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ORIGINAL ARTICLE

Conceptual and Pragmatic Considerations in the Use of Cognitive-Behavioral Therapy with Muslim Clients

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Abstract Islam is one of the leading religions of the world. Its adherents, who number approximately one billion, are present in all parts of the world and can be found in all ethnic and racial categories. Cognitive-behavioral therapy (CBT) is one of the most prominent and empirically-supported of all psychological treatments. In light of such facts, a discussion of the relationship between the philosophical underpinnings of CBT and the Islamic worldview is in order. In this paper, some of the philosophical and theoretical tenets of both Islam and CBT are first discussed. Secondly, and as to heighten clinical awareness, several points of concordance and dissonance between these systems are discussed and highlighted through an illustrative case study. Finally, the authors conclude by offering a number of suggestions for future research.

Keywords Cognitive therapy · Islam · Culturally-sensitive therapy · Culturally-adapted therapy

Islam is one of the major religions of the world, both in terms of its richness of history as well as its current widespread adoption. There are approximately one billion adherents of Islam (typically referred to as Muslims; which literally means a person who submits to God), and these adherents can be found in all parts of the world, including Europe and North America (Esposito 2005). Given the unfortunate events that unfolded during the previous decade, and tensions between various parts of the world, negative references to Islam have become ubiquitous in both the media and public discourse alike. In part because of this recent history, consideration of the relationship between concepts and practices from the West and Islam are needed; this article attempts to bridge this gap with respect to Cognitive-Behavioral Therapy (referred to herein as CBT).

Recent empirical work suggests that Muslim individuals are affected by psychological disorders at a rate that is similar to other individuals of various beliefs in the Western world (Al-Issa 2000). This fact, as well as the tendency for psychological disorders to have similar epidemiology and associated features in Islamic and Western samples (Beshai et al. 2012), suggests that psycho-social treatments developed in the West might be applied in a straightforward manner with Muslim clients. CBT has received wide recognition in the scientific arena as an *efficacious* treatment for a number of psychological disorders (Chambless and Ollendick 2001). Unfortunately, most of the studies that have examined the efficacy of CBT have been conducted with individuals of a Western, Judeo-Christian background. Although a few investigations have examined the efficacy of CBT with Muslim individuals (e.g., Azhar and Varma 1995), the effectiveness of such therapeutic technique with this population is yet to be examined in detail, and thus is not well established.

A number of authors (Hodge and Nadir 2008; Abudabbeh and Hays 2006; Hamdan 2008; Carter and Rashidi 2004) believe that CBT can be tailored to successfully treat Muslim clients. However, as argued below, the theological underpinnings of Islam may sometimes be at odds with the more traditionally Western, or individualistic values upon which CBT was founded. This paper considers potential points of convergence and divergence of Islam and CBT, and the practical issues that may result

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from this philosophical discord. To start, brief introductions to both Islam and CBT are provided. Following these introductions, some of the philosophical matches and mismatches between the two disciplines are discussed. The practical challenges that may emerge as a by-product of adapting the process of CBT for use with Muslim clients are then highlighted via a case example, and subsequently discussed. Finally, a number of suggestions for future work are provided.

This paper is not intended to be a step-by-step manual for conducting CBT with Muslim clients. Certainly, this type of prescriptive literature is an end-goal of this line of thinking, however, the current literature is simply not at the level required to support such prescriptions with any amount of empirical rigor. Rather, this paper will aim to highlight the potential discordance between the Islamic tradition and CBT's theoretical foundations, only delving into practical considerations and prescriptions where supported or suggested by the literature. Ultimately, it is hoped that clinical awareness (which often precipitates and guides sound clinical judgement) regarding this issue is raised as a by-product of this discussion.

Islam: The Straight Path

Much like other organized religions, Islam is a diverse and broad theological system, which includes cosmological beliefs, values, canons, and sets of associated religious and social practices. Thus, any attempt to provide a unitary definition of it or to claim a singular set of Islamic values is at best fruitless, and at worst disingenuous. As Hodge and Nadir (2008) note:

> No single Islamic narrative exists, just as no single western narrative exists. Rather, a multiplicity of narratives exist, each shaped by local cultures, race and ethnicity, political realities, degree of spirituality and other contextual factors such as the degree of familiarity with the dominant culture (p. 32).

However, just as there are several cultural commonalities that can be said to bind divergent Western narratives together, such as "individualism, self-determination, egalitarian gender roles, explicit communication that clearly expresses individual opinion, and identity rooted in work and love" (Hodge and Nadir 2008, p. 32), the same can be said for Islamic narratives, including cultural values such as "community, consensus, interdependence, self control, complimentary gender roles, implicit communication that safeguards others' opinions, and identity rooted in religion culture and family" (Hodge and Nadir 2008, p. 32). Thus, although the approximately 7 million Muslims in the United States today represent over 80 countries of origin and consequently an undoubted diversity of political and cultural views, collectively their core values and ways of thinking about self and other can be reliably contrasted with more individualistic Western views.

Although a full historical account of the rise of Islam is beyond the scope of this paper, it should be noted that much of the Islamic tradition comes from the Holy *Qur'an* (translated as "recitation"), which is believed by Muslims to be the word of Allah. The significance of the *Qur'an* can be inferred from the quote by Smith (1992), who stated that "the *Qur'an* is to Muslims what Christ is to Christians" (p. 56). Unlike the orthodoxy of Christianity, however, Islam is often described as an orthopraxy (literally, "proper practice"). In other words, the Islamic tradition places less emphasis on righteous belief and articles of faith, but rather gives prominence to pious *acts and behaviors* (Esposito 2005). Indeed, one verse from the *Qur'an* asserts "Act! God will see your actions and so will his messenger and those who believe" (9:105). As such, Muslims are guided to follow the example of the Prophet Muhammed and adhere to the *Sunnah* (a term which refers to the Prophet's teachings). However, this is not to say that articles of belief are irrelevant in Islam. On the contrary, adherence to a number of unique belief statements distinguishes Islam from other religious ideologies.

