



KHALIL CENTER

A ZAKAT FOUNDATION PROJECT

MUSLIM MENTAL HEALTH FIRST RESPONDERS' MANUAL

In the Name of Allah, the most Beneficient, most Merciful. All praise is due to Him and Him alone. We pray that He accepts this project from us as a devotion for His sake and we ask that He send His choicest blessings and salutations upon His messenger and slave, our Master Muhammad and upon his noble family, wives, and companions.

Table of Contents

Introduction 3

Manual Objectives 5

1. Understanding Mental Illness 6

1.01 Mental Illness in Muslim Communities 8

1.02 Common Concerns 9

1.03 Summary 12

2. Spiritual Manifestations of Psychological Conditions 13

2.01 Terms 13

2.02 Schizophrenia 14

2.03 Trauma and Dissociation 15

2.04 Summary 16

3. Treatment Modalities 17

4. Islamically Integrated Psychotherapy 18

4.01 Terms 18

4.02 Mental Health in Islamic Theology 18

4.03 Traditional Islamically Integrated Psychotherapy (TIIP) 20

4.04 Internal Framework of the Human Psyche 22

4.05 Summary 24

5. Psychological Implications on Islamic Jurisprudence 26

6. Counseling: Process and Skills for First Responders 27

6.01 Building Alliance 28

6.02 Empathic Response 29

6.03 Listening 30

6.04 Practice 31

6.05 Summary 32

7. Responding to Crisis 33

7.01 Understanding Crisis 33

7.02 Crisis Response 33

7.03 Referral 34

7.04 Mental Status Exam 36

7.05 Summary 37

8. Understanding and Responding to Suicide 38

8.01 Understanding Suicide 38

8.02 Concepts 38

8.03 Active versus Passive 39

8.04 Response and Intervention 40

8.05 Wall of Safety 40

8.06 No Harm Contract 41

8.07 Summary 41

8.08 No Harm Contract Sample 42

9. A Collaborative Care Approach 43

9.01 Roles 43

9.02 A Collaborative Care Model for Adjudicating Legal Cases between Practitioners and Clergy 43

10. Legal and Ethical Privileges and Responsibilities 45

10.01 Confidentiality 45

10.02 Mandated Reporting 46

10.03 Cultural Considerations 48

10.04 Suicide and Mandated Reporting 49

10.05 Summary 49

11. Scenarios: What Would You Do? 50

12. Common Questions: How Do You Respond? 53

Introduction

The Muslim population represents a significant portion of the diversity in Western and non-Western countries. There are approximately 1.57 billion Muslims in the world and one-fifth of the world's Muslim population live in countries where Islam is not the majority religion (Pew, 2008). Just like their non-Muslim counterparts, Muslims living in Western countries have significant psychological, social, and communal issues. However, given the limited availability of services in the Muslim community coupled with reported lower social supports among American Muslims (Pew, 2007), they can be perhaps even more vulnerable to these sources of stress.

O. M. Ali, Milstein, and Marzuk (2005) found that after 9/11 there has been an increase in seeking out imams (religious scholars/leaders) to address a series of issues related to mental health within the Muslim community. This highlights the need for mental health services within the Muslim community in North America as well as the reality that the Muslim clergy often serve as the first response to psychological distress. Unfortunately, relatively few religious scholars have any formal training in mental health care, creating concern about the efficacy of their treatment using pastoral healing methods alone. Additionally, evidence suggests that Islamic traditional pastoral models are best utilized for less severe disorders (Razali, 1999) and that severe mental illness should be either deferred to professionals or treated through a collaborative approach.

Therefore, in addressing this large faith group, an Islamically integrated mental health care approach would be the optimal model of service delivery. There is significant data to suggest that Muslims are among some of the cultural groups that benefit tremendously from a psychological stance in treatment that integrates Islamic spirituality (Azhar & Varma, 1995a, 1995b; Azhar, Varma, & Dharap, 1994; Razali, Hasanah, Aminah & Subramaniam, 1998). In fact, Muslims who identify strongly with Islamic values are less likely to seek counseling services (Abdullah, 2007; Podikunju-Hussain, 2006) and express a hesitancy to trust mental health professionals for fear that their Islamic values may not be respected (Mahmoud, 1996). Additionally, data collected from an Islamically oriented mental healthcare facility in the US, Khalil Center, showed that almost 75% of their Muslim clients coming to the center for psychological services avoided seeking help from non-Muslim professionals and opted to come to Khalil Center instead, with 98% of them affirming a desire for Islamic spiritual integration. This makes a strong case for the value of Islamically integrated collaborative mental health care.

However, it is important to note that given the hesitancy of Muslims in seeking out mainstream mental health care and the limited supply of Islamically integrated mental health care options, this manual was created with the aim of facilitating a communal and collaborative response in addressing mental health care disparities for North American Muslims.

Mental health first responders play a unique role in the immediate response and care of individuals/families/groups going through crisis situations. Most crises will present themselves in various ways, including but not limited to: psychological trauma, community trauma, grief and loss, and response to emotionally and physically overwhelming situations. While the needs of people experiencing crises may differ,

the goal will always be to understand the concerns in the moment, determine level of care needed, and guide towards the next steps for care. This can mean providing a space for empathic listening and open conversation, direction towards needed supports (shelters, hospitals, law enforcement, etc.), or referral for counseling services. In fact, it is evident that most individuals turn to community leaders, indigenous healers, faith leaders and even primary care before turning to mental health care (see diagram below). Therefore, having first responders serve as an avenue to help direct patients to the most appropriate treatment options would go a long way toward breaking down the barriers for psychological care.

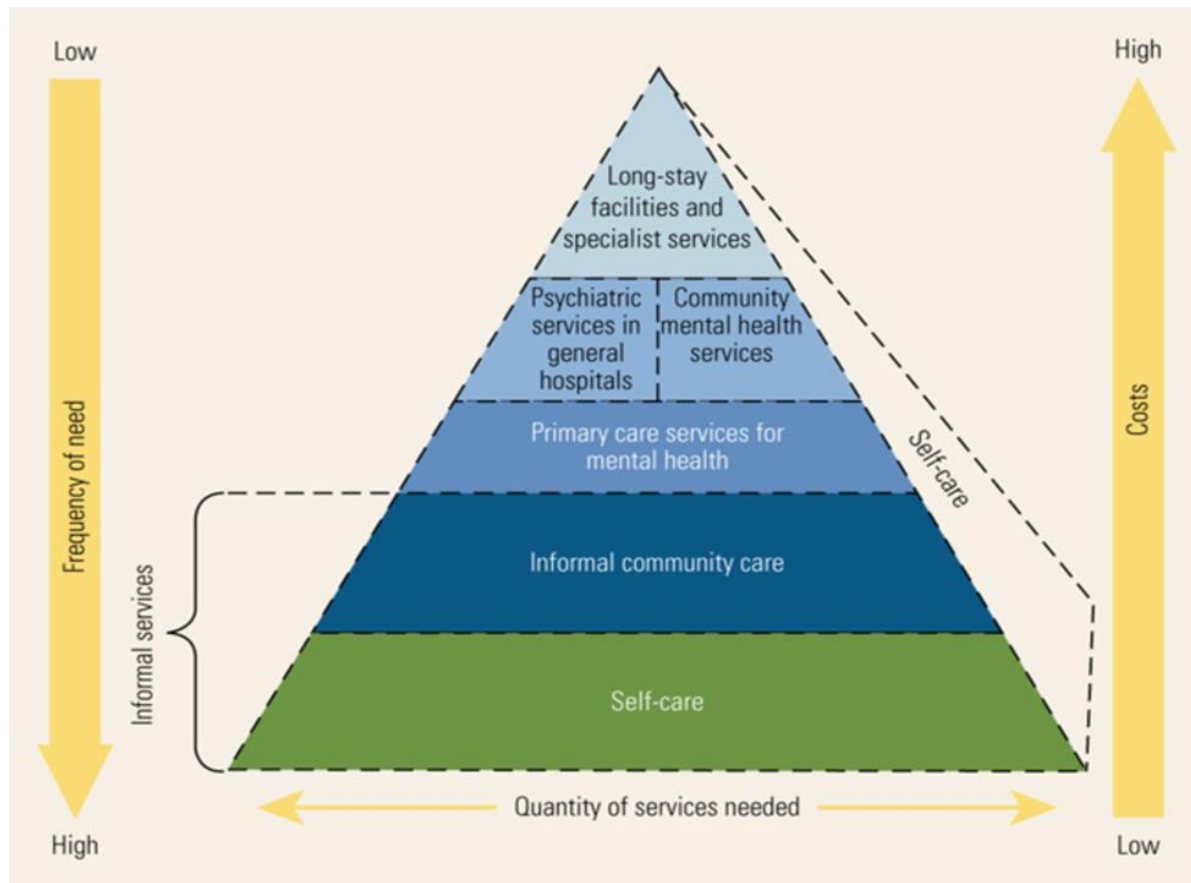


Diagram 1. Patients Help Seeking Mental Health Care Treatment Choices (Samhsa, 2008)

