role of acculturation or religiosity amongst the sample, so it is unclear whether this issue is relevant to Muslims who have spent a number of years in a society where their views may be open to influence from outside traditional Muslim perspectives. However, the participants included in the study lived in a region of Wales where the Bangladeshi community forms only 2 % of the total population in the region.

Rasool (2000) discusses the alternative supernatural/spiritual aetiology of ill health and distress from an Islamic perspective. Here the focus is on difficulties being a test rather than Jinn. This view purports that difficulties form part of a "continuum of being" (Rasool 2000, p. 1479). The author refers to previous researchers and theorists, who take the view that challenges lead a person to become closer to Allah, and that prayer is the operative element in overcoming any challenge. This may also increase the sense of agency and comfort for Muslims during times of challenge because:

> Solace (is found) in the knowledge that whereas life is a test, true comfort can be found in the hereafter
> (Benawi and Stockton 1993, p. 153)

Al-Krenawi and Graham (2000a, b) in their paper on mental health work with Arab Muslim clients also discuss supernatural explanations that may be adopted. They include angels, tests from God, evil eye (sorcery), and punishment from a previous life. Any of these explanations and others may or may not be relevant to individual members of the diverse Muslim population. However, the overarching point is that therapists should be aware that their clients may view these problems as "…resting with an external locus of control" (Al-Krenawi and Graham 2000a, b, p. 17).

One of the major limitations of the literature available in this area is the limited amount of published empirical research. The majority of the publications identified during this review are commentaries and case studies written by professionals who either are Muslim, or have regular contact with Muslim clients. This may infer a greater understanding and knowledge base from which to write. However, it also introduces the possibility that the author's own beliefs may over-influence their writing. On the other hand, it is important not to preclude the literature that does not draw on empirical evidence, particularly if the main rationale for this is its difference to Western/secular theories. It does, however, mean that its clinical use should be approached with caution. The direction of future research and the accompanying epistemological issues are discussed in the Conclusions section below.

Coping Strategies

The role of religious leaders and the importance of incorporating religious beliefs into therapy is also a common theme within published literature on this topic. Following a

discussion of the findings from empirical research, various ways services can provide culturally appropriate care are presented here including: involving religious advisors in services, showing awareness of religious beliefs, providing culturally specific services, and adapting established therapeutic models to include a religious component.

As reported above, mental ill health may be commonly perceived as occurring by God's will. Therefore, a religious response is often sought, perhaps the most common method being recitation of the Qur'an, fasting, and repentance (Hussain 2001). Prayer is a significant feature of Muslim faith regardless of whether difficulties are faced or not. One of the five pillars of Islam is the five-time daily prayer, with group prayer being particularly privileged (Al-Radi and Al-Mahdy 1989). This form of ritualistic prayer is called Salat, but there are also two other forms of prayer, Zikr and Dua, which are seen as more individual and may be performed in an attempt to overcome mental or physical illness (Inayat 2005a, b).

If this perspective is adopted, then support may be more likely to be sought from religious quarters (e.g. Imaams, scholars, traditional healers) as opposed to formal mental health services. Ali et al. (2005) report that the role of Imaams in particular reaches "beyond religious and spiritual concerns" (p. 205), into the realms of counselling for amongst other things, family problems, bereavement, depression, and anxiety.

There are convincing arguments for involving Imaams in formal mental health services. Salas and Jadhav (2004) highlight their role in an inpatient service where amongst other things they provide religious support to patients, advice to staff, and attempt to "dispel preconceptions about mental distress" amongst patients and families. Traditional healers may also be useful collaborators for services, particularly in engaging the family through "a common worldview" (Al-Krenawi and Graham 2000a, b). However, the authors also outline practices of traditional healers that may contradict the therapeutic relationship by Western standards. They report the role of the healer as active and the clients as passive, and also highlight the belief that healers hold supernatural powers.

As detailed above, there are clear differences between the role of an Imaam, who may offer advice and support, and that of a traditional spiritual healer. Another option may be to consult a Hakim, for herbal remedies, although this is perhaps more pertinent to a medical setting. Carolan et al. (2000) conducted focus groups with 40 Muslims in America (35 of whom were first-generation migrants) and found that where support is sought it is accessed according to a "continuum of need", in the following order:

1. Advice from friends and family
2. Advice from spouse family
3. Advice from a Muslim professional
4. Advice from a non-Muslim professional known to the community (Carolan et al. 2000)

This perspective has also been supported more recently (Al-Mateen and Afzal 2004), with the additional caveat that stigma also plays a part in the reluctance to access services.