Central to the Islamic code of conduct are the Five Pillars of Islam (Kaltner 2003). The pillars include declarations of faith, daily prayers, customary giving, fasting during the month of Ramadan, and pilgrimage to Mecca where health and finances permit. Although the five pillars are an integral element of the tradition, Islam abounds with a number of other observances and obligatory practices (Esposito 2005). Such practices include dietary restrictions such as refraining from the consumption of alcohol and pork, sexual abstinence outside of a heterosexual marriage, and prescriptions of modest dress. While these customs are adhered to by most devout Muslims, cultural and sectarian differences within Islam influence the interpretation of these and other observances (Kaltner 2003).

One of the fundamental aspects of Islam is submission to God or Allah. Indeed, a common term among Muslim people with respect to the possibility of future events, is "in'shallah" (literally, "God-willing"), which reflects a degree of fatalism (known in Arabic as *qada*) with respect to the future. Theological debates regarding individual responsibility and "free will", versus predeterminism, fatalism and resignation, have long been part of the Islamic traditions. However, Acevedo (2008) makes clear that the interpretation of Islam as an inherently fatalistic religious system is an overly simplistic misinterpretation. Where early Western scholars of Islam proclaimed that the Islamic tradition leaves no room for human intervention in their own destiny, Acevedo argues to the contrary, pointing out

that the traditional notions of Islamic volition need not be "at odds with the Westernized, Judeo-Christian version that fosters the ethic of individual self-empowerment…and progressive social change in the West" (Acevedo 2008, p. 1712). Rather, he argues, on the basis of empirical survey data, that what is commonly mistaken for "Islamic fatalism" may best be interpreted as "a greater acceptance for central authority and a relinquishment of life's outcomes to an omnipotent deity" (p. 1740). Thus, the fatalistic tendencies of Islamic belief systems do not completely eradicate free will of the individual, but rather place emphasis on fate as a dynamic reciprocal interaction between the will of God and the will of the individual.

Relatedly, another debated topic within Islam is whether the adversity that befalls humans can be attributed to God, and what causal role humans have in their own misfortunes (Haque 2004). In commenting on the causal attributions individuals in Muslim cultures may make in regards to mental disorders, El-Eslam and Abu-Dagga (1992) asserted that:

> The belief in God's will as a fatalistic determinant of events is quite common among Moslem Arabs. Symptoms, like any other event, may be part of this attribution which leads individuals no further in attempts to formulate any knowledge about them. Part of this fatalistic belief may be that whatever appeared through God's will (e.g., symptoms), will also disappear by God's will (e.g., through prayers of affected individuals) (p. 152).

Thus, traditional Islamic thought may incline Muslims adherents to look upon mental illness and other misfortunes as a trial from God, which is intended as a test of one's spiritual steadfastness and fortitude. Also, adversity may be attributed to a "deviation from the original positive nature [of humans] by following one's own whims" (Haque 2004, p. 49). Again, current views probably represent a more balanced synthesis of the two discordant notions. However, there is little doubt that Islam generally imbues supernatural forces with a causal role in the course of human illness and well-being. With these Islamic values and doctrinal elements in mind, we now turn to a brief introduction of CBT and its major philosophical foundations.

The Philosophical and Theoretical Bases of Cognitive-Behavioral Therapy

As with Islam, defining CBT and demarcating its boundaries is no simple task. In the years following its inception, the theoretical and practical territory of CBT has grown at a tremendous rate (Dobson and Dozois 2010). Given such complexity, authoritative statements about the values and tenets of CBT are hazardous, as the field has grown and there is a range of views within its general framework (Dobson 2010).

There is marked epistemic tension between two schools of thought within CBT (Ingram and Siegle 2010). On the one hand, Rationalism maintains that an absolute, objective reality exists and is accessible through the senses. The second philosophical trend, constructivism, argues that objective reality *per se* does not exist and individuals are therefore actively involved in the idiosyncratic construction of reality. The philosophical and theoretical divergence between these two camps is so fundamental that it influences even the language used to describe each approach (e.g. "irrational" versus "maladaptive"; "cognitive distortions" versus "biases"). Although the tension between these two perspectives has not been resolved, most CBT modalities tend to gravitate towards the constructivist position (Clark et al. 1999). A middle ground suggests that while an absolute, external reality may exist, it is our beliefs and thoughts of our lived reality, and the subsequent ways in which humans feel and behave, which are the key ingredients in human adaption (Dobson and Dobson 2009). As such, more emphasis will be placed upon this rendition of CBT in the following discussion.

With this said, almost all cognitive theorists and practitioners propound an attitude of "collaborative empiricism", wherein "client's beliefs are seen as hypotheses that can be tested by examining supporting or refuting evidence" (Steiman and Dobson 2002, p. 300). This scientific attitude of information gathering within CBT is supposedly unimpeded by biases and is driven by free inquiry, wherein conclusions are made *a posterior* (i.e., subsequent to data collection).

Dobson and Dozois (2010) stated that at the core of all CBT approaches are three essential propositions: (1) thinking and cognitions affect behavior; (2) cognitive activity is accessible and is amenable to change; and (3) desired behavioral change may follow from changes in thinking. Consistent with constructivism, these elemental features stem from the notion that individuals are not disturbed by the events that occur in the external world, rather they are distressed by their internally-generated reactions to external stimuli. As such, humans are not impartial consumers of external reality. Instead they are *meaning-making* organisms (Clark et al. 1999), in that they interpret particular contexts and of the relationship of such contexts to the self. Individuals are thus viewed as "the architects of their own misfortunes" (Dobson and Dozois 2010, p. 26).

