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Religious and cultural aspects of psychotherapy in Muslim patients from tradition-oriented societies

JAN ILHAN KIZILHAN

Cooperative State University, Department of Social Science – Mental Health and Addiction, Villingen-Schwenningen, Germany

Abstract
Patients from collective cultures with a tradition-bound Islamic cultural background (e.g. people from the Middle East and some Far-East countries such Pakistan and Indonesia), have a different perception of disease and different conceptions of healing, which up till now have not been sufficiently appreciated in modern multimodal therapeutic approaches and health management. Taking patients' value systems into consideration in a culture-sensitive way, with reference to their notions of magic, healing ceremonies and religious rituals and especially patterns of relations and experience in the treatment of psychological diseases in medical psychotherapeutic work, with due regard to scientific psychotherapeutic standards, can be used as an intercultural resource and lead to establishing partnership-like relationships between patients and therapists.

Introduction

In the first half of the 20th century, psychiatric and psychotherapeutic work in the western world involved the study of patients' religious-spiritual attitudes in general and their possible pathogenic influences in particular. Already then, Sigmund Freud put forward his hypothesis that religion is based on an underlying 'obsessional neurosis' and on the regressive, illusional wish for protection by an almighty father, which is contrary to the need for 'education grounded in reality', described the interaction between psychotherapy and religion (Freud, 1964–1968). Subsequently, other scientists, among them William James (1902/1997), Eberhard Schaetzing (1955) and Klaus Thomas (1964), discussed religion in the context of neuroses of general diagnostics of psychological disorders.

It was only after the 1980s that researchers started dealing with religion as a supporting potential. New resource orientation and the realization that patients' value systems and world views can be important for psychotherapeutic success and that they must be taken into account in a culture-sensitive manner have stimulated experiments and studies that have brought about a new relationship between psychotherapy and religiosity/spirituality (Grom, 2012).

As a consequence of these studies, some researchers are calling for the biopsychosocial model to be expanded to include the religious-spiritual dimension (Petreet et al., 2011) so that the ideological questions, which are connected to psychological disorders that are known to date, can be taken into consideration. The positive and negative role religion plays for the patient should be taken into account and included in planning the therapy.

In the meantime, numerous studies point to an interaction between religiosity and health in the western Christian world; for many patients, religion has a protective influence on the state of health (Koenig & Larson, 2001; Matthews et al., 1998; Mueller et al., 2001; Sloan & Bagiella, 2002). But there are also studies that were unable to confirm this positive connection (Jarvis et al., 2005; McCullough et al., 2000; Sloan & Bagiella, 2002).

In Islamic countries, there have been only a few investigations into this issue (Kizilhan & Haag, 2011; Vasegh & Mohammadi, 2007). For this reason, the focus of this article is on the interaction between religion and psychotherapy in people with a tradition-oriented Islamic background.

Religion, culture and psychiatric disorders

Religion has a considerable influence on the everyday life of the Islamic family, irrespective of whether

Correspondence: Professor Dr. Jan Ilhan Kizilhan, Cooperative State University, Department of Social Science – Mental Health and Addiction, Schrambergerstrasse 26, 78054 Villingen-Schwenningen, Germany. Tel: + 49-7720-3906217; E-mail: kizilhan@dbw-vs.de

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in its native setting or living abroad. The family, in turn, determines thinking, emotions and behaviour, through rituals, ceremonies, etc., and tries to help understand and heal psychological disorders (Ilkilic, 2002). Great importance is attached to uncovering individual and cultural resources that can bring about a change in behaviour.

If a Muslim believer experiences his weakness and his limits as a result of a disease, this can be an opportunity for him to come closer to his Creator. This in turn can help the patient to work on his behaviour in order to regain his health through his faith. Belief in God's providence and predestination determines a Muslim patient's attitude towards psychotherapy. The attitude seems passive here, since God has already predetermined everything. However, apart from predetermination, Islamic scholars also interpret the principle of *Qadar* belief as meaning that the disease is the result of God's will, but that healing is possible through treatment. According to this belief, it is incumbent upon people to take advantage of therapeutic possibilities in order to get well (Ilkilic, 2002).

Overcoming and understanding disease can be brought about not only through faith and religious coping but also through such traditional treatment techniques as magic and patriarchal collective thought structures, which existed even before Islam (Agorastos, 2011).