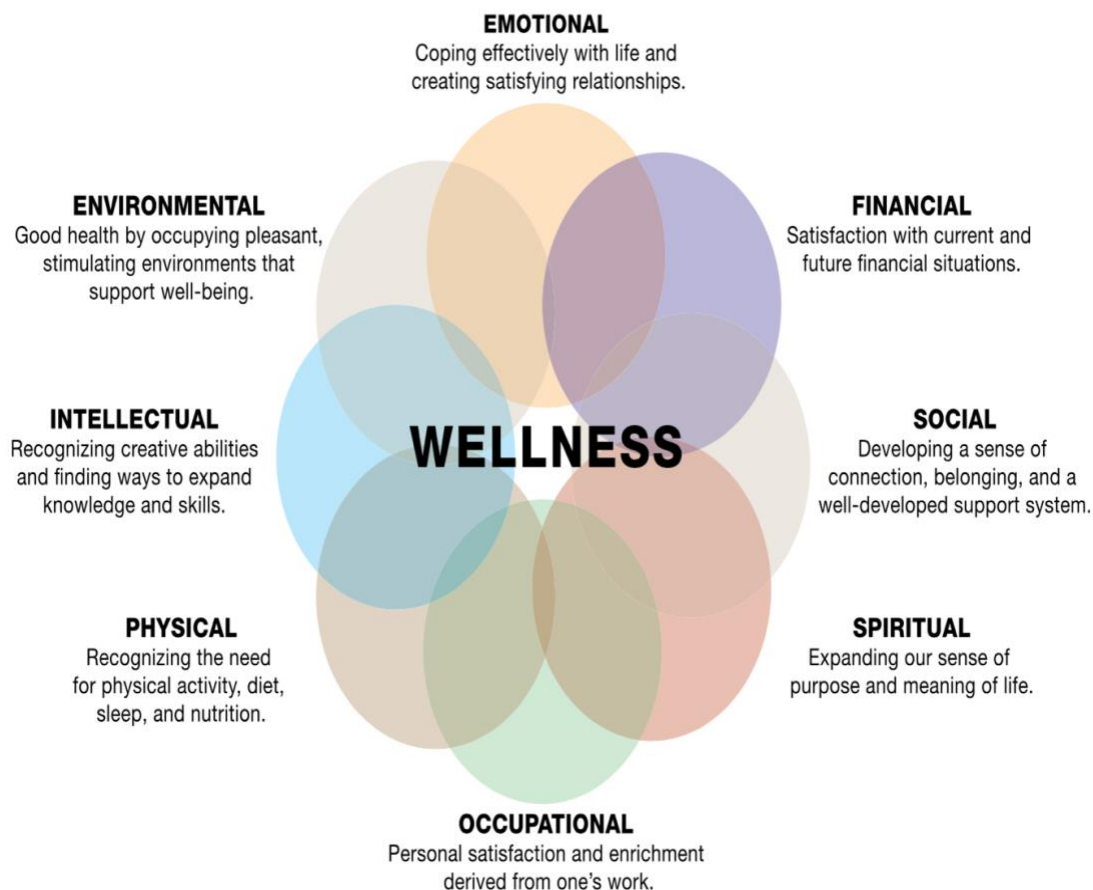
Manual Objectives

- Develop the ability to identify possible psychopathology and have an understanding of the system of referral.
- Expand awareness of mental health referral sources and procedures to collaborate/assist with expert mental health clinicians.
- Orientation to an Islamically oriented model of mental health care.
- Understand active and empathic listening skills towards fostering a productive relationship between chaplain/imam and congregant.
- Increase awareness of relational processes that influence self and others.
- Identify crisis situations and have specific tools for responding to crisis.
- Understand clergies' scope of mandated reporting, clergy rights, how to screen and identify for the possible presence of mental illness.
- Facilitate a greater appreciation and understanding of the role of mental illness in Islamic law.

Understanding Mental Illness

Mental Illness: A spectrum of mental health disorders that affects mood, behavior, and spirituality. This includes but is not limited to: anxiety, depression, obsessive compulsive disorder, dysfunction in social relationships, and personality disorders. These concerns get classified as a disorder when they impact someone's functionality: the ability to engage in daily tasks (attending work/school, social interactions, routine, etc.).

Mental Health: Our overall well-being. This is fluid and an ongoing development in our lives. It impacts how we respond to stress and make decisions in our lives. A person's mental health needs continued and consistent care and attention. Components of mental health include: physical, emotional, spiritual, and psychological health. All of these are inter-connected and rely on each other for continued health and strength.



There are many situations and reasons (triggers) people will experience mental illness. Some of the more common triggers include:

- Losing a loved one
- Marital dissatisfaction
- Experiencing physical or sexual abuse
- Existential or spiritual problems

- Predisposing biological variables
- Job loss or failure to meet academic expectations
- Loss of home and displacement
- Isolation
- Disputes among family members
- Bullying and peer related issues

While some situations are temporary, and have a short-term impact, some lead to more long-term concerns and illnesses.

Often a common concern or question is whether psychiatric medications are warranted in the treatment of mental health care issues. The answer to the question generally must be based upon the assessment of the nature of dysfunction manifested in the patient.

In fact, as early as the 9th century, Abu Zayd Al-Balkhī (d. 322AH/934CE), the first documented cognitive psychologist divided clinical mental health issues into two potential possibilities:

- 1) Exogenous diseases which are caused by environmental situations and stressors such as loss of a loved one or job.
- 2) Endogenous disease which is caused by internal biochemical variables that can often be due to heredity.

Though modern literature may see both of these dimensions on a continuum without a clean separation between the two, it is useful to see the origin of the distress as mostly being neurochemically loaded in origin or environmental in origin. In response, Abu Zayd al-Balkhī recommended that endogenous distress be treated through medicinal or herbal prescriptions while exogenous treatments be focused on talk therapy or as he termed it, the ‘counsel of a wise hakīm’ that would help induce positive thinking.

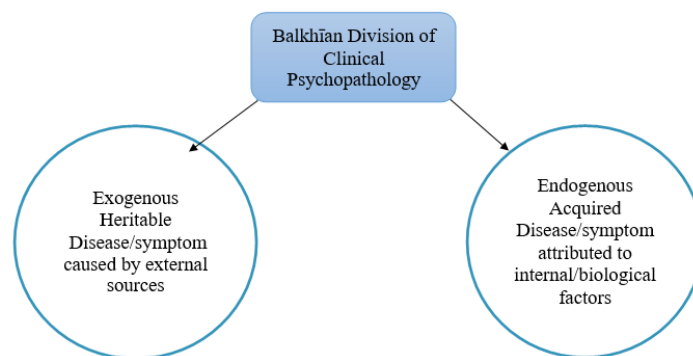
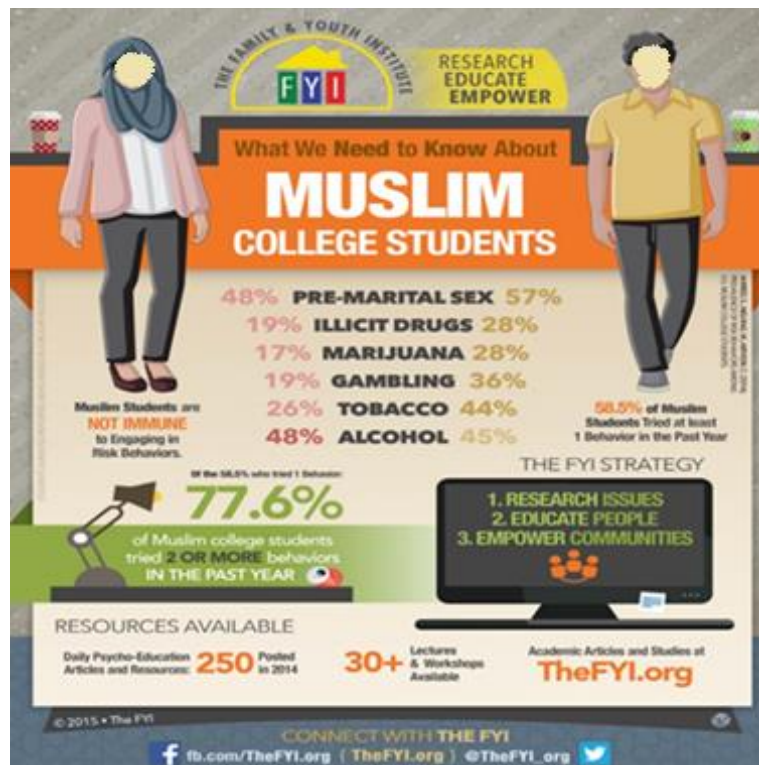


Figure 1

1.01 Mental Illness in Muslim Communities



The Family Youth Institute has summarized various data on American Muslim youth and charted it, in the above infographic showing that about 58% of Muslim college students engage in risk behaviors (drug use, pre-marital sex, and alcohol use).