Most cognitive-behavioral theoreticians and practitioners agree that individuals possess cognitive entities or structures, known as *schemas*, which are in part responsible for the ongoing construction of reality (Alford and Beck 1997). The word "schema" is often considered as

synonymous with terms such as "core belief", and "irrational belief" (DeRubeis et al. 2010). These aspects of thinking are sometimes viewed as structural, as they represent deep-seated attitudes about the world and the self within it. These core beliefs are described as relatively stable, and should be contrasted with more automatic, surface-level thoughts and attitudes that wax and wane as a function of adversity and stress (Ingram et al. 1998).

Cognitive-behavioral practitioners often structure their treatment in a serial manner, with the maladaptive automatic thoughts as the first target for change. In a later phase of treatment, the therapist may delve into the schematic world of the client, with change in dysfunctional core schemas as the goal (Persons and Davidson 2001). Indeed, some cognitive-behavioral modalities, such as Rational Emotive Behavioral Therapy (REBT), mainly strive for this deep-seated change in its clients: "one of the main goals [of Rational Emotive Therapy] is to help clients make a *profound philosophical change* that will affect their future as well as their present emotions and behaviors" (Ellis 1980, p. 326; italics in original).

As mentioned above, some individuals possess maladaptive interpretations of reality that exist in the form of dysfunctional core beliefs or schemas. Individuals with dysfunctional core beliefs are prone to cognitive errors in the processing of new incoming information, as incoming information is interpreted in a way that conforms to the maladaptive schemas (Alford and Beck 1997). Some of these errors, such as *all-or-nothing thinking, overgeneralizations,* and *making "should" statements*, are characterized by an absolutistic and rigid thinking pattern.

According to a meta-analysis by Blagys and Hilsenroth (2002), there are six distinctive activities which permeate treatment sessions and that distinguish CBT from other therapeutic approaches. The first of these activities is the use of homework and outside-of-session techniques. Such techniques provide the client with an opportunity to practice the skills acquired during therapy, and thus generalize these techniques to real world situations. The second unique element of CBT is the therapist's direction of session activity, as cognitive-behavioral therapists exert relatively more control over the process of therapy than seen in other treatment modalities. The third distinctive activity is the psychoeducational nature of CBT. Indeed, Dobson and Dozois (2010) commented that all CBT approaches are either explicitly or implicitly educative in nature, with a strong emphasis on skill development with the client. The fourth activity that distinguishes CBT from other modalities is the focus on current and future functioning of the client. This emphasis contrasts with psychodynamic approaches, which place a therapeutic emphasis on past experiences and events. The fifth distinguishing feature of CBT is the emphasis of providing clients with information regarding their disorder and its associated symptoms. This feature is concordant with the didactic and instructional nature of CBT. The final distinctive activity used by cognitive-behavioral therapists is the allocation of a relatively large amount of time to evaluate, challenge and modify the client's cognitions. This activity is congruent with the core proposition of CBT, which is that desired behavioral and emotional changes follow from change in cognition.

With both Islam and CBT now briefly outlined, we turn our attention to the practical and ethical challenges that may emerge if these two "philosophies" meet in the course of psychotherapy. A case vignette is provided to make real the possibility of the proposed ideological clash.

Cognitive-Behavioral Therapy for Muslim Clients

The philosophical underpinnings of Islam and CBT suggest several points of divergence (see Table 1). First, Islamic principles are more in line with rationalism than with constructivism—that is, accepting of the view that an objective reality exists, but also that knowledge of the true nature of this reality is not possible through the senses, given the metaphysical character of the "real" world. The *Qur'an* is thus the only portion of objective reality that is accessible through the senses. For the devout Muslim, the *Qur'an* is the indisputable Word of the Almighty and therefore any statement contained within the *Qur'an* is objectively true for a dedicated Muslim (Geels 1997). Therefore, if the *Qur'an* stipulates that one "*should*" respect and obey one's parents, or "*should not*" engage in sexual activity outside of a heterosexual marriage, then noncompliance with such "should" statements is objectively "wrong". In contrast, CBT holds that "should" statements are inappropriate (Ellis 1980; Beck 1979) in the sense that they may often be substituted with probability statements, and thus may not be fully applicable to clients with strong religious views. Although particular actions may be viewed as objectively "wrong" or "right", the cognitive-behavioral therapist can, nonetheless, help the client reduce their propensity to over-generalize from these instances. Also, in contrast to the theoretical and philosophical underpinnings of CBT, in Islam it may be possible to separate the action from its doer, even though this distinction will likely be difficult given the orthopraxic nature of the tradition (Esposito 2005).