In a study of female patients of Turkish origin who had suffered trauma as a result of rape, Kizilhan (2011) was able to show that compulsive cleaning was more frequent among them than among German female patients who suffered from PTSD after sexual traumatization. Patients of Turkish origin practised religious rituals and showed a religious behaviour in everyday life more often than did their German counterparts. It was possible to demonstrate that it was not so much the religious upbringing as the daily religious practices that were associated with compulsive cleaning (Kleinman, 1980). Care of the body on various occasions is specifically prescribed in Islam. It can be interpreted as part of Islamic cultural upbringing (Assion, 2005) and can play a special role in the case of sexual violence against women with an Islamic upbringing and religious fixedness.

This and other results are important because it was possible to show that through their cultural conditioning and the role religion plays in their everyday life, they develop a different disease perception from that of people living in the industrialized countries (Heine & Assion, 2005).

Collective health management

Even today, people from tradition-oriented Islamic parts of the world are characterized by a collective way of thinking in which personal wishes, interests and complaints are regarded as secondary. Harmony and security in the family and in the peer group are deemed considerably more important than individual autonomy. The individual regards himself/herself as part of a solidary community from which tasks and duties flow. His main task is to see to it that no harm comes to the solidary community in general and the nuclear and extended family in particular. Hence, for instance, if a member of this family is taken ill with a psychological disorder, personal feelings and complaints cannot be expressed for fear of possibly burdening or harming the family (Tagay et al., 2009). This collective health management is used in efforts to keep the members of a group healthy in the interests of the collective. But from the individual point of view, this can initially result in making such difficult and traumatic themes as sexual violence and torture taboo in order to protect oneself and the collective from being dishonoured individually and collectively. In this collective health management approach, collectively dysfunctional cognition of 'loss of honour' and fear of destruction of the entire family and of being ostracized by the community of one's origin always plays an important role. Traditional marriage, forced marriage or 'honour killing' can be mentioned here as catch-words representing the most radical forms, but this should not be generalized for the entire society.

In Islamic, family-focused societies, the attitude towards sexuality can be mentioned here as an example of a mix of patriarchal customs and traditions on the one hand and the Islamic code of conduct on the other. This frequently leads to considerable uncertainty in dealing with this subject if not to its being made a social taboo altogether (Baumeister, 2007). High moral notions and restrictions, especially among women, result in considerable concern and anxiety because they run the risk of having their honour wounded at any moment. Sexual harassment or abuse is verbalized in treatment only if there is sufficient confidence that it will not be made public in the community (Vasegh & Mohammedi, 2007).

Just as sexual behaviour has emerged from Islamic and, in part, from patriarchal values and norms, so can certain forms of representation of psychiatric diseases be conditioned by culture in specific ways (dissociative tearing out of hair as a sign of loss of femininity, removal of the uterus in certain women following rape, etc.), which are alien or even unknown to western psychiatry.

Culture-specific psychiatric diseases

The incidence of psychiatric diseases among people from traditionally oriented religious societies living in their native countries and abroad seems to be elevated (Kardel et al., 2001). Depression (Koch,

2003), somatization disorders (Glier & Erim, 2007; Schmeling-Kludas, 2005), as well as schizophrenia, schizotypal and delusional disorders are more frequent among them (Assion, 2005; Haasen et al., 2005). The cause of this elevated rate of schizophrenic disorders may also be misdiagnoses due to different disease notions and ways of coping with disease, and to difficult diagnostic criteria of ICD-10 or DSM-IV, which are adapted to western norms. Among migrants, such problems may also be due to possible communication problems between the patient and the physician (Kizilhan, 2010). In a study involving 100 Turkish and 50 German patients suffering from psychosis, Haasen et al. (2005) were able to demonstrate that misdiagnoses due to cultural differences in the psychopathology could be found in 19% of the Turkish patients and in only 4% of their German counterparts.

Thus, for instance, hallucinations and delusions can be regarded as conditions that are specific to schizophrenia, but this does not need to be the case in all cultures (Cochrane & Bal, 1987). Some studies have shown that delusion of persecution can occur more frequently in some cultures in non-schizophrenic psychological disorders as well (Ndeteiand Singh, 1982). Even thoughts, which seen in the cultural context need not be pathological, are evaluated as being disturbed or delusional. According to Westenmeyer (1987), the difficulty lies in differentiating between delusion and faith and between hallucination and trance, and can lead to wrong evaluations (Westenmeyer, 1987; Lay, 2007). All in all, diagnostic studies exemplified by psychoses show that in other cultures the frequency of psychotic symptoms leading to psychoses is lower, but that they are rather a reaction to stress, comparable to neuroses or depression in western culture (Haasen et al., 2005; Machleidt & Salman, 2003).