With regard to marriage and divorce: the American Muslim divorce rate according to an estimate of Ba-Yunus in 2000 is at 32.33% and 21.3% in a sample of middle-upper class young professionals in the Bay Area of California. Chapman & Cattaneo, 2013, found in their study that 68.2% of Muslim couples had significantly negative interactions, and 56.1% had at least one moderate to major issue in their marriages.

The 2016 National Survey on Drug Use and Health (NSDUH) by the Substance Abuse and Mental Health Services Administration (SAMHSA) found that 1 in 6 US adults live with mental illness. American Muslims report similarly to the prevalence of anxiety disorders present in the general population. The National Comorbidity Study (2007) found the rates of anxiety disorders to be at 19% and that 31% of adults will likely experience an anxiety disorder in their lifetime. American Muslims are least likely to have someone they can count on if they are in trouble (Pew, 2011)

The epidemiological data on Muslim mental health is limited and is an ongoing project. Despite limited data, it is clear that mental illness is a significant and prevalent issue in our community. It is a concern that must be approached in a holistic and culturally/religiously sensitive method.

Risk Factors:

- Spiritual disconnect
- Family/social/community disconnect
- Recent trauma or life change
- Minimal or no external support
- Lack of routine
- Lack of community or social engagement

Protective Factors:

- Family and community support
- Spiritual strength and connection to religion/religious spaces
- Education/career
- Self-awareness
- Emotional support
- Active lifestyle
- Family, peer, community connections and engagement

1.02 Common Concerns

The following are a few of the many mental illnesses and concerns that people can experience. The descriptions provided have been condensed and simplified to understand the basic ideas only.

Anxiety: Excessive nervousness or worry that can lead to feeling panic. The panic can manifest in physical symptoms such as chest pain, fast heart rate, headaches, bodily aches and pain, etc.

Vignette: Salām is a 40-year-old woman. She has had a successful career, is a mom of three children (in high school and middle school) and has a healthy relationship with her husband. Salām is an only child, has always aimed high, and succeeded in her goals. About a year ago, Salām’s father passed away. About six months ago, Salām noticed that she is restless and agitated. She gets overwhelmed at work and is unable to focus. She feels exhausted at home and is unable to participate in family activities. A week ago, Salām experienced extreme dizziness, difficulty breathing, and shaking while at work. She went home right after and felt extreme exhaustion the next day.

Q1: What are the primary concerns?

Q2: What risks are there to assess for if any?

Q3: What information may you need before providing guidance?

Q4: What are a few things you will want to address with her (immediate concerns)?

Depression: Depressed mood and loss of interest over a specific period of time that impairs a person’s functionality. Symptoms include: fatigue, loss of interest in daily activities and socialization, sleep and appetite disturbances, and many more.

Vignette: Ahmed is a 30-year-old man, recently married, and in graduate school. He and his wife work full-time, however, their financial situation is tight. Three months ago, Ahmed’s mother told him that she and his father will be moving back to their home country. Over the last month or so Ahmed noticed that he has been feeling exhausted. He would regularly go to the gym and now he has no desire to go. He also realized he has been overeating. He has started to distance himself from his wife as well. He realizes he has also lost motivation to

go to school. Ahmed comes to you because he recently has started missing his prayers. He feels guilty but also feels no energy or desire to pray.

Q1: What are the primary concerns?

Q2: What risks are there to assess for if any?

Q3: What information may you need before providing guidance?

Q4: What are a few things you will want to address with him (immediate concerns)?

Obsessive Compulsive Disorder (OCD): “Waswasa” – An anxiety-based disorder that causes someone to have intrusive and ruminative thoughts that leads to heightened anxiety and accompanying repetitive ritual behaviors. These repetitive compulsive behaviors can include excessive washing or other religious rituals.

Vignette: Abdullah is a 23-year-old male that lives at home with his parents. He started to attend psychotherapy sessions after 6 months of exhibiting obsessive compulsive symptoms of a religious scrupulosity type also known as waswasa in Muslim cultures. In preparation for his five daily prayers, he would perform the required ablution that includes the washing of the face, hands, arms, feet, and wiping of the head. However, he becomes excessively concerned upon nearing the completion of his ablution that he has not washed all of his limbs fully, thereby repeating the ablution. Additionally, Abdullah knows that passing wind will nullify his ablution, which will require a new ablution. Abdullah starts hyper surveillance of his inner feelings and reports sensing that he may have passed wind, causing him to repeat his ablution yet again. This persists for prior to every prayer such that it consumes his entire day and leads to enormous amounts of water wastage. Abdullah’s obsessive thoughts of breaking his ablution and fear of being punished in the afterlife for not completing his religious rituals leads to a vicious cycle of compulsive washing thereby leading to his dysfunction. For the past 6 months he has not been able to work on account of his repeated washing.

Q1: What are the primary concerns?

Q2: What risks are there to assess for if any?

Q3: What information may you need before providing guidance?

Q4: What are a few things you will want to address with him (immediate concerns)?

Post-Partum Depression: Symptoms of depression present in mothers, before or after their baby is born. Some of the symptoms are loss of appetite, sleep disturbance, irritability, and difficulty bonding with baby.

Vignette: Syeda is a 24-year-old mother of a 6-month-old baby boy. She lives with her husband and in-laws. Syeda comes to you with guilt, sadness, and anger. She always feels tired, is emotionally and physically exhausted, and feels alone in raising her child. Her husband works a demanding full-time job. She finds minimal support from her in-laws. She has found it difficult to hold her baby or spend time with him other than to feed or change him. She feels like she is being punished at times but also struggles to find motivation. Her feelings have become so overwhelming that all she wants to do is sleep. She has started to feel disconnected spiritually and emotionally from everyone.

Q1: What are the primary concerns?

Q2: What risks are there to assess for if any?

Q3: What information may you need before providing guidance?

Q4: What are a few things you will want to address with her (immediate concerns)?

Marital Distress: Dissatisfaction in marital relationship due to communication gap, differences in expectations, etc. Dissatisfaction in relationships can lead to depression and other mood disorders as well as spiritual disconnect and isolative behaviors.

Vignette: Rabia and Rasheed have been married for five years. They had been introduced through family and got married a month after. In their five years, both of them have found it difficult to agree on role expectations and responsibilities in their marriage. They also have a difference of opinion in regard to family structure which has caused tension around having children. Both of them have realized that they have had very different upbringings. Their constant disagreements escalate to arguments and fighting. Now they find it difficult to communicate with each other. Rabia expresses that Rasheed is never home and is always working. Rasheed expresses that Rabia is distant and does not speak to him much when he is at home anyway.

Q1: What are the primary concerns?

Q2: What risks are there to assess for if any?

Q3: What information may you need before providing guidance?

Q4: What are a few things you will want to address with them (immediate concerns)?

Family Distress: This is a common problem found in Muslim families, specifically when there is a cultural clash between parents and children. Dissatisfaction with relationships and emotional disconnect from family members can lead to isolative behaviors, depression, or anxiety. Lack of communication and connection may also lead to children engaging in risky behaviors and keeping it hidden from adults in the home.

Vignette: Abdullah is a 60-year-old immigrant, lives at home with his wife and youngest son, and works an office job. His two elder children are married and two middle children are living outside the home for work and school. Abdullah struggles to understand his children's choices and finds himself feeling disconnected from them. He and his youngest son fight constantly about school, grades, and his son's social life. The fights cause tension between him and his wife as well. Abdullah expresses that he feels alone and stuck. He wants to reconnect with his children but does not know how.

Q1: What are the primary concerns?

Q2: What risks are there to assess for if any?

Q3: What information may you need before providing guidance?

Q4: What are a few things you will want to address with him (immediate concerns)?

Grief and Loss: Losing a loved one is a painful experience. Everyone experiences this process differently. While some people are able to process their loss (at their own pace) and continue with their daily functioning, others can develop mood disorders such as depression.

Vignette: Zakariya, a 35-year-old father of two, lost his father a year ago. The loss was sudden and unexpected. Zakariya took care of all the janazah arrangements and has taken over his mother's care as well. Over the last few months, Zakariya's wife has expressed concerns that he is not eating or sleeping much, does not participate in family activities, and barely talks when he is home. He has started missing work often as well and will sleep all day sometimes. When he is with the family, he is irritable and will get angry with the children very quickly. When he is not sleeping he will spend an extensive amount of time in prayer or just sitting at his prayer rug. Zakariya has noticed some of these things himself and feels that his family is avoiding him. He does not know what to do.