The scientific method and the spirit of scientific investigation are not only accepted within Islam, but are also encouraged (Iqbal 2007). In fact, many Muslim scholars and historians see the natural world as an extension of the Divine, and thus the systematic study of nature and humankind can be seen as a branch of theology (Izutsu 2002). With this said, unlike the theoretically unbounded

Table 1 Major philosophical differences between Islam and CBT

	CBT principles	Islamic principles
Reality	Objective reality does not exist. Individuals actively construct their own renditions of reality	Objective reality exists, but is mostly inaccessible through the senses. The *Qur'an* is the only tangible measure of objective reality
Empiricism/ science	Client and therapist impartially gather evidence ("collaborative empiricism") and make conclusions *a posteriori*	Science and empiricism can be viewed as extension of theology, but in as much as they agree with *a priori* principles
Source of individual misfortune	Individuals are the architects of their own misfortunes	Both good and evil come from, or are allowed by, Allah. He may use illness/disorder to punish and/or instruct his creation
Behavioral/ emotional change	Desirable change in behaviors and emotions necessarily follow change in cognition	Desirable change in behaviors and emotions *do not* necessarily follow from cognitive change, but do so if God wills
Self-control	Individuals are free and thus capable of controlling their cognitions	Individuals' actions are *not* entirely free. Metaphysical entities act upon, and to some extent, control human behavior
Individual rights	The self is separate and discernable from others. Thus, self-interests and individual rights are promoted	The self is *not* separable from others. The collective's rights and interests eclipse those of the individual

process of hypothesis testing embraced by CBT, the same process within Islam operates under an a priori set of precincts. Thus, for the traditionally Muslim client, the data gathering and hypothesis testing processes end when such processes appear to violate a pre-existing Islamic belief or ideology. For instance, it would be inappropriate to ask a gay Muslim client which presents with maladaptive beliefs regarding homosexuality (e.g., "homosexuality is wrong") to gather refuting evidence of such belief, given that homosexuality is condemned within the Hadith (collections of sayings of the prophet) and the *Qur'an* (7:80–81).

A large degree of *construction* takes place when religious devotees read scriptural texts such as the *Qur'an*, since idiosyncratic interpretations may be assigned to various passages. However, the strict adherent is largely incognizant (or rejecting) of this possibility; to him/her, the passage blatantly and objectively means what he/she thinks it means, unless challenged by a religious authority, or upon (re)examination of the situation or circumstances. Secondly, since both fortune and misfortune such as psychological disorder may often be seen to emanate from (or at least to be allowed by) God (Nobles and Sciarra 2000; Haque 2004), Muslim clients are not necessarily viewed as the authors of their own adversity. This interpretation has implications upon the CBT socialization process (i.e., teaching the client about cognitive-behavioral principles) which usually takes place during the initial stages of therapy (Alford and Beck 1997).

Moreover, if all events, and even psychological problems, are products of reciprocal interactions between the will of God, and the individuals will (Acevedo 2008), then cognitive processes, whether adaptive or maladaptive in the classic sense, make little difference. On this interpretation, both sickness and well-being are dependent to some degree upon Allah's will and celestial providence. This notion is in discord with the mediational proposition of CBT, in that desirable changes do not necessarily follow from change in cognition, but only if and when God allows change via changes in cognition, or other processes outlined by Western psychological science. On the one hand, these fatalistic notions regarding one's personal adversities are capable of engendering acceptance of change, and therefore may actually facilitate the therapeutic process. For example, Aflakseir and Coleman (2009) examined disabled Iranian Muslim veterans of the Iran-Iraq war, and found that positive coping of a religious nature was positively associated with overall mental health status, and in fact, negatively associated with symptoms of Post-Traumatic Stress Disorder. On the other hand, this lack of personal power over one's circumstances my promote helplessness and therapeutic stagnation:

> Very difficult to manage is an almost universal attitude known as *in'shallah* (as God wills), a pervasive belief that good or bad outcomes, including whether one becomes ill, improves, or dies, are entirely in God's hands. This passivity mimics helplessness and makes achieving a therapeutic alliance in which the patient is actively involved in his or her own care extremely difficult (Dubovsky 1983, p. 1456).

Dubovsky's (1983) position is probably an exaggeration of the fatalistic nature of Islam, as several verses in the *Qur'an* (e.g., 13:11) state that humans, with the help of God, must toil in order to change their condition. However, his statement is not totally without merit, as it highlights the possible danger of over-applying this Islamic notion in the bounds of therapy. When this principle is applied to the process of change, one wonders where human

responsibility ends and that of God begins. Or, stated simply, how many times must a person fail in his/her attempts to change before realizing that change is not in God's will?

Though the literature regarding the psychology of Islam has been scarce, and has traditionally relied only on clinical observations, theological speculation, and anthropological methods (Abu Raiya et al. 2007), an empirically based literature is now beginning to develop. Abu Raiya and Pargament (2010) have utilized this new empirical base to make several suggestions for clinical practice with Muslim clients, including utilizing positive aspects of religion to cope with stressors, as discussed above. Abu Raiya and Pargament (2010) also suggest that clinicians inquire directly about the place of religion in clients' lives, and assess for and normalize religious struggles, referring clients to a member of the religious community if needed.

With these clinical suggestions in mind, several factors may affect potential conflict between CBT and Islam. First, there is likely a direct and positive relationship between the probability of ideological clash, and the level of religious devotion exhibited by the client. As such, the core values of CBT become increasingly likely to threaten the client's religious beliefs as these beliefs increase in intensity or commitment. For example, Thomas and Ashraf (2009) posit that a primary area of dissonance between Western psychotherapeutic traditions and Islamic ideology is the specific emphasis that CBT and similar Western therapies place on individualism. They note that even the language used in the process of treatment, or even just to describe these therapies, such as "self-esteem", "self actualization", or "self statements" can be offensive from the Islamic perspective which places heavy emphasis on community and individual submission to God. With this perspective in mind, it becomes easier to understand that greater adherence to values which give precedence to community over those of the individual will be more likely to conflict with CBT, which clearly places a heavy emphasis on the self, and the responsibility of self for therapeutic change.