Other authors comment on stigma in relation to Muslims accessing mainstream mental health services. Al-Krenawi and Graham (2000a, b) suggest that accessing services may have a negative impact on marriage prospects, particularly for women. The authors suggest that one way to reduce stigma is to locate mental health services less overtly, for example, in general medical clinics. This may also overcome the problem that some Muslim families may not have any knowledge of available services (Stein et al. 2003). In a recent conference presentation, Amer (2006) highlighted a number of ways to make services more accessible to Muslims (see Table 2).

As Amer's (2006) recommendations, and the literature presented so far within this review point out, there are a number of adaptations that may be made to service settings and processes, to make them more useful to Muslim clients. Many of these adaptations have obvious face validity; however, further research is necessary to assess whether they do in fact have a positive impact on attitudes towards interventions, and their outcomes.

Another challenge relates to Muslim clients accessing therapy to begin with. It has been suggested that Western therapists may be seen as inaccessible simply because of pre-conceptions, such as maintaining a different worldview (Al-Mateen and Afzal 2004), or an inability to incorporate religious perspectives into therapy (Daneshpour 1998), a view that may also be mirrored by therapists (Patel and Shikongo 2006). Therefore, Amer's suggestions of outreach work, environmental changes, and increased resources, in addition to the incorporation of religion/spirituality in professional training, are obvious ways to begin overcoming such perceptions.

Directions for Future Research and Conclusions

Epistemological and Paradigmatic Challenges

There is a paucity of published empirical research in this area, perhaps because it is not being conducted, not being submitted for publication, or not being published. One problem may be that the methodology and design selected are inappropriate to the research area. A number of studies detailed above adopt a quantitative approach, but they have common design flaws such as low sample size, the failure to use evidence-based interventions, and poor matching of controls and non-controls. It may be that the knowledge base could be significantly improved by quantitative research which is more rigorously designed. However, it is our view that enquiry in this area does not map onto the key areas of quantitative research; generalisability, reliability, and objectivity.

There is not the scope within this review to explore the "fit" of this research area with quantitative approaches. However, some specific examples of the challenges include the heterogeneity of the population, the complex interplay of religious and secular concepts in therapy, and the individual nature of religiosity, culture, and lived experience.

It is possible that Western approaches to therapy, and associated research are completely incompatible with Muslim study. Western approaches typically locate the source and locus of control for any problem within the individual/system. This significantly limits the scope for incorporating Islamic teachings on, for example, the subjects of God, interconnectedness (with family, community, God), and self. It may also be restricting the type of research being conducted. A number of authors suggest the need for a Muslim psychology, and perhaps there is also the need for Muslim psychological research. However, this view presents a false dichotomy of Muslim and non-Muslim, which does not allow for intra-Ummah variation.

It is our view that regardless of whether research is labelled as Muslim research or not, qualitative research presents the best starting point for exploring the key issues for therapy with Muslim families. Gilgun (2005) presents a number of "products" of qualitative research pertinent to family psychology, which may be equally relevant to Muslim families. These include theory and model building, textual analysis, and, perhaps most relevant to this area of enquiry, "descriptive accounts of lived experience" (Gilgun 2005, p. 42).

Table 2 Top ten challenges to providing accessible mental health services to Muslims (adapted from Amer 2006)

Challenge	Solutions
Diversity of the community	Read different people's beliefs Hypothesise
Awareness and information	Outreach practice Discuss with clients Increase provider knowledge
Stigma and shame	Normalisation Availability of ethnic-specific services
Help-seeking behaviour	Consultation and training for other sources of support, e.g. spiritual leaders Integration of religious interventions in treatment
Language and communication	Ethnic language services Alternative communication
Misconceptions and stereotypes	Awareness and exploration of internalised biases Cultural competence training Formalised and fair procedures Evaluation of client perceptions
Non-conscious values	Awareness of non-conscious biases Develop collaborative, appropriate goals Acknowledge the unseen within therapy
Euro-American treatments	Culturally competent services Application of ethnic belief systems within therapeutic models Integration of culture and religion
Etiquette	Be sensitive to issues within the physical environment Be inclusive within documentation
Resources	Address need for culturally relevant resources Training courses Professionals Reading Research Develop shared databases of information

Roy-Choudhury (2003) presents a similar argument for using qualitative methodology within family therapy. He refers specifically to discourse analysis, which he argues may be used to

> …Tease out specific interactional co-ordinates of different types of psychotherapy…(and that this may allow for greater analysis of the) …Many permutations of gender, culture, religion and so on.
> (Roy-Choudhury 2003, p. 82)

Similarly, a recent analysis of qualitative research methodologies within the systemic paradigm concluded that grounded theory, discourse analysis, and narrative analysis were the most applicable to systemic research. (Burck 2005).