- Q1: What are the primary concerns?
Q2: What risks are there to assess for if any?
Q3: What information may you need before providing guidance?
Q4: What are a few things you will want to address with him (immediate concerns)?

Sexual Abuse: Sexual abuse, experienced during childhood or adulthood, has significant mental health considerations. The trauma of this leads to mood disorders, isolation, guilt, anger, and many negative emotions that become difficult to process.

Vignette: Aisha is 30 years old, works full-time at a school, and lives alone. In the past she has had a very close relationship with her sister. However, she has always struggled with her relationships with her parents. Aisha was sexually abused by a family member when she was a teenager. The abuse went on for a year. Her family found out about the abuse and it ended. Since then, her parents have encouraged her to move on with her life and focus on the positive. Her sister was the only person she felt she could talk to but lately she feels disconnected from her too. Aisha has very few friends who she will see once in a while though she does not feel a strong connection with them. As she is getting older, her parents keep pushing for her to get married, but she expresses no interest in marriage. Recently, she has lost interest in leisure activities and finds herself losing motivation and energy very quickly.

- Q1: What are the primary concerns?
Q2: What risks are there to assess for if any?
Q3: What information may you need before providing guidance?
Q4: What are a few things you will want to address with her (immediate concerns)?

1.03 Summary

- Mental illness includes a broad range of different disorders that effect a person's mood, behavior, spiritual wellness, and thoughts.
- Muslims are equally susceptible to mental illness or mental health concerns.
- People experience mental illness in various ways based on their protective and risk factors: understanding those differences is an integral part of approach and treatment.

Data about mental illness specific to Muslim communities is an ongoing project that has already given significant information about the level of distress Muslims are experiencing with depression, anxiety, and relationship dissatisfaction.

“Spiritual” Manifestations of Psychological Conditions

Oftentimes, Muslim beliefs around the cause of symptomology are unrelated to biological or psychological processes. Typical attributions are made toward jinn possession as causal explanations (Kianpoor & Rhoades, 2005). Other attributed causes include consequences for past sins, black magic, being cursed by the evil eye (envious individuals who cast a hexing glance at the subject), or separation from the divine (Salib & Youakim, 2001). As a result, many Muslims typically exclusively seek pastoral, nonclinical treatment such as faith healing (Farooqi, 2006; Kianpoor & Rhoades, 2005).

Despite the religious reality of metaphysical explanations for the causes of mental illness, it is important to consider some possible psychological disorders that may better explain or account for the reported symptoms that can often resemble possession or magic. Thus, if there is a strong case for a psychological explanation of symptomology, it would be critical to utilize mental healthcare supports either in conjunction with spiritual treatments or in place of spiritual interventions. This is in consideration of the potential to do greater harm if psychological interventions are not sought out.

2.01 Terms

Psychosis	A loss of connection with reality that impairs a person’s thoughts and behavior. Can include visual or auditory hallucinations or delusions. Can co-occur with another mental illness or traumatic experience.
Positive Symptoms	A cluster of symptoms associated with schizophrenia. Positive symptoms are the ones most typically associated with schizophrenia or psychosis. These include hallucinations, which are often auditory (often hearing voices). These symptoms are the ones that generally cause people to lose touch with reality.
Negative Symptoms	A cluster of symptoms associated with schizophrenia. Negative symptoms in schizophrenia include: • Apparent lack of emotion or small emotional range • Reduced ability to plan and follow-through with activities • Neglect of personal hygiene • Social withdrawal, decrease in talkativeness • Loss of motivations
Regressive Behavior	Behavior that is indicative of a previous developmental stage. For example, a nine year old wetting the bed
Dissociation	An involuntary escape from reality characterized by a disconnection between thoughts, identity, consciousness and memory

In differentiating between spiritual and psychological issues, the two most common erroneous or co-occurring ‘supernatural’ manifestations of illness are:

1. Psychotic Disorders (i.e. Schizophrenia)
2. Traumatic Stress and Dissociative Disorders (i.e. Post-Traumatic Stress Disorder)

Other disorders, such as severe depression or anxiety, may present with psychotic symptoms.

2.02 Schizophrenia

Schizophrenia is a mental illness that impacts an individual's thoughts, emotions, and behaviors. It can present in people between the ages of 16-30. Early onset of schizophrenia, in children though possible, is usually better explained by other disorders. The symptoms of schizophrenia are divided in two categories:

1. Positive symptoms:
 - Hallucinations: seeing or hearing something/someone that is not there. These are vivid and feel real to the person experiencing them
 - Delusions: having a strong belief about something that is not real. Delusions may present as paranoid beliefs such as "he/she is trying to hurt me"
 - Movement irregularity: rigid or irregular physical movements of the body
2. Negative symptoms:
 - Social withdrawal: Isolating behaviors such as avoiding gatherings or social interactions
 - Extreme apathy/flat affect: feeling and expressing nothing. This can present as having no emotional expression in their facial expressions or tone of voice
 - Lack of drive or initiative: minimal motivation and desire to engage in daily activities such as school, work, or even daily life skills (showering, brushing, etc.)

Some of the indicators of schizophrenia are:

- Age of onset - Early 20s for males & late 20s for females)
- Reduced intellectual functioning
- Personality changes
- Having other family members who had schizophrenia or a psychotic disorder/symptoms

How Do You Get Schizophrenia?

The most common theory to explain the manifestations of schizophrenia is known as the "stress-diathesis" model. In essence, it is believed that individuals are predisposed by heredity to schizophrenia when presented with excessive environmental stressors (e.g. college, family, work, etc.) at a particular age, generally early 20s for a male and late 20s for a female. This interaction between the biological and environmental unlocks the schizophrenic genes leading to the beginnings (prodromal phase) of this often-chronic disease.

Myths About Schizophrenia:

There are many misconceptions about mental illness, and schizophrenia in particular.

Myths	Facts
All People with Schizophrenia are Violent	Schizophrenia presents on a spectrum. The presence of violent behavior is less common than other symptoms
People with Schizophrenia Cannot Maintain a Job	A significant number of individuals with schizophrenia can maintain a job and typical lifestyle with medication and therapeutic treatment plans
Schizophrenia is Caused by Bad Parenting	There is no evidence to support this. There are many theories and possibilities of the cause of schizophrenia such as drug use, trauma, or, in most cases heredity. However, parenting has not been identified as one of those causes

2.03 Trauma and Dissociation

Trauma: Occurs when a person is confronted with a threat to the physical integrity of self or another, a threat that overwhelms coping resources and evokes subjective responses of intense terror, helplessness, and horror.

The symptoms of a dissociative disorder usually first develop as a response to a traumatic event, such as abuse or witness to violence/war, to keep those memories under control. Stressful situations can worsen symptoms and cause problems with functioning in everyday activities. However, the symptoms a person experiences will depend on the type of dissociative disorder that a person has.

Dissociation: An involuntary escape from reality characterized by a disconnection between thoughts, identity, consciousness, and memory.

Impact of Trauma:

Trauma impacts all aspects of development. It may cause psychologically regressive behaviors such as emotional dysregulation or impaired impulse control. The age of the person at the time of the abuse is a significant indicator for the types of regressive behaviors that the individual may present with.

Indicators of Trauma:

- Intrusive thoughts/flashbacks - re-experiencing of traumatic events - can be dreams, intrusive thoughts, powerful emotional reactions, body memories
- Numbing and avoidance - avoiding triggers, however, this can actually turn out to be avoiding daily things that “make life worthwhile”
- Seeing body as “dirty” - feeling shameful about one’s body, can feel repulsive, contaminated - and will spend years managing to cope with these feelings
- Sense of self is damaged and infused with shame. Self-concept can be disturbed
- Dysregulation of emotion:
 - Anxiety and stress management

- Uncontrollable fits of rage and anger
- Relationship with others:
 - Destructive coping mechanisms
 - Unconscious tendency to see oneself as 'less than' and imbalance between rights. 'In order to equalize I have to serve more than the other person'
 - Sexual dysfunction
- Sometimes inappropriate social boundaries
- Sexually aggressive or sexually blunted: accompanied by guilt

What Maintains Traumatic Symptoms?

Someone suffering from trauma will typically desire to avoid and bury the traumatic memories. However, avoidance helps only temporarily as the stress is either manifested through somatic symptoms, 'possession-like' behaviors, dreams, or can be easily triggered

When any memory cue even if remotely related to original trauma is available in environment, it will cause those emotions to re-emerge, even if one doesn't consciously remember the original event that caused them to have that emotion.

Possible Interventions:

- Doing both Ruqyah and psychological treatment
- Being able to, in a safe space, therapeutically process what happened
- Rewiring and dampening some of those initially strong neuro-connections developed between memories and overwhelming emotions
- Psychotropic medications

Spirituality Helps!