Secondly, the possibility of ideological tension is also likely related to the nature of the presenting problem. That is, even at low levels of religious devotion, therapies aimed at changing aspects of one's psychology that are perceived to be fundamental to Islam may also increase the probability of ideological clash. For example, the use of cognitive-behavioral techniques to treat a Muslim client with public-speaking anxiety would almost certainly be less contentious than using this same therapeutic modality to treat a Muslim client for sexual anxiety, as the latter may stem from negative core beliefs which are religious in nature. Taken together, these first two points basically assert that tension is more likely to develop in situations in which there is sufficient discord between the fundamental values held by the client, and those of CBT, whether arrived at via extreme or fanatical levels of religious devotion, lofty goals of cognitive therapy, or perhaps more moderate levels of both variables.

Third, the possibility of conflict is also likely related to the level of modification therapists introduce to standardized forms of CBT. Despite the theoretical and philosophical differences between Islam and CBT highlighted in Table 1, several authors have made the case that there are significant areas of convergence as well. Hodge and Nadir (2008) have argued that while CBT is fairly congruent with Islamic values, some of its elements must be tailored to suit Muslim clients, and provide a list cognitive self-statements that they have modified utilizing Islamic tenets, in an effort to effect the same change or impact in Islamic patients that the original statements may have in Western patients. They note: "Whereas the basic elements of self-control and change are consistent with the Islamic belief system, modifying the statements to reflect Muslim beliefs and practices speaks straight to the spiritual beliefs and practices of Muslims" (Hodge and Nadir 2008, p. 38). For example, relating to self-worth, the statement "I am a worthwhile person with positive and negative traits" (p. 34) is transformed into "We have worth because we are created by Allah. We are created with strengths and weaknesses" (p. 37). In this way, the level of change needed to modify existing CBT statements and procedures can be used as an indicator of the potential for conflict that may have otherwise occurred. Thus, although there is a risk associated with altering CBT in this way, a growing body of literature regarding spiritually modified psychological therapies (including CBT) suggests that such modifications are more appropriate for clients "whose lives are shaped by spiritual narratives that diverge from Western secular empiricist world views" (Thomas and Ashraf 2009, p. 185), and further, that such modifications are more effective with these clients.

Finally, the probability of tension is also likely to be dependent upon the level of cognitive change targeted in treatment. As Ellis (1980) stated, treating the superficial correlates of disorder may "help some clients live 'better' with their disturbed thinking but at the same time interfere with the full development of flexible, open, and scientific attitudes—which according to REBT are characteristics of optimum and sustained mental health" (p. 332). Indeed, for both ethical and practical reasons, it may be very challenging to change core maladaptive schemas that have salient religious overtones with a devout Muslim. In such cases, treatment at the level of automatic thoughts and their associated symptoms may represent the range of possible intervention.

Case Study: Islamic Traditions Meet the Modern Secular West

Consider the following case scenario: Khadija is a 23-year-old nursing student who resides with her parents in a large American city. She describes herself as a "good Muslim", and practices her religion consistently, although not in a strict manner. A few months ago, Khadija grew fond of a non-Muslim male student at her university. This affection was reciprocated, and they soon began what she described as a non-sexual romantic relationship. As the relationship developed, she began to experience sudden episodes of intense heart palpitations, shortness of breath, dizziness, and trembling. She described such episodes as "out of nowhere" and that they ended in a matter of minutes. Upon further enquiry, a preliminary timeline of events became clear. Khadija indicated that these episodes appeared shortly after she spoke with her parents regarding the relationship. Her parents expressed displeasure about the relationship and told Khadija that it was inappropriate for her to be involved with a non-Muslim man. They urged her to end the relationship immediately and repent to God for what she has done. Khadija indicated that she remains torn and angry for allowing herself to "fall" for this male. She sought treatment for the anxiety episodes, as well as for the intense guilt and sadness she felt.

The case of Khadija highlights how the values of Islam may challenge the establishment of treatment goals, and may hinder therapeutic progress. First, honour and obedience to one's parents is a *Qur'anic* commandment (Al-Issa 2000), especially if they are pious Muslims who direct their children in the way of Allah. Secondly, Muslim women are prohibited from romantic involvement with non-Muslim males, especially outside the boundaries of marriage (Esposito 2005). Given the sequence of events, Khadija's apparent panic attacks may be a product of the dissonance between her core beliefs and her behaviors and desires towards her male colleague. This dissonance became especially salient with the explicit disapproval of her parents.

From a cognitive-behavioral perspective, the therapeutic options are somewhat limited in a case such as this. The therapist may choose to help Khadija to dispute her core religious beliefs. Nevertheless, "cognitive structuring may be seen as offensive and disrespectful if it is aimed at challenging core cultural beliefs" (Abudabbeh and Hays 2006, p. 151). Thus, this option is not ethical without the informed consent of the client, and while it is possible for the therapist to explore this possibility with Khadija, this is a decision that the *client* would make during the course of therapy. If Khadija is unable or unwilling to discuss her core religious beliefs, the therapist might choose to ameliorate her anxiety symptoms using behavioral techniques (e.g., exposure therapy, relaxation training, etc.). Depending on how the therapist defines treatment "success", the latter option may be optimal. The success of the treatment is dependent upon the goals of the client, however. Therefore, if Khadija's goal was to relieve the panic attacks, and if the exclusive focus upon surface level cognitions and symptoms brought about such relief, then the treatment could be considered successful, regardless of the therapist's perspective.

Another option exists. Depending on how knowledgeable the therapist is, he or she may help Khadija form alternative interpretations of the Islamic beliefs related to her maladaptive cognitions. Indeed, Nielsen (2004) used the *Qur'an* to bolster treatment techniques, and was thus able to "successfully" remediate a Muslim female client's symptoms of guilt and depression. In some cases, consultation with a religious leader from the Muslim tradition may help to present different ways to conceptualize and respond to the presenting problems. Undoubtedly, the possibility of reinterpreting certain passages in the *Qur'an* depends upon how integral such passages are to Islam, and how open the client may be to their reinterpretation.