Our view is that qualitative research presents a more appropriate approach to study in this area than quantitative methodologies, because it provides more room to explore the intricacies that are inherent to religious and cultural discourses. Narrative analysis in particular appears to be the most suitable approach. The literature gathered during this review suggested that an approach that gives room for the exploration of stories and metaphors would be useful, both as a research tool and a bridge between Islamic and

Western starting points. This perspective is also consistent with Burck's (2005) view that it was useful in examining how:

> …Individuals accounted for themselves and their experiences, how they reflected on their multiplicities and contradictions, and how they positioned themselves in relation to dominant notions of self
> (Burck 2005, p. 258)

An Argument for Narrative Research in this Area: The Use of Stories and metaphors

Many of the articles and texts identified during this review have included quotes from the Qur'an, or hadiths (sayings of the prophet Mohammed). It was indicated, within the section on bereavement, that a story about the Prophet Mohammed's own loss is a source of support for the general Muslim population. Additionally, Hanley's (2007) qualitative study includes quotes from the participants which refer to verses from the Qur'an.

Whilst direct quotes have not been included in this review, some examples of how they are used within an academic piece include Valiante's (2003) report on solution-focussed family therapy which includes more than ten quotes from the Qur'an, and three of the four "models of self" referenced in this review also include direct quotes in the text. On many more occasions, the Qur'an is referred to without quoting directly from it, both in commentaries and in empirical research papers. Where research has reported an Islamic component to therapy, it has invariably included hadiths and Qur'anic verses within that framework.

Whether this is a consistent commonality or occasional similarity is unclear, but it has also been a feature of conversations we have had with Muslim therapists, and presentations heard at conferences attended whilst preparing this review. It certainly presents a possible area for further research. Some examples of how this could be investigated include interviewing Imaams or Muslim therapists to see if the use of stories and metaphors is a fundamental part of the counselling they provide. If so, then it may be important to see if it was an aspect that people who have accessed these services found to be helpful.

There are three main reasons for investigating therapeutic narratives further. Firstly, the quotes provide a religious perspective on life and its challenges. Secondly, if they are a common feature of the literature discussed here, they may also be commonplace in Muslim culture more generally. Finally, the use of narrative presents one of many overlaps between Western and Muslim therapeutic practices.

Additional Directions for Future Research

According to census statistics, 54 % of Muslims in Britain are migrants (Census 2001). There are now also third- and fourth-generation British Muslims, who may have a very different perspective to their parents and grandparents. Much of the research conducted in this area has had a majority first-generation migrant sample, so it is unclear whether the themes raised remain applicable to this evolving community.

Therefore, it may be appropriate to consider the issues raised in this review within the context of acculturation and re-acculturation. Acculturation can be considered developmentally and influenced by issues such as length of time in each country, age, and religious background (Al-Mateen and Afzal 2004). This process involves increased adoption of the practices and values of the new country. Re-acculturation on the other hand refers to an increase in the practices and values of the country of origin (Al-Krenawi and Graham

2005). Both processes and the further complication of multiculturalism/religious conversion (Daneshpour 2003) provide areas for further research. For example, are the Muslim models of self influenced by these features, and does it result in specific issues that may result in a person or family accessing therapy?

Ali et al. (2004) raise issues for further clinical investigation such as alcoholism and suicide, which are important due to their contravention of Muslim instruction. Al-Issa's review provides a good starting point for identifying difficulties that warrant further investigation. It offers two platforms for this: the exploration of difficulties that are prevalent in Muslim countries, and the relevance of Western conceptualisations of difficulties to Muslims.

There is a significant need for the literature relating to mental health and therapy from a Muslim perspective, which goes beyond the level of expert opinion, commentaries, and case studies. This is especially relevant to the models of self discussed at the beginning of this review. The main outcome of this research would be to find out how the theoretical/scholarly perspectives translate into the language, beliefs, values, and behaviour of the general Muslim population.