Integration of spirituality/religion has proven efficacy in the treatment of various disorders (Pargament, 1997; George, Larson, Koenig & McCullough, 2000; Koenig, 2001; O'Conner, Pronk, Tand & Whitebird, 2005). Ascribing a spiritual meaning to life after discharge decreased the likelihood of relapse.

2.04 Summary

- Psychotic disorders and trauma-based illnesses often are associated with spiritual illness.
- Schizophrenia is a mental illness in which a person may present with psychotic symptoms.
- Schizophrenia has both positive symptoms (e.g. hallucinations, delusions) and negative symptoms (e.g. rigid emotional expression, lack of motivation).
- Schizophrenia and trauma present on a spectrum. Symptoms may present differently.
- When an individual experiences trauma, the person's development is affected along with emotional and mental well-being.
- A person who experiences trauma may show regressive (immature) behaviors.
- Trauma may cause other mental illness such as depression and anxiety. It also causes extreme distress such as intrusive thoughts, emotional dysregulation, and impaired daily functioning.
- Traumatic symptoms continue to occur because of a person's need to protect themselves from the memory of the trauma.
- There is evidenced based research that supports the efficacy of the integration of spirituality in treatment.

Treatment Modalities

Treatment plans and methods are aimed at maintaining a person's overall wellness. Therefore, treatment will include goals towards physical, emotional, mental, spiritual, and behavioral wellness.

Holistic Wellness: A person's overall state that impacts their social, emotional, professional/academic, and spiritual functioning.

Methods:

Treatment may include one, several of these methods, or a combination. This is determined on a case-by-case basis.

1. Medication Management:

Psychotropic medications are prescribed under the care of a doctor, usually a psychiatrist. In cases where physical symptoms are severe, or sometimes in cases where functionality is severely affected, medication will be recommended. The individual will be provided with all information regarding the medication including: usage, side effects, expectations, duration of use, and supportive services needed with medication.

2. Talk Therapy/Counseling:

- There are a variety of therapeutic modalities utilized to help an individual to better process, understand, and treat their psychological distress. Some therapeutic modalities focus on restructuring one's thinking and thoughts and adjusting behaviors, others are focused on emotional processing and regulation, while others attempt a deeper intrapsychic psychoanalysis of patients in the interest of cathartic healing through understanding.
- Traditional Islamically Integrated Psychotherapy (TIIP): is an integrative modality that is rooted in an Islamic epistemological and ontological foundation that integrates modern behavioral science in nurturing psycho-spiritual equilibrium model.

3. Group Therapy

Group therapy is a useful tool for individuals to receive support from other people experiencing similar situations. These groups are guided by professionals. The structure allows for members to both receive support/guidance and empower others with support/guidance as well.

4. Family Support

A part of talk therapy will be to include support from loved ones. Having a support system in daily life is a source of healing. It is a reminder of what our loved ones mean to us as well our responsibilities towards them.

Islamically Integrated Mental Healthcare

4.01 Terms

<i>Tarbiyah</i>	Process of character refinement
<i>‘Aql</i>	Cognition
<i>Rūḥ</i>	Spirit
<i>Qalb</i>	Heart
<i>Nafs</i>	Behavioral inclinations
<i>Iḥsās</i>	Emotions/Sensation
<i>Inkishāf</i>	Introspective awareness
<i>Inqiyād</i>	Compliance
<i>I’tidāl</i>	Achieving balance across human elements: <i>rūḥ</i> , <i>‘aql</i> , and <i>nafs</i> , <i>iḥsās</i>
<i>Ittiḥād</i>	All parts of one’s psyche unite and work together in serving its primordial goal of connecting with Allah (<i>ma ‘rifah</i>) and actualizing their full spiritual potential
Therapeutic Alliance	The relationship between client and therapist that is essential towards building trust and understanding, creating a safe space for healing and working on therapeutic goals.

4.02 Mental Health in Islamic Theology

From an Islamic theological perspective, psycho-spiritual health is directly related to a human beings’ ability to actualize their primordial spiritual purpose. All human beings are created to tread a path that will ultimately ensure their salvation in the afterlife and their ability to acquire God’s pleasure. Health is thus, from an Islamic theological perspective, indicated by an individual’s successful ability to remain on this path of worship. Hence, any obstacles that obstruct their ability to tread this path is seen as detrimental to human functioning, irrespective of whether it meets the clinical threshold or not and whether or not it merits clinical intervention. As this pursuit is lifelong, there are moments when individuals will be able to successfully maintain a level of optimal functioning, while at other times spiritual or psychological impairment may cause them to stray from the path. Hence **any obstacles** that obstruct their ability to tread this path is seen as detrimental to human functioning and worthy of attention. This includes psychological, physical or emotional struggles that get in the way of our ability to worship Allah freely.

Modern psychiatric practice, on the other hand, defines disorder based on the Diagnostic and Statistical Manual of Mental Disorders (DSM) (American Psychiatric Association, 2013) and the International Classification of Disorders (ICD) that views mental illness as a significant impairment across social, occupational, or familial functioning with marginal attention afforded to human character flaws that lie beneath the clinical threshold. Thus, clinical terminologies are not synonymous with Islamic conceptions of optimal mental health, dysfunction, or even impact of disorder upon a patient’s religious status as this lies outside of the scope of normative clinical practice. A fundamental difference between an exclusively clinical conception of dysfunction

and Islamic holistic health is that Islam does not restrict dysfunction solely to the temporal world or to clinical impairment.

As outlined above, character flaws that adversely impact a patient's afterlife are also taken into consideration as well as those character traits that lead to poor functioning prior to their becoming significantly impairing. Clinical treatments within the Islamic theological framework are considered to be in service of the larger Islamic ethos rather than being restricted to symptom reduction or restoration of normative worldly functioning. These afterlife considerations significantly play into clinical decision-making on the part of a practitioner's or patient's selection or compliance with various modalities of treatment. Behaviors that may not be clinically significant according to the DSM or ICD may be seen as pathological in Islamic terms. For example, narcissistic traits that may not meet the clinical threshold of narcissistic personality disorder are seen as a potentially severe pathological character flaw in Islamic spirituality. The prophetic traditions, for example, warn of three spiritual "destroyers" (*muhlikāt*): "avarice (*shuḥḥ*) that is obeyed, material longing (*hawā*) that is complied with, and a man's admiration of his self (*i'jāb al-mar' bi nafsihī*)."¹ (al-Bazzār, Musnad al-Bazzār hadith no. 7293; see also al-Mundhirī, al-Targhīb wa al-Tarhīb, in which he grades the ḥadīth as fair, or *ḥasan*) Islamic spiritual masters warn that admiration of the self invites one down the path of arrogance (*kibr*), and arrogance is the root of a multitude of spiritual diseases. Most importantly, however, the ḥadīth informs us that the severity of arrogance in the heart is such that "he who has an atom's weight of arrogance in his heart will not enter the Garden" (Ṣaḥīḥ Muslim).

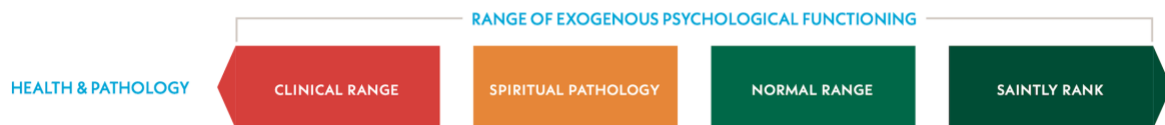


Figure 2

Although in modern clinical practice, treatment of character defects may be seen as potentially ethically controversial, a reconciliation between the two approaches is to offer such treatments within the religious frame of reference of the client that is consistent with their self-identified treatment goals as opposed to through a proselytizing approach (Keshavarzi & Haque, 2013). This mode of thinking is consistent with growing trends toward bringing spiritually-oriented psychotherapies into the mainstream healthcare practice (Richards et al. 2015). Certainly there exists significant research to demonstrate the clinical efficacy of the incorporation of spirituality into psychological practice oftentimes associated with better mental health outcomes (Anderson, Heywood-Everett, Siddiqi, Wright, Meredith, & McMillan, 2015; Hook, Worthington, Davis, Jennings, Gartner, & Hook, 2010; McCullough, 1999; Smith, Bartz, & Richards, 2007; Worthington, Hook, Davis, & McDaniel, 2011; Worthington, Kuru, McCullough, & Sandage, 1996; Worthington & Sandage, 2001).

4.03 Traditional Islamically Integrated Psychotherapy (TIIP) - Overarching Therapeutic Goals and Principles of Change



Figure 3

Process of Change (Patient)

Based upon the above the TIIP approach articulates four overarching patient goals of the psychotherapeutic encounter (Figure 3). It is noteworthy that the mechanisms of change listed below go hand in hand with the patient goals listed hereunder, as the therapist employs those mechanisms of change in order to induce the patient goals at each phase of the therapy. These phases are sequential and follow one another in a stage-wise manner.