From gods and spirits to psychology

In the archaic and antique civilizations of the Middle East (Babylonian–Assyrian and Egyptian medicine) the understanding of psychological diseases was based on magic–religious ideas. One believed, for instance, that psychosis was caused by spirits and was to be regarded as punishment for insulting the gods (Kirmayer, 2008).

The Babylonians believed that psychological complaints were, among other things, the result of moral misconduct for which a deity claimed the soul. Religious ablutions, prayers, pilgrimages and offerings complemented the magical acts in order to appease the gods. This way the so-called priest doctors and faith healers specialized not only in magic rituals, but also in special therapeutic techniques (treatment with medications, massage techniques, prescription of certain foods).

Traditional healers

Quite often, people avail themselves of the services of traditional healers and religious priests experienced in magic and healing (Kardel et al., 2001). Consequently, various traditional healers, religious priests, so called *Khavajas*, are still active in many rural areas in the Near and Middle East.

Traditional healers include bone healers, religious healers, who work as magicians or wizards, Arab physicians who follow the tradition based on the theory of the four humours, herbalists, and women skilled in the art of healing who are consulted especially when it comes to gynaecological and obstetrical problems (Assion, 2005; Yavuz, 2007).

Bone healers are consulted for the treatment of sprains, suspected dislocations or real bone fractures, etc. Religious healers from the Near and Middle East are usually conversant with the Koran, but this is not a prerequisite. Non-Islamic traditional healers can also be found in many countries in the Orient. In the Turkish-Arab culture, they are known as *Khavajas*. Religious healers are deemed able to recognize the 'evil eye', 'evil spirits' or 'black magic' as causes of disease (see Box 1). Traditional healers are consulted for a wide spectrum of problems ranging from psychological, neurological and psychosomatic conditions such as depression, epilepsy or chronic complaints, to family, economic or job difficulties (Gün, 2003).

Research methodology

Research design and approach

The research design and approach is based on a literature review, case study (Mayring, 2002; Yin, 1994) and on the experiences of the author as Head of the Department of the Psychosomatic Clinic with Muslim patients in Germany for 16 years (so far over 4,000 Muslim patients have been treated in this department).

The main topic of the article (religion, culture, Islam, collective health management, treatment, etc.) based on the study of Kizilhan (2011) with 2,089 Muslim inpatients and research of Muslim patients in Europe and Middle East (Ilkilic, 2002; Rasheed et al., 2004; Tagay et al., 2009). In the second step a general search for similar or same subjects was searched.

Literature review

The search of 'religious and cultural aspects of psychotherapy in Muslim patients from tradition-oriented societies' was used with electronic search engines and manually. Articles, exhaustive papers

Box 1. White and black magic as a model to explain psychological disorders in a case study of an Islamic-background patient; the relevance of magic images in psychotherapy. The patient was treated in 2010 in Germany.

White and black magic

The terms white and black magic have been known in the Near and Middle East and among the Muslim population in the Balkans for centuries and are in common use in everyday parlance. Protection from influences of evil spirits or forces is sought through white magic by performing magic acts. White magic is used to protect family relations and honour from harm. Black magic, on the other hand, is resorted to in order intentionally inflict harm on someone. For this purpose, amulets are placed in the intended victim's home, magic knots are tied, magic texts written and read, certain things added to food or soil from graves is used in various ceremonies. The existence of good and evil spirits as a model to explain psychological disorders, conflicts in relationships, accidents, etc., was already discussed by the Islamic Prophet Mohammed (Heine & Assion, 2005), and this belief is still present in rural society's thought patterns.

over 600 electronic articles which met the selection criteria were retrieved using selected keywords from a search of ScienceDirect, CINAHL, Blackwell-synergy, Medline, OVID, PubMed, *BMJ Journal*, and http://scholar.google.co.th. There were four studies found from the research reports. The inclusion criteria included: (1) articles and books, published between 2003 and 2013, which made reference to applied Islamic, healing, psychotherapy or religious therapy among adult patients; (2) English, Turkish and German references of psychotherapy in Islamic patients; (3) at least one psychological or physiological outcome measure; and, (4) studies conducted in Turkey, Arabia, Iran, Iraq, Germany the USA or UK. Keywords used for the searches consisted of: Islam, Muslim, psychotherapy, religion, psychological and physiological outcomes.