Conclusions

This review has raised a number of the key themes that may be relevant when working therapeutically with Muslim families. There is a significant amount of religious, cultural, and national diversity within followers of Islam, and as therapists, we should be cognisant of this point at all times, as is the case with every client/system. It can be easy to fall into the trap of presumed homogeneity, particularly when scholars and theorists present much of the available literature in this way.

On the other hand, the Muslim community is connected by its faith and this interconnectedness was a consistent theme across domains such as the family, the community, the therapist, and with God. This may increase the resonance for some of the themes raised such as views on death and loss, anxiety, and its sociopolitical context. There are also concepts that easily integrate Islamic philosophy and Western models of psychotherapy, such as the use of stories and metaphors.

The literature highlighted during this review is extremely helpful as a platform for hypothesis development. However, empirical research is necessary to investigate the role of these themes for the clients and families in terms of their mental health. Until then, and perhaps beyond, the most useful use of these themes is to use them as prompts for curious enquiry.

Finally, and perhaps most importantly, the current political climate is creating an unnecessary and unhelpful divide between Western and Islamic cultures. It is the responsibility of individuals and services to challenge this problem and to ensure it is not perpetuated in mental health services. This is pertinent to all associated areas, from research to therapy, and service developments.

References

Ali, S. R., Liu, W. M., & Humedian, M. (2004). Islam 101: Understanding the religion and therapy implications. *Professional Psychology: Research and Practice, 35*(6), 635–642.

Ali, O. M., Milstein, G., & Marzuk, P. M. (2005). The Imam's role in meeting the counselling needs of Muslim communities in the United States. *Psychiatric Services, 56*(2), 202–205.
Ali Razivi, S. A. (1994). *Muslim tradition in psychotherapy & modern trends*. Pakistan: Institute of Islamic culture.
Al-Krenawi, A., & Graham, J. (2000a). Culturally sensitive social work practice with Arab clients in mental health settings. *Health & Social Work, 25*(1), 9–22.
Al-Krenawi, A., & Graham, J. (2000b). Islamic theology and prayer: Relevance for social work practice. *International Social Work, 43*(3), 289–304.
Al-Krenawi, A., & Graham, J. R. (2005). Marital therapy for Arab Muslim Palestinian couples in the context of reacculturation. *The Family Journal: Counselling and Therapy for Couples and Families, 13*(3), 300–310.
Al-Mateen, C. S., & Afzal, A. (2004). The Muslim child, adolescent and family. *Child & Adolescent Psychiatric Clinics of North America, 13*, 184–200.
Al-Radi, O. M., & Al-Mahdy, M. A. (1989). Group therapy: An Islamic approach. *Transcultural Psychiatric Research Review, 26*(4), 273–276.
Amer, M. (2006). Confronting the top 10 challenges to effective mental health services for Muslims. In *Keynote presentation: Faith, culture & mental health conference (Manchester 30th November 2006)*.
Benawi, R., & Stockton, R. (1993). Islamic values relevant to group work, with practical implications for the group leader. *Journal for Specialists in Group Work, 18*(3), 151–160.
Burck, C. (2005). Comparing qualitative research methodologies for systemic research: the use of grounded theory, discourse analysis and narrative analysis. *Journal of Family Therapy, 27*, 237–262.
Carolan, M. T., Bagherinia, G., Juhari, R., Himelright, J., & Mouton-Sanders, M. (2000). Contemporary Muslim families: Research and practice. *Contemporary Family Therapy, 22*(1), 67–79.
Carter, D. J., & Rashidi, A. (2003). Theoretical model of psychotherapy: Eastern Asian-Islamic women with mental illness. *Healthcare for Women International, 24*, 399–413.
Carter, D. J., & Rashidi, A. (2004). East meets weat: Integrating psychotherapy approaches for Muslim women. *Holistic Nursing Practice, 18*(3), 152–159.
Census. (2001). Web data accessed from http://www.statistics.gov.uk/cci/nugget_print.asp?ID=958 on January 19, 2008.
Daneshpour, M. (1998). Muslim families and family therapy. *Journal of Marital and Family Therapy, 24*(3), 355–390.
Daneshpour, M. (2003). Lives together, worlds apart? The lives of multicultural Muslim couples. *Journal of Couple & Family Relationship Therapy, 2*(3), 57–71.
Gilgun, J. F. (2005). Qualitative research and family psychology. *Journal of Family Psychology, 19*(1), 40–50.
Hanley, J. (2007). The emotional wellbeing of Bangladeshi mothers during the postnatal period. *Community Practitioner, 80*(5), 34–37.
Hedayat, K. (2006). When the spirit leaves: Childhood death, grieving, and bereavement in Islam. *Journal of Palliative Medicine, 9*(6), 1282–1291.
Husain, S. A. (1998). Religion and mental health from the Muslim perspective. In H. Koenig (Ed.), *Handbook of religion and mental health* (pp. 279–290). San Diego, CA: Academic Press.
Hussain, A. (2001). Islamic beliefs and mental health. *Mental Health Nursing*. Article accessed via internet: http://findarticles.com/p/articles/mi_qa3949/is_200103/ai_n8948262. Accessed February 2, 2008.
Inayat, Q. (2005a). The Islamic concept of the self. *Counselling Psychology Review, 20*(3), 2–10.
Inayat, Q. (2005). Islam, divinity, and spiritual healing. In R. Moodle, & R. W. West (Eds.), *Integrating traditional healing practices into counselling and psychotherapy* (pp. 159–169). UK: Sage.
Jenkins, S. M., Buboltz Jnr, W. C., Schwartz, J. P., & Johnson, P. (2005). Differentiation of self and psychosocial development. *Contemporary Family Therapy, 27*(2), 251–261.
Johnson, P., Thorngren, J. M., & Smith, A. J. (2001). Parental divorce and family functioning: Effects on differentiation levels of young adults. *The Family Journal, 8*, 265–272.
Khalid, S. (2006). Counselling from an Islamic perspective. *Journal of Healthcare Counsellors and Psychotherapists, 2006*, 7–10.
Majid, A. (1998). The politics of feminism in Islam. *Journal of Women in Culture and Society, 23*(2), 321–361.
Matsumoto, D. R. (2001). *The handbook of culture and psychology*. UK: Oxford University Press.
McGoldrick, M., Garcia-Prento, N., & Giordano, J. (Eds.). (2005). *Ethnicity and family therapy* (3rd ed.). New York: The Guildford Press.
McGoldrick, M., Giordano, J., & Pearce, J. K. (Eds.). (1997). *Ethnicity and family therapy* (2nd ed.). New York: The Guildford Press.