1. *Inqiyād* or compliance: A strong therapeutic bond must be engendered in order for the patient to develop trust and commitment to the treatment process. Given that the patient will be requested to undergo difficult therapeutic tasks and endure an uncomfortable process of facing their intrapsychic issues, their motivation and willingness to engage in this process is necessary. In fact, the lack of motivation or noncompliance can compromise treatment, even if the most skillful practitioner equipped with the most effective interventional tools were to work with the patient. This commitment to comply with interventions is required to ensure the efficacy of treatments that are co-constructed by the therapist and patient. Thus, through the therapeutic vehicle of *murābatāh* or the formation of the therapeutic alliance, the patient will be more likely to embrace the demands and enthusiastically participate in this process.
2. *Inkishāf*, or introspective self-awareness. Introspective self-discovery is the next goal for the patient to experience. This is facilitated via the mechanism of *mukāshafah* or the guided self-examination the patient may start to gain insight into their cognitive, emotional, behavioral, and spiritual tendencies. Empathic exploration and evocations of internal experiences are central to this process (see chapter 7). An awareness of the internal psychological processes at play and sources of tension or distress is essential to creating an accurate and effective conceptualization of the patient and accompanying treatment plan. Imām al-Ghazālī states that *inkishāf* must be engendered within the context of a psycho-spiritual relationship with a spiritual mentor as it can be very difficult to uncover one's own blindspots without the mirror of a practitioner, helping the patient uncover their internal psycho-spiritual world.
3. *I'tidāl*, or equilibrium. An overarching process goal of the TIIP therapeutic modality is for patients to achieve *i'tidāl* or a state of balance and equilibrium among all of the composite parts of their psyche (i.e. *'aql*, *rūḥ*, *nafs*, *iḥsās*, *qalb*). An internal struggle will emerge during this process whereby the patient must be willing to endure the discomfort required for change to facilitate psychospiritual

equilibrium (*i'tidāl*). If, for example, a patient harbors excessive fear (*khawf*), they may suffer from a psycho-spiritual imbalance that leads to symptoms of anxiety. The patient will require therapeutic intervention not only to gain insight into the nature of their anxiety but to also help direct them towards balancing their excessive fear with healthy dosages its opposite i.e. hope in God (*rajā'*). This was referred to above reversion therapy as mentioned by Imām al-Birgivi and is a tool employed in the process of *mu'ālajah* described below.

4. *Ittiḥād*, or integrative unity. All therapeutic strategies and sequence of sessions are designed to address these three aforementioned overarching goals toward engendering the fourth and final goal of integrative unity, or *ittiḥād*. This is facilitated through *muwāṣalah* or continuation of the therapeutic process beyond the removal of clinical pathology or psychological imbalance. After balance has been achieved across each of the elements of the psyche, an integration of each of these elements such that they serve a unity of purpose is desired. There should be a unification of the different parts of the psyche that aid one another in the psycho-spiritual journey. In fact, disintegration is among the most central problems that many psychological theories address. Whether it is through parts therapy, treatment of trauma and dissociation, aspirations for congruence in humanistic therapies, gestalt therapy or otherwise, pathology is often characterized by some form of internal psychological disintegration. Thus, integration of the disparate parts of the human psyche can contribute to intrapsychic dissonance. A unity of purpose that allows one to move beyond the mere survival needs of the human experience can engender psychological resilience. By *ittiḥād*, we intend the integration of the interconnected parts of the psyche and the formation of an internal unity that allows the person to holistically serve their primordial goal of connecting with God (*ma'rifah*) and actualizing their full spiritual potential. Through achieving this state of integration, the believer achieves a synthesis of their total being with the will of God such that their actions become directed by God's desires. The previous step of *i'tidāl* has primed them to rid themselves of clinical pathologies (*takhliyah*) through *mu'ālajah* in order to be prepared for the further development of their psycho-spiritual capacities and the inculcation of positive virtues and traits (*tahliyah*). The restoration of a holistic balance is intended to provide a patient an insight into themselves that can eventually allow them to function as their own therapists and to independently identify when they are deviating from this unity or previously achieved equilibrium.

Core Mechanisms of Change Corresponding to the Process of Change (Practitioner)

These are the core mechanisms that the TIIP practitioner will employ in order to help their patient move across the developmental phases of psychotherapy and rehabilitation. Each of these therapeutic mechanisms that are utilized by the practitioner are the facilitators of the patient processes of change outlined above, for example *mukāshafah* utilized by practitioner should engender *inkishāf* in the patient.

1. *Murābaṭah*, or alliance and therapeutic connection. Many of the spiritual ascetics engage in a form of contractual bond or termed *bay'ah* or *'aqd*. Though, this is beyond the scope of the TIIP psychotherapy, the process of identifying the objectives, scope and mutual responsibilities of any human relationship is necessary. In psychotherapeutic practice this is known as the informed consent. However, in an Islamically oriented psychotherapy it is necessary for the patient and therapist to recognize the spiritual mandates of this relationship, which includes ethical conduct with one another and a bond built on shared faith and spiritual kinship. Thus, chapter 2 highlights the internal and external aspects of the relationship that are instrumental for effective treatment. In short, a strong therapeutic relationship is a critical in establishing a psychological forum conducive to

introspective self-awareness in addition to the appropriate training and knowledge-base of human psychology. Imām al-Ghazālī emphasizes the internal characteristics of righteousness while Imām al-Birgivi above outlines the characteristic of genuineness (*ṣidq*). Imām al-Bayjūrī mentions that in the process of enjoining the good and removal of evil (*amr bi-l-ma'rūf wa-l-nahy 'an al-munkar*) the practitioner must possess: i) knowledge of what he is enjoining upon the recipient, ii) that the intervention does not generate greater harm and iii) that the intervention is effective in leading the recipient to good or ceasing pathological behavior (al-Bayjūrī, 2002, p 329). If the first two conditions are not found, then it is prohibited for the practitioner to intervene while in the final scenario it is permissible to intervene though not mandated. Typically, spiritual practitioners' advice that in the early phases of forming the relationship, empathic following techniques should be utilized. This should include working on reducing patient defensiveness, developing trust, increasing comfort, engendering motivation to change and sparsely challenging the patient until the therapeutic relationship is adequately established is recommended. Once this is established a more directive process can be employed that would enhance the efficacy of one's interventions.

2. *Mukāshafah*, or uncovering: Classical Islamic scholars and physicians, such as Abū Zayd al-Balkhī (d. 312 AH/934 AD), Abū Bakr al-Rāzī (d. 303 AH/925 AD), Abū 'Alī b. Miskawayh (d. 408 AH/1030 AD), and ascetic scholars like Shāh Walī Allah, insist on the centrality of seeking assistance in order to gain awareness of one's cognitive, behavioral, emotional, and spiritual selves (Arberry, 2007; Badri, 2013; Hermansen, 1982; Keshavarzi & Haque, 2013). This is achievable through the patient's surrender to the supervision of a mentor, who leads the patient to a self-awareness of their personal faults, virtues, and intrapsychic dilemmas. The TIIP model sets this as a critical mechanism for change by providing an introspective forum conducive to the unveiling of the psycho-spiritual realities of the patient's self. The role of the practitioner is to create interventions designed to help facilitate the goal of self-awareness and collaboratively assess the patient's psyche.
3. *Mu'ālahjah* or intervention. *Mu'ālahjah* is the process of facilitating change or reformation in a patient. The therapist serves the role of a practitioner and spiritual guide (*murabbi*) by employing Islamically-integrated interventions targeting the four elements of the human psyche in the interest of engendering psycho-spiritual equilibrium (*i'tidāl*). The first part of the interventional process is to work on eliminating the internal psycho-spiritual imbalance and providing treatment with opposites (*mukhālafah*). This entails identifying the intrapsychic imbalances of the elements and applying resistance training toward the other extreme in order to restore the balance. This process essentially uses the concept of *mujāhadah* or spiritual struggle against the inclinations for avoidance of this process. For example, for avoidance behaviors, confrontation of feared or disliked actions will have to be implemented in order to counteract the unhealthy aversion to its positive opposites. If the alliance has been adequately formed, then it is likely that the patient will have been primed and prepared to undergo this process, as this phase is tantamount to psychological transformation. The ultimate goal of this phase is to free the patient major psycho-spiritual sicknesses (*takhliyah*) in order to move on to the next phase. Certainly, the practitioner is to artfully utilize any of the therapeutic tools within their possession within the therapeutic forum toward helping counterbalance the maladies of any of the components of the psyche. It is important for the therapist to identify the primary area(s) that drive underly the pathology and begin with this component of the psyche first. For example, if the patient demonstrates an emotional dysregulation that underlies their trauma, then it is important to start working on the emotion as opposed to addressing thoughts or behaviors, as these can be addressed in later sessions.