Case study

The case studies based on a study of Kizilhan and Haag (2011), where 23 inpatients (13 women, 10 men) with psychosomatic disorder were interviewed, all of them of Muslim origin.

Research instrument

Guided interviews dealing with religion, culture, mental disorder, relations between therapist and patients, psychotherapy with Muslim patients (Rasheed et al., 2004) were conducted, transcribed, coded and categorized following grounded theory methodology and qualitative content analysis according to Mayring (2002).

Sample and data collection

Patients with a Muslim background at the Psychosomatic Clinic were given appointments for an interview and a written explanation of the study in which they were also asked to participate. On the day of their interview they agreed to participation in the study. The interview was done by a Turkish-, Kurdish- or an Arabic-speaking psychologist, depending on the language that the patients spoke. The interviews took approximately 30 to 45 min.

Between May and October 2010, 23 patients (13 women and 10 men) of the Department for Migrant Inpatients of the Michael-Balint-Klinik, a psychosomatic clinic in Königsfeld, Germany, were recruited. The native language inpatient department of the Michael-Balint-Klinik in Königsfeld has provided a bilingual inpatient department for Turkish, Kurdish, Arabic, Persian, and Russian immigrants since 1999. This service is made available to those patients who either do not have sufficient knowledge of the German language to convey their complaints or who wish to speak to someone acquainted with their cultural or religious background.

Ethical considerations

The case study was presented to and approved by the Directory of the Clinic and the Ethics Committee of the Cooperative State University Baden-Württemberg (BW) and was conducted in the inpatient Migration Department in the Psychosomatic Clinic in Königsfeld in Germany. The case studies are made anonymous and cannot be referred back to any patients (Denzin & Lincoln, 2005).

Inclusion criteria for the study were age of consent (18 years) and a written agreement to participate in the study; exclusion criteria were psychosis diagnosis, organic brain disorders and addiction.

Casuistry

A 58 year-old man from Turkey first noticed the influence of black magic in 1980 when he discovered a pile of soil at the entrance to his flat. The feeling that this was a magic occurrence crept over him. Full of anxiety he visited a *Khavaja*, who confirmed his suspicion. The soil was from the graves of seven deceased persons. Someone wanted to harm him and make his life a living hell.

From then on, he had experienced the influence of evil forces on almost all areas of life: on his marriage, on a relationship and even on his vehicle. He had also discovered that it was important for him to abide by the rules of the Koran because he did not want to lose his chances of going to paradise one day by violating any of them. Thus he sought protection through prayers, obtaining numerous books on the subject, including *Recipes for Protection Against Curses* and *Protective Prayers*.

Since 1996, he had been living alone in a two-room flat and avoiding all social contact. Only once a week he would visit a mosque for prayer to return to his flat and lock himself in again.

In psychopathological terms, a mild depressed mood was noticeable, attended by an increased desire to speak, agitated mimicry, gesticulation and restlessness. The flow of speech was well modulated; the patient looked suspicious and tense. During the psychotherapy sessions he continually spoke about black magic, which 'influences [him] considerably, as a result of which [he] lost [his] job.' He did not see a way of stopping this black magic.

The patient was able to get involved in the treatment and to build up a good relationship only thanks to the therapist's knowledge of the patient's cultural notions of magic. In the course of the treatment, the patient learned to cope with his ideas on magic, with everyday life and gradually to take up his work again, which stabilized him considerably. His ideas on magic remained, which had apparently resulted in deep-seated insecurity and anxiety since childhood, and were thematized in the therapy.

From 1980 to 2010, the patient's condition was diagnosed as paranoid schizophrenia and was treated without success with numerous neuroleptics. In our treatment, the diagnosis we acted on was delusional disorder and depression. Culture-specific disease descriptions and the use of terms such as white and black magic, the conviction of being 'cursed' and yet sufficiently protected by the aura of God and white magic are alien to western psychiatry and difficult to integrate into psychotherapy. However, from the perspective of people with traditional religious perceptions there is no sharp distinction between folk and 'classical' medicine (Assion, 2005). As our case study shows, people who grew up abroad and who have been socialized in part by western and in part by traditional Islamic cultures see no contradiction between going to see a psychiatrist and consulting a *Khavaja*, where the psychiatrist's job is seen as providing 'solely' medication therapy, whereas the traditional healer's purview is the soul and the relationship with God.