Aside from these largely conceptual issues that may potentially impact the therapeutic environment, it of course remains crucial on a more pragmatic level for the therapist to be aware and respectful of cultural expectations that Muslim clients may present with in therapy. For example, Carter and Rashidi (2004) present a list four primary practical considerations that should be kept in mind when treating Muslim clients. First, and perhaps most simply, the patient's prayer schedule and other religious obligations should be considered when arranging times for therapy. Second, the therapist must be sensitive to cultural expectations and customs concerning eye contact. Whereas direct gaze into another person's eyes is often considered a sign of respect and understanding in Western culture, respect and humility are conveyed in Islamic cultures by exactly the opposite—averting one's eyes downward. Third, gender considerations must be taken into account. Carter and Rashidi (2004) suggest that female clients should be paired with female therapists when possible, or alternatively that a family member of the female client should be present during therapy if only a male therapist available. Similarly, cultural customs may require that the male therapist refrain from physical contact with the female client for any reason (i.e., handshakes), and refrain from walking behind the client. Finally, the importance of the family in Islamic cultures must be considered. Carter and Rashidi (2004) note that family unity and stability are central Islamic values, and may therefore influence individuals to consult

family members before making consequential decisions both in everyday life, and especially within the therapy setting.

Indeed, as in the case of Khadija, the desire of the individual is often to satisfy the collective, and the interests of the individual may be considered secondary to those of the family in Islam (Al-Issa 2000). Tensions between these different priorities are reflected in the discordance between traditional community-oriented Islamic values outlined above and contemporary Western systems of professional ethics, such as the American Psychological Association's (APA) Ethics Code, and the Canadian Psychological Association's (CPA) Code of Ethics for Psychologists which generally recommend giving precedence to the rights of individual persons over groups (APA 2002; CPA 1991). Thus, in this sense, respecting the client and his/her rights becomes an ethical priority during therapy. Applied to Muslim individuals, questions such as "who is the client" may not be readily answerable, given the interconnectedness of the self in the Islamic tradition; the boundaries delineating the self from others are hazy and undefined. An integral aspect of this work then is to clarify who the client actually is, as psychologists are ethically enjoined to work on behalf of their clients, even while the broader implications of such work on other extended members of the client's family, or society at large, are recognized and discussed.

Thus far, the focus has been to identify possible ideological schisms between Islam and CBT. However, it should be mentioned that several unique facets of CBT make it particularly appropriate for many Muslim clients. First, given the significance of action and behavior in Islam, CBT's emphasis on homework and outside-of-session assignments may be particularly appealing to Muslim clients (Abudabbeh and Hays 2006). Secondly, much like in Chinese culture, Islam is generally viewed as a hierarchical system, in which knowledge flows downwards from the expert (i.e., therapist) to the apprentice (i.e., client; Hodges and Oei 2007). Therefore, the more directive approach espoused by cognitive-behavioral therapists may be fairly effective with Muslim clients (Carter and Rashidi 2004). Third, practical and instructive strategies mesh particularly well with the Islamic traditions of study and reverence for knowledge (Hodge and Nadir 2008). Therefore, CBT's psychoeducative and informative emphasis is especially suited for this population. Finally, CBT's focus on current and future functioning is congruent with Islamic values, which discourage believers from dwelling on past events (Hamdan 2008).

The potential harmony between Islam and CBT must be appreciated and harnessed to conduct religiously sensitive therapy with Muslim clients. A number of future directions and potentially guiding hypotheses in this area of research are now offered.

Future Directions

Several authors have suggested that self-statements central to CBT can be adapted to better suit the Muslim client. For example, as discussed above, Hodge and Nadir (2008) have provided Islamic modifications to ten cognitive self-statements. These changes have intuitive appeal, but further scientific validation of their effectiveness is needed. Do these changes represent a superficial "re-packaging" of CBT, or are they more pervasive, unwittingly transforming the modality into an entirely different approach? Given the territorial expansion of CBT in the last few decades, these questions are difficult to resolve. Researchers in this area need to compare the effectiveness of a religiously adapted CBT with secular versions of the modality, perhaps using benchmarking strategies (cf., Wade et al. 1998). If the enhanced efficacy of the adapted CBT receives empirical support, then this result could affect the decision regarding which version of CBT to use with Muslim clients. Even if the evidence shows equal efficacy, an adapted CBT may be more acceptable to Muslim clients, and might be associated with greater acceptance, or reduced dropout and withdrawal. Further research is needed in order to elucidate the more practical and ethical courses of action with this population.

Research which tests spiritually-adapted CBT is already beginning to accumulate. Azhar and Verma (1995) investigated whether the inclusion of religious themes in addition to standard therapy were more effective in treating depressed, religious clients than standard treatment administered alone. Patients who were given the combined therapy (regular therapy fused with religious motifs) showed more rapid improvement than the standard therapy group at a 3-month interval. However, these differences vanished when the groups were re-assessed after 6 months. Longer-term follow-ups were unfortunately not included in this study. Propst et al. (1992) have also compared standard CBT, Christian CBT, pastoral counselling, and waitlist control in the treatment of dysthymic disorder and depression. All three treatments produced significant improvements in comparison to the control condition, but Christian CBT and pastoral care eventuated in lower levels of depression than the standard CBT at the end of treatment. These results suggest that religious adaptations of CBT may enhance treatment efficacy. However, there are very few such studies to date. Secondly, the studies that do exist suffer form a number of methodological problems, the most notable of which is the employment of modest sample sizes (for a more thorough review, see Hodge 2006).