4. *Muwāṣalah* or continuity of treatment. The second phase of intervention helps to direct the patient toward the goal of *ittiḥād* or integrative unity. It is directed toward the consolidation of gains acquired as well as a review of therapeutic strategies employed to develop *i'tidāl* so that the patient can reassess the knowledge acquired in the facilitation of change. Additionally, higher aims are set for the patient toward the acquisition of character virtues given that core sickness has been eliminated (*takhliyah*). Other avenues and modalities of increasing spiritual growth and resilience are also explored as the therapist moves toward termination of psychotherapy. For example, if the patient had overcome social anxiety that initially inhibited him from being able to meet the rights of his family members, then at this stage, he will work toward strengthening those bonds through service and strengthening familial connection. At this stage working on the inculcation of virtues (*tahliyah*) that can serve as resilience building for the patient would be most suitable.

In conclusion, traditional Islamically Integrated Psychotherapy (TIIP) provides an overarching framework for the intersection of the modern behavioral sciences and the Sunni Islamic intellectual heritage. The various aspects of the human psyche discussed above are laid out in greater detail providing more specificity as well as providing a demonstration of its practical clinical utility in the coming chapters. In particular the core mechanisms employed by the practitioner is discussed in chapter, while section three of the book outlines the components of the ontological framework of the psyche.

4.04 Internal Framework of the Human Psyche

Keshavarzi & Haque (2013) outlined the composite parts of the human psyche as the (a) *‘aql* or cognition, (b) *nafs* or behavioral inclinations (c) *rūh* or spirit and (d) *qalb* or the heart (see Figure 4). The *qalb*, or heart, is the container for all health and pathology. It is important to note that the term “heart” can imply the physical structure as well as the spiritual aspect of it. Inputs from any of the domains results in the “blackening” or conversely “radiance” of the heart (see Table 1).

Elements of Human Psyche	Effects
Cognition – <i>Aql</i> - Reason - Logic - Thoughts - Beliefs - Knowledge - Biases	Heart – <i>Qalb</i> - Formation of Personality Traits - Narcissism - Arrogance - Jealousy - Envy - Deceit - Self-Consciousness - Kindness - Openness - Shyness - Modesty - Behavioral Expressions - Effects on Relationships - Residual Effects on: <i>Aql</i> <i>Nafs</i> <i>Ruh</i> <i>Ihsaas</i>
Behavioral Inclination – <i>Nafs</i> - Appetite - Desires - Sexual Needs	
Spirit – <i>Ruh</i> - Sensations - Unconscious Elements - Dreams - Visions - Catharsis - Sudden Awareness - Wisdom - Purpose and Meaning	
Emotion – <i>Ihsaas</i> - Adaptive/Maladaptive Emotions - Response to Exogenous Stimuli - Endogenous Emotions	

Table 1

1. ***Qalb*** – By *qalb* we refer to the spiritual heart, which is the receptacle of all health and pathology. Input from any of the other components results in either the illumination or darkening of the heart:
2. ***Nafs*** – Keshavarzi & Haque (2013) opt to semantically translate the terms *nafs* as behavioral inclinations. Based upon the conceptualization provided by al-Ghazālī, Mullā ‘Alī al-Qārī, al-Suhrwardī, the *nafs ammārah bi-l-sū’* or the *nafs* inclining toward evil is contained within the aspect of the human being as a social animal with survival/aggressive instincts (*quwwat ghaḍabiyyah*) and appetitive/carnal drives (*quwwat shahawiyyah*). Therefore, in its untrained state, the *nafs* is hedonistic and can expand its appetite. It is possible to liken the *nafs* in this sense to Freud’s conceptualization of the id. However, through refinement and training, the *nafs* is capable of advancement, nurturance, and development through various stages (ie *lawwāmah* and *muṭma’innah*) that elevates it beyond its animalistic lowly aims toward the divine directives of the *laṭīfah rabbāniyyah* or *rūh samāwī ‘ulwī*. The central mechanism for achieving this aim is through *mukhālafat al-nafs* or going against its animalistic instincts.
3. ***‘Aql*** – The *‘aql* is a rational faculty by which man is capable of attaining both certain and probabilistic knowledge. According to al-Taftāzānī, when man’s internal and external senses are functioning properly, the *‘aql* is what provides man the ability to come to realize certain and intuitive knowledge (al-Taftāzānī, Sharḥ al-‘Aqā’id pg. 104, along with al-Farhārī’s *al-Nibrās*). It is a metaphysical light that emanates from the *laṭīfah rabbāniyyah* that provides the faculty of reasoning, knowledge acquisition,

appreciation of consequences and ability to distinguish truth from falsehood (al-Bayjūrī 2002, al-Ghazālī, p 137). It allows individuals to appreciate the consequences of their actions and mediates and subjugates the harmful whims of the *nafs* (Ibn ‘Ābidīn, 2006). It is a faculty of reasoning that is necessary for ethical accountability and its absence would permit exclusion from liability and accountability under Islamic law.

4. **Rūḥ** – The *rūḥ* can be divided into two components, (a) the human being’s spirit and life force (*rūḥ ḥayawānī*) and (b) the spirit’s inclination (*rūḥ samāwī ‘ulawī*) toward the sacred and longs for reconnection and remembrance of the divine. The former is a drive that is the origin of putting the drives of the *nafs ammārah* into motion. The latter is the portion of man’s inner self that thirst’s for deeper meaning, purpose and transcendence to its primordial state of aspiring for divine presence that corresponds to the *nafs muṭma’innah*.
5. **Iḥsās** – The *iḥsās* component of man’s inner experiential experience and it is what we refer loosely to as an individual’s basic emotions. This is a secondary aspect of the human experience and may not warrant admissibility as a separate and distinct aspect of the human psyche. However, it has been included for conceptual purposes that is conducive to clinical case conceptualization. It can be seen as a byproduct of the interaction between *nafs*, *rūḥ* and *‘aql*. Emotions can have adaptive or healthy manifestations or become dysregulated and unhealthy, such as man’s innate anger, which is positive when it produces assertiveness and dysfunctional if it produces aggression.

All of the four of man’s inner domains are inevitably inter-connected. Thus, a change in any one domain will be expected to have an accompanying impact on the rest of the system (**Error! Reference source not found.** 4). Take, for example, a person suffering from hedonistic behavioral addictions. Such addictions can be expected to lead to cognitive rationalizations that will engender distortions in a person’s belief system or may result in emotional dysregulation, such as despondency, and hence a reduction in ritual religious practices that affect the spiritual heart. Figure 4 with these elements placed next to each other are **not** to be viewed as equivalent, given that the diagram does not denote a hierarchical structure. Rather, it provides a conceptual map conducive for therapeutic conceptualization and application.

TRADITIONAL ISLAMICALLY INTEGRATED PSYCHOTHERAPY

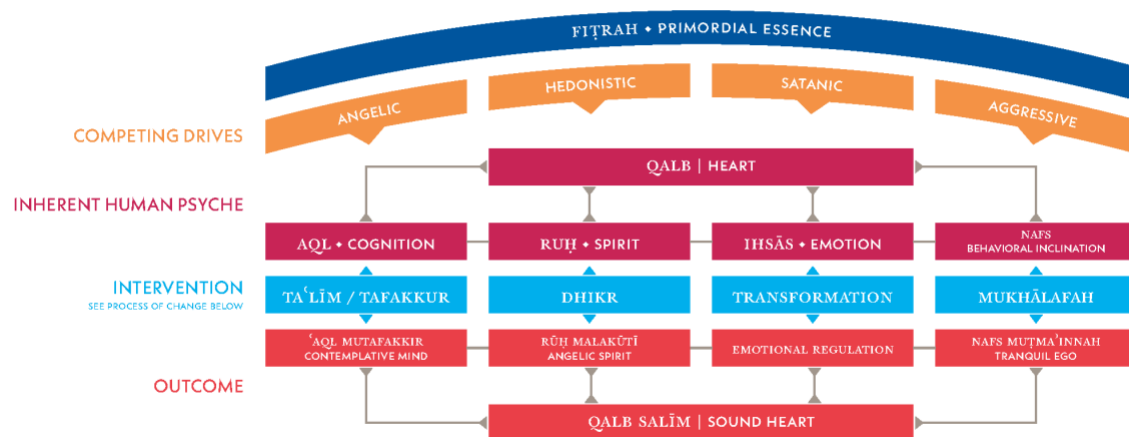


Figure 4

Psychological Implications on Islamic Jurisprudence

Muslims are required to follow the laws legislated through the Qur'an and the prophetic traditions. In Sunnī Islam, four classical schools codify Islamic law through a process of principled legal derivation from the classical Islamic sources: the Qur'an, the prophetic tradition (*sunnah*), legal consensus (*ijmā'*), and analytical reasoning (*qiyās*). These four Sunnī schools of Islamic law, the i) Ḥanafī, ii) Mālikī, iii) Shāfi'ī, and iv) Ḥanbalī schools, are attributed to their eponymous founders, the legal masters Abū Ḥanīfah Nu'mān ibn Thābit (d. 150/767), Mālik ibn Anas (d. 179/795), Muḥammad ibn Idrīs al-Shāfi'ī (d. 204/820), and Aḥmad ibn Ḥanbal (d. 241/855) respectively.