Treatment

Medical psychotherapeutic work with patients from a foreign culture requires willingness on the part of the therapist to deal with unfamiliar patterns of relationships and experience in order to take advantage of intercultural work as a resource (Glier & Erim, 2007). Thus, according to Machleidt & Salman (2003), therapists can help develop a psychological and physical basis for integration based on a person's cultural notion of health with a view to regarding and understanding that person holistically. From the given situation in a person's life, the patient's relevant views and resources can be integrated with psychiatric and psychotherapeutic treatment concepts. The reflection of backgrounds and phases of adaptation processes are required here, and patients should be actively motivated to influence and shape their adaptation processes.

Religious priests and the use of traditional medicine will probably continue to play an important role in the future in the treatment of psychologically challenged people from tradition-oriented societies. Instead of reacting with prejudice, religious–spiritual ways of thinking and behaviours should be integrated into the treatment, since this group of patients will time and again revert to traditional religious explanations for psychological diseases.

Case study

Two years ago, a 58-old Turkish patient who had worked in a factory in Istanbul for 12 years was taken ill with agoraphobia accompanied by panic attacks and various physical complaints without any physical cause. He was no longer able to go to work. The patient, who comes from a traditional Islamic family from the Black Sea region, had moved to Istanbul due to financial difficulties. There was a history of family conflicts. He was particularly hurt by his daughter's relationship with a man to whom she was not married. During the therapy, apart from family discussions, especially with the daughter, the patient talked about his anxieties and physical complaints with reference to the Koran. Hence, the patient had memorized verses from the Koran and whenever he found himself in a crowd he would start breathing properly and regularly, take out his prayer beads from his trouser pocket and quietly recite the verses he had memorized until the anxiety subsided. Thanks to his strong-rooted religious fixedness and modern psycho-education, he developed an understanding of his disease and its cause. Following an 8-month period of psychotherapy, the patient was able to mingle in crowds and work again. He was able to accept his daughter's relationship, among other things, by

getting to know her friend because she was able to convince him that this was a serious relationship.

In this case, internal conflicts were expressed through expressions of pain, and anxieties through avoidance. One explanation may be the extant disease notion, disease perception and the unusualness of psychological disease, which is in part considered taboo in society. From the psychodynamic perspective, somatization provides socially disadvantaged groups and people with stressful experiences with a means of shifting social humiliation, feelings of guilt, and inferiority from the conscious experience to the physical level in order to preserve self-respect and to hope that the physician and medicine can help them.

Relationship between patient and therapist

For patients from family-focused societies, the joint development of an explanation model is unusual; they expect the therapist to come up with a complete explanatory model after the first therapy session (Gatchel et al., 2007; Herzer, 2000), because in the past this was customary when a traditional healer was consulted. It is therefore helpful, right after diagnosing the condition, to inform the patient about the treatment strategy and its purpose, which is unusual to the patient (Kizilhan & Haag, 2011).

The aspects outlined in Table 1 should be taken into account during the examination and treatment when dealing with patients from family-focused societies.

In these societies, because of their traditional upbringing and socialization, relationships to other people, including the therapist, are important, especially so in view of the fact that many patients have already consulted traditional healers, who have special communicative competencies. Hence, such characteristics on the part of the therapist as understanding, patience, respect, politeness, attention, friendliness and openness are valued more than his professional expertise (Gilson et al., 1994).

In patients from family-focused societies, the physician (the clinical psychologist is also regarded as a physician/'doctor') is considered a father-like friend of the family (Machleidt & Gül, 2010). He represents an authority figure cultivating an active and knowing way of providing advice and of dealing with the patient and his family. He will have to accept this cultural transference if he does not wish to cause considerable confusion. In contrast to patients conditioned by western-style individualism, where the focus is on mobilizing the individual's own potential,

Table 1. Interaction in the treatment of male and female patients from family-focused societies (Kizilhan & Haag 2011).