Multiple authors (e.g., Cooper and Hunt 1998; Dobson and Dobson 2009; Padesky 1994) have commented about the therapeutic significance of changing core maladaptive schemas. As Ellis (1980) stated, deep-seated philosophical

change may be more persistent and long lasting in its effect than superficial modifications of surface-level symptoms and cognitions. Unfortunately, very little empirical research has evaluated this assertion. Most research paradigms with CBT have defined therapeutic success as the diminution of symptoms, and most have not tested the longevity of treatment gains. If Ellis is correct, questions must be raised in regards to the way therapy is conducted in general, and the way it is conducted with religious clients in particular. As such, the deconstruction of maladaptive core beliefs, even religiously-oriented ones, may be more therapeutically beneficial for the client. Such work depends upon the client's willingness and readiness to examine the implications of religious beliefs during treatment.

Some cognitive-behavioral theorists have argued that mental disorders result from the interaction between cognitive vulnerability (e.g., core maladaptive schema) and environmental stressors that implicate the self (e.g., Ingram et al. 1998). In a system that emphasises familial interconnectedness, such as Islam, it may be possible for disorders to arise not as a reaction to stressors upon the individual, but as a reaction to stressors which implicate the collective (e.g., distant family members losing their resources). To our knowledge, cognitive vulnerability studies have not yet studied this expanded notion of self in relation to disorder onset and maintenance.

Finally, to our knowledge, no empirical investigation has examined the effects of fatalistic beliefs on disorder onset and prognosis. As was mentioned, fatalistic ideologies about the origins of one's misfortunes may enhance therapy through the promotion of acceptance, or they may hinder the therapeutic process by fostering helplessness and passivity. Research which examines such constructs is especially pertinent to Muslim clients, who may be prone to embrace fatalistic notions in regarding life adversities.

Conclusion

This 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 complimentary. The purpose of this discussion was to heighten awareness regarding conducting cognitive therapy with Muslim clients. As argued by Lo and Fung (2003), accurate and appropriate clinical decisions follow from awareness of diversity issues. Even though some ideological points of discord may exist, CBT is likely an effective therapeutic modality for a large portion of this population of clients. In fact, the beliefs of some modern Islamic sects and more secular Muslims fit exceptionally well with the humanistic underpinnings of CBT. The probability of ideological discord between these two systems may increase as the level of adherence to either philosophy also increases. In other words, if the client's religious beliefs fall at the extreme end of the continuum of devotion (or the therapist's cognitive beliefs fall equally at this extreme), tension becomes a more probable outcome. Whatever the level of adherence, until more empirical evidence is gathered in support of adapting CBT for use with Muslim clients, the cognitive-behavioral approach should be judiciously applied when treating clients of the Muslim faith. Increased knowledge about the Islamic faith and its traditions is likely to enhance the use of culturally appropriate assessment and treatment methods.

References

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

Abu Raiya, H., Pargament, K. I., Stein, C., & Mahoney, A. (2007). Lessons learned and challenges faced in developing the psychological measure of islamic religiousness: Development and evidence of reliability and validity. *Journal of Muslim Mental Health, 2*, 133–154.

Abudabbeh, N., & Hays, P. A. (2006). Cognitive-behavioral therapy with people of Arab heritage. In P. A. Hays & G. Y. Iwamasa (Eds.), *Culturally responsive cognitive-behavioral therapy: Assessment, practice, and supervision* (pp. 141–159). Washington, DC: American Psychological Association.

Acevedo, G. A. (2008). Islamic fatalism and the clash of civilizations: An appraisal of a contentious and dubious theory. *Social Forces, 86*(4), 1711–1752.

Aflakseir, A., & Coleman, P. G. (2009). The influence of religious coping on mental health of disabled Iranian war veterans. *Mental Health, Religion and Culture, 12*, 175–190.

Alford, B. A., & Beck, A. T. (1997). *The integrative power of cognitive therapy*. New York, NY: The Guilford Press.

Al-Issa, I. (2000). Does the Muslim religion make a difference in psychopathology. In I. Al-Issa (Ed.), *Al-Junun: Mental illness in the Islamic world* (pp. 315–353). Boston: International Universities Press.

American Psychological Association. (2002). Ethical principles of psychologists and code of conduct. *American Psychologist, 57*, 1060–1073.

Azhar, M. Z., & Varma, S. L. (1995). Religious psychotherapy in depressive patients. *Psychotherapy and Psychosomatics, 63*(3–4), 165–168.

Beck, A. T. (1979). *Cognitive therapy of depression*. New York, NY: The Guilford Press.

Beshai, S., Dobson, K. S., & Adel, A. (2012). Cognition and dysphoria in Egypt and Canada: An examination of the cognitive triad. *Canadian Journal of Behavioural Science, 44*(1), 29–39.

Blagys, M. D., & Hilsenroth, M. J. (2002). Distinctive activities of cognitive-behavioral therapy: A review of the comparative psychotherapy process literature. *Clinical Psychology Review, 22*(5), 671–706.

Canadian Psychological Association. (1991). *Canadian code of ethics for psychologists*. Ottawa, ON: Author.

Carter, D. J., & Rashidi, A. (2004). East meets west: Integrating psychotherapy approaches for Muslim women. *Holistic Nursing Practice, 18*(3), 152.

Chambless, D. L., & Ollendick, T. H. (2001). Empirically supported psychological interventions: Controversies and evidence. *Annual Review of Psychology, 52*(1), 685–716.

Clark, D., Beck, A. T., & Alford, B. A. (1999). *Scientific foundations of cognitive theory and therapy of depression*. New York: Wiley.