Messent, P. (1992). Working with Bangladeshi families in the east end of London. *Journal of Family Therapy, 14*, 187–304.

Patel, C. J., & Shikongo, A. E. (2006). Handling spirituality/religion in professional training: Experiences of a sample of Muslim psychology students. *Journal of Religion and Health, 45*(1), 93–112.

Rasool, G. H. (2000). The crescent and Islam: healing, nursing and the spiritual dimension. Some considerations towards an understanding of the Islamic perspectives on caring. *Journal of Advanced Nursing, 32*(6), 1476–1484.

Roy-Choudhury, S. (2003). Knowing the unknowable: What constitutes evidence in family therapy? *Journal of Family Therapy, 25*, 64–85.

Rubin, S. S., & Nassar, H. Z. (1993). Psychotherapy and supervision with a bereaved Moslem family: An intervention that almost failed. *Psychiatry, 56*, 338–348.

Salas, S., & Jadhav, S. (2004). Meeting the needs of Muslim service users. *Professional Nurse, 20*(1), 22–24.

Shah, Q., & Sonouga-Barke, E. S. (1995). Family structure and the mental health of Pakistani mothers and their children living in Britain. *British Journal of Clinical Psychology, 34*, 79–81.

Skinner, R. (2006). An Islamic model of self. In *Keynote presentation: Faith, culture & mental health conference (Manchester 30th November 2006)*.

Stein, S. M., Chrisite, D., Shah, R., Dabney, J., & Wolpert, M. (2003). Attitudes to and knowledge of CAMHS: Differences between Pakistani and white British mothers. *Child and Adolescent Mental Health, 6*(1), 29–33.

Valiante, W. C. (2003). *Family therapy and Muslim families: A solution focused approach*. Article accessed via internet: http://www.crescentlife.com/articles/islamic%20psych/family_therapy_and_muslim_families.htm. Accessed February 2, 2008.

Yaqoob, S. (2003). *Towards Islamic psychology*. Article accessed via internet: http://www.crescentlife.com/articles/islamic%20psych/toward_islamic_psychology.htm. Accessed February 2, 2008.