Contact	Friendly, responsive, waiting for instructions from the psychotherapist.
Hierarchy	Focused on hierarchy and status (the psychotherapist enjoys a high status in the hierarchy).
Respect	Expecting intimacy while maintaining sufficient distance and adhering to cultural rules (e.g. reaching out the hand when greeting same-sex individuals, or standing up when they enter the room).
Harmony	Mindful of harmony in the relationship. More often than not, conflicts, quarrels, arguments are avoided. Does not want to be exposed. May possibly not contradict the physiotherapist so as not to question his authority.
Shame and guilt	Islamic family-focused societies especially are characterized more by a culture of shame than a culture of guilt. Hence, physical complaints tend to relate more to parts of the body that are less associated with shame.
Collective thinking	Psychological conflicts can be regarded as weakness, which in turn can lead to rejection by the collective. (The person is weak and of no use to the collective). On the other hand, a physical complaint is something that is 'visible' and it is accepted as a disease.
First the body, then the soul	In the initial hours of treatment, the focus is mainly on physical complaints, which can also be understood as indirect indications of psychological conflicts. If there is a sufficient level of confidence in the relationship, possible psychological conflicts and stresses are then thematized.
Advice and clear instructions	The patient expects the therapist to provide him with information about his disease, advice, also in the form of counselling, and clear instructions about what he needs to do (medication, massages, physical examination).
The imaginary family in individual therapy	Complaints, possible conflicts and stresses in individual therapy are always seen in relation to the family situation ('As a result of my back pain I am unable to work and hence unable to provide for my family; I will lose my children's respect if they find out that I am also suffering from depression', for example).
Patient's passive behaviour	Not the individual with his personal characteristics and his burden, but rather factors outside the individual – such as family, occupational or social conditions – are held responsible to a considerable extent ('My pain has become unbearable ever since a relationship has developed between my daughter and a man to whom she is not married. Once they marry, I won't feel so ashamed in the community anymore and I'll be better able to bear the pain').

patients from the other side of the cultural divide expect and should be provided with more help from the therapist as a person of authority (Machleidt & Gül, 2010). However, this means that, in order not to impact the therapy in a destructive way, the therapist should develop an awareness of his own cultural fixedness, thereby putting himself in a position in which he does not impose on the patient his own (counter) transferences and all individual and societal prejudices and stereotypes, which occur as collective transferences. Only then is a patient's readiness to change his behaviour at the psychological and physical levels possible.

The role of the family, in the sense of a collective form of life, especially among traditionally oriented Islamic people, is central and it is imperative that it be taken into consideration when developing a therapy plan for individuals belonging to this group of patients, and family discussions should always be encouraged. In the first family discussion, due consideration should be given to the hierarchy and family constellation, religious fixedness, the desire for harmony and avoidance of conflicts, which figure prominently. The reality of life in the family is always tied up with the 'others'; the 'collective spirit' is predominant. Unlike in western thinking, notions of 'self' are not individually oriented. The individual is regarded in connection with others and in the context of prescribed religious rituals and values and defined in terms of others. Hence, attitudes and behaviour are determined primarily by social and religious roles.

Summary

Time and again, in psychotherapy, religiosity is a theme when dealing with patients from Islamic, tradition-oriented societies. Accordingly, it should be included in psychotherapy using appropriate modules which have been tested and discussed in psychotherapeutic research. Patients' spirituality and religiosity should always be taken into consideration and respected. An open approach to religiosity, up to the inclusion of the use of spiritual and religious intervention, is recommended in psychotherapy, taking into account ethical principles. However, the psychological and/or psychotherapeutic objective, that of healing the patient, should be the sole objective of religious and spiritual intervention.

Limitations of the study

The limitations of this research refer to the design and method. From a report or overview design perspective the subjectivity of the researcher played a role. To counter his subjectivity, the researcher tried to report as fully as possible more studies from Islamic countries from Middle East and Europe.

Prospective investigations are required, including unselected, randomized samples of the immigrant populations from different cultures and their countries of origin to explore the interaction of culture, religion, immigration and psychotherapy. Furthermore the influence of the social and religion adaptation in the host country as integration in working life, being a member of social security systems, feeling themselves socially accepted versus being confronted with social discrimination in relation to religion and mental health should be investigated. Differences between nationalities and religion as in Iran, Turkey or Indonesia and their relation to psychotherapy should also be investigated.

Take-home points

Religion is often an integral part of culture and needs to be addressed by the multiculturally aware clinician and therapist. Religious and spiritual issues are not new. What is new is that the clinicians and therapist professions are starting to recognize the value of incorporating this aspect into a treatment. It is essential for clinicians and therapists to gain knowledge, understanding, and competence of the various religious beliefs, values, and traditions as well as cultural world views when healing a diverse group such as the Muslims in their homeland or country of residence. However, a world view of their clients and clinicians can better provide culturally sensitive treatment.

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