Cooper, M., & Hunt, J. (1998). Core beliefs and underlying assumptions in bulimia nervosa and depression. *Behavior Research and Therapy, 36*(9), 895.

DeRubeis, R. J., Webb, C. A., Tang, T. Z., & Beck, A. T. (2010). Cognitive therapy. In K. S. Dobson (Ed.), *Handbook of cognitive-behavioral therapies* (3rd ed., pp. 277–317). NY: The Guilford Press.

Dobson, K. S. (2010). *Handbook of cognitive-behavioral therapies* (3rd ed.). New York, NY: Guilford Press.

Dobson, K. S., & Dobson, D. J. A. (2009). *Evidence-based practice of cognitive-behavioral therapy*. New York, NY: Guilford Press.

Dobson, K. S., & Dozois, D. J. (2010). Philosophical and theoretical bases for the cognitive-behavioral therapies. In K. S. Dobson (Ed.), *Handbook of cognitive-behavioral therapies* (3rd ed., pp. 3–38). New York, NY: The Guilford Press.

Dubovsky, S. L. (1983). Psychiatry in Saudi Arabia. *American Journal of Psychiatry, 140*, 1455–1459.

El-Eslam, F., & Abu-Dagga, S. (1992). Lay explanations of symptoms of mental ill health in Kuwait. *International Journal of Social Psychiatry, 38*, 150.

Ellis, A. (1980). Rational-emotive therapy and cognitive behavior therapy: Similarities and differences. *Cognitive Therapy and Research, 4*, 325–340.

Esposito, J. L. (2005). *Islam: The straight path*. New York, NY: Oxford University Press.

Geels, A. (1997). The function of the *Koran* and the psychology of religion. *International Journal for the Psychology of Religion, 7*(4), 237–240.

Hamdan, A. (2008). Cognitive restructuring: An Islamic perspective. *Journal of Muslim Mental Health, 3*(1), 99–116.

Haque, A. (2004). Religion and mental health: The case of American Muslims. *Journal of Religion and Health, 43*(1), 45–58.

Hodge, D. R. (2006). Religiously modified cognitive therapy: A review of the literature. *Social Work, 52*, 157–166.

Hodge, D. R., & Nadir, A. (2008). Moving toward culturally competent practice with Muslims: Modifying cognitive therapy with Islamic tenets. *Social Work, 53*, 31–41.

Hodges, J., & Oei, T. P. S. (2007). Would confucius benefit from psychotherapy? The compatibility of cognitive behavior therapy and Chinese values. *Behavior Research and Therapy, 45*(5), 901–914.

Ingram, R. E., Miranda, J., & Segal, Z. V. (1998). *Cognitive vulnerability to depression*. NY: The Guilford Press.

Ingram, R. E., & Siegle, G. J. (2010). Cognition and clinical science: From revolution to evolution. In K. S. Dobson (Ed.), *Handbook of cognitive-behavioral therapies* (3rd ed., pp. 74–93). NY: The Guilford Press.

Iqbal, M. (2007). *Science and Islam*. Westport, CT: Greenwood Press.

Izutsu, T. (2002). *God and man in the Qur'an: Semantics of the Qur'anic Weltenschauung*. Kuala Lumpur, Malaysia: Islamic Book Trust.

Kaltner, J. (2003). *Islam: What non-Muslims should know*. Philadelphia: Fortress.

Lo, H. T., & Fung, K. P. (2003). Culturally competent psychotherapy. *Canadian Journal of Psychiatry, 48*(3), 161–170.

Nielsen, S. L. (2004). A Mormon rational emotive behavior therapist attempts *Qur'anic* rational emotive behavior therapy. In P. S. Richards & A. E. Bergin (Eds.), *Casebook for a spiritual strategy in counseling and psychotherapy* (pp. 213–230). Washington, DC: American Psychological Association.

Nobles, A. Y., & Sciarra, D. (2000). Cultural determinants in the treatment of Arab Americans: A primer for mainstream therapists. *American Journal of Orthopsychiatry, 70*, 2.

Padesky, C. A. (1994). Schema change processes in cognitive therapy. *Clinical Psychology and Psychotherapy, 1*, 267–278.

Persons, J. P., & Davidson, J. (2001). Cognitive-behavioral case formulation. In K. S. Dobson (Ed.), *Handbook of cognitive-behavioral therapies* (pp. 86–110). New York, NY: The Guilford Press.

Propst, L. R., Ostrom, R., Watkins, P., Dean, T., & Mashburn, D. (1992). Comparative efficacy of religious and nonreligious cognitive—behavioral therapy for the treatment of clinical depression in religious individuals. *Journal of Consulting and Clinical Psychology, 60*, 94–103.

Smith, W. C. (1992). Can believers share the *Qur'an* and the *Bible* as word of God? In J. D. Gort, H. M. Vroom, R. Fernhout, & A. Wessels (Eds.), *On sharing religious experience: Possibilities of interfaith mutuality* (pp. 55–63). Amsterdam: Editions Rodopi.

Steiman, M., & Dobson, K. S. (2002). Cognitive-behavioral approaches to depression. In T. Patterson (Ed.), *Comprehensive handbook of psychotherapies: Cognitive-behavioral approaches* (pp. 295–318). New York: Wiley.

Thomas, J., & Ashraf, S. (2009). Exploring the Islamic tradition for resonance and dissonance for cognitive therapy for depression. *Mental Health, Religion and Culture, 14*(2), 183–190.

Wade, W. A., Treat, T. A., & Stuart, G. L. (1998). Transporting an empirically supported treatment for panic disorder to a service clinic setting: A benchmarking strategy. *Journal of Consulting and Clinical Psychology, 66*, 231–239.