According to all of the four schools of Islamic law, a central prerequisite for legal responsibility (*taklīf*) of an adult Muslim is *ahliyyah*, or legal competence. Complete competence (*ahliyyah kāmīlah*) requires the existence and soundness of two faculties: i) mental competence, and ii) physical capacity. A child possessing both of these faculties (*ṣabīyy mummayiz*) and a mentally ill person with deficient intellect (*ma'tūh*) are considered possessive of only partial competence (*ahliyyah qāṣirah*) and thus, able to voluntarily transact and perform legal obligations, albeit with the permission and consent of their guardian (*walī*). The post-pubescent (*bāligh*) person of assumed sound intellect (*'āqil*), however, is considered fully responsible (*mukallaḥ*), competent of disposing wealth and engaging in contracts, bound to fulfill ritual obligations, and subject to criminal and civil law.

The presence of mental competence is understood in Islamic law to be indicative of the presence of willful intent (*irādah*) and sound understanding (*idrāk*), which are requirements for full responsibility and liability under criminal, civil, and ritual law. As a general principle, all individuals are assumed to be legally competent unless there is proof to suggest otherwise.

By this standard definition, it is clear that clinical definitions of mental illness may or may not fit into some of these categories. With respect to clinical mental illnesses, they may be categorized into three possible scenarios based on legal consequence in Islamic law (Bint Abdur Rahman, 2013):

- 1) Complete impairment and loss of mental faculties (*'aql*) such that it compromises one's ability to appreciate the consequences of their behavior (*idrāk*). This category qualifies an individual to meet the conditions of *junūn* (insanity), thereby exempting them from all legal obligations and mandating interdiction (*ḥajr*) from executing legal/contractual affairs. This category generally includes the more severe maladies such as psychotic disorders, manic episodes, moderate to severe intellectual deficiencies, and potentially panic attacks.
- 2) Partial impairment or loss of mental faculties, sometimes referred to as *junūn juz'ī* (partial insanity). This category refers to an individual who is impaired only in a specific area of functioning and thereby legally exempt only in those circumstances. An example of this might include an extreme obsessive compulsive disorder in which an individual is unable to control their compulsive behaviors and which can potentially impact the legal effectiveness of contractual statements like that of divorce issued while in that state of mind.
- 3) Potential mental impairments, which have no impact on *ahliyyah*. These include milder depressive clinical episodes and do not alter the legal status of the individual. The patient is still fully responsible under the law irrespective of their clinical status. This may include dysthymia or milder expressions of anxiety disorders.

It must be kept in mind that the absence of impact upon *ahliyyah* does not preclude or undermine the potential importance of treatment. Although impairment may not meet the legal threshold to afford any dispensation for

fulfilling their legal obligations, treatments are still valuable, particularly if they can nurture optimal functioning and enhance their ability to more fully carry out religious duties.

Islamic legal jurists actually differ with regard to the status of clinical treatments and interventions. Whereas all four Sunnī schools concur that seeking medical treatment is permissible, the Shāfi'īs elevate it to being religiously praiseworthy (*mustaḥabb*) if a positive prognosis of treatment is established in the scientific literature and it is established that treatment will enhance one's ability to be a fully contributing member of society (Qureshi, 2016). On the other hand, some Ḥanafis offer that if prognosis of treatment is positively established then treatment is mandatory (*wājib*), since the established means of being able to fulfill religiously obligatory acts are themselves mandatory. In other words, since psychological treatment is a means of being able to meet the basic prerequisites of *taklīf* and rendering one capable of following the commands of Islamic law, adopting such means would be mandatory.

Mental health treatments can be of two types: (i) clinical treatment, or (ii) pastoral/spiritual interventions. Though there is significant overlap between the two, clinical or medical care as a modality of mental health treatment has historically been recognized by Muslims and evidenced by numerous hospital systems in the Muslim world that contained psychiatric wards and specific treatments for the mentally ill (Rajab, 2015). Spiritual or pastoral interventions are directed towards spiritual sicknesses considered to be less severe and which do not cause significant clinical impairments.

Ritual and Civil Law

In ritual law, Muslim jurists unanimously agree that during a period of complete insanity the *majnūn* (mentally insane) is relieved of the legal responsibility to perform any of the acts of worship. Differences among the jurists did arise, however, regarding the clinically insane individual who could recover, temporarily or permanently, from their insanity during the period of *taklīf* (legal responsibility) (Ibn 'Ābidīn, *Radd al-Muḥtār* 2:247; al-Mawṣilī, *al-Ikhtiyār* 5:41). In the case of ritual prayers, a complete day of uninterrupted insanity qualifies an individual to be classified as continuously (*muṭbiq*) insane and thus absolved of the responsibility to pray, while for fasting the minimum is a month, and in charity a year ('Abd al-'Azīz al-Bukhārī, *Kashf al-Asrār* 4:264). Regardless of the duration of insanity, a *majnūn* is treated as exempt from liability and legal responsibility with the exception of cases of damage to property or body, in which cases the guardian (*walī*) of the insane is obligated to compensate for damages or pay blood-money (*diyyah*) from their wealth. (al-Mawṣilī, *al-Ikhtiyār* 5:41; al-Maqdisī, *al-Mughnī* 8:383).

Insanity additionally affects issues of personal status, including marriage, divorce, informed consents, healthcare decision-making and child custody. Insanity, for example, may be considered valid grounds for annulling a marriage contract (Ibn 'Āking, *Radd al-Muḥtār* 3:501; Ibn al-Humām, *Fatḥ al-Qadīr* 4:303–306). A mentally ill husband is considered incapable of deciding on a divorce (*ṭalāq*) or even mutual annulment (*khul'*). On the issue of child custody and legal guardianship, virtually all Islamic jurists agree that a child's custodian has to be sane and mentally competent as insanity may be grounds to revoke the right of child custody for the duration of the madness (Ibn 'Ābidīn, *Radd al-Muḥtār* 3:556; al-Zurqānī, *Sharḥ al-Zurqānī* 4:475; al-Bahūtī, 5:498–499; al-Shirbīnī, 5:198).

The *majnūn* is also incapable of serving as a witness in court (*shāhid*), making a bequest (*waṣīyyah*) from their own wealth, serving as a guardian (*walī*) or legal representative (*wakīl*), or even as a judge (*qāḍī*) or manager of an endowment (*waqf*) (al-Ramlī, 8:292; Ibn 'Ābidīn, 5:486, 417; al-Mawṣilī, 2:163).

Counseling: Process and Skills for First Responders

6.01 Building Alliance

The Prophet (may Allah bless him and grant him peace) used to receive people warmly, welcome them and let them be comfortably seated. After he would shake their hand he would never draw away his hand from the other person's hand until the latter drew away his hand. Most of the time, the Prophet would face complete the person he was talking to, demonstrating active and attentive listening, while communicating utmost importance of the individual seeing him (Barise, 2005).

Goal: Building an alliance creates a safe space for the person to speak openly and encourages trust between responder and the person.

Components of Alliance:

- Attention: This means you are paying attention to the person and the message they are trying to relay. You are paying attention to their verbal and non-verbal messages.
- Safety: The physical space you are in is free of distractions and is a place the person feels safe. This may mean speaking to someone in a space they feel comfortable in or making sure your space is comfortable and open.
- Privacy: Ensuring privacy and confidentiality is key in building an alliance. When people have assurance that their information will remain private it creates a trusting and emotionally safe environment to open up.
- Unconditional Positive Regard: creating a non-judgmental listening space. This means you are listening to the person and keeping your judgments out of your responses and guidance. This can be difficult to do. Maintaining awareness about personal biases can help be prepared for possible reactions you may have which helps to keep them out of the safe space you are establishing.
 - Unconditional: There are no conditions that the therapist places on the client in this relationship
 - Positive/Non-Judgmental: The therapist cares about and likes the client as a human being
 - Regard: The therapist thinks positively and believes in the client

Nonverbal Strategies in Building an Alliance:

- S – face client squarely
- O – adopt an open posture
- L – lean toward the client
- E – frequent eye contact if culturally appropriate
- R – relax

Islamic Considerations and Applications:

- It is essential to get within frame of reference of person: Avoid approaching the person's crisis or dilemma from your mindset. Understand where that person is emotionally and meet them there.
- Understanding does not = agreement. You can understand a person's pain or struggle without agreeing with their choices and decisions. Being a first responder means to understand and empathize with the situation they are bringing to you.

- After understanding their experience, this will strengthen your ability to offer suggestions and empathetically attune towards Islamic ideals later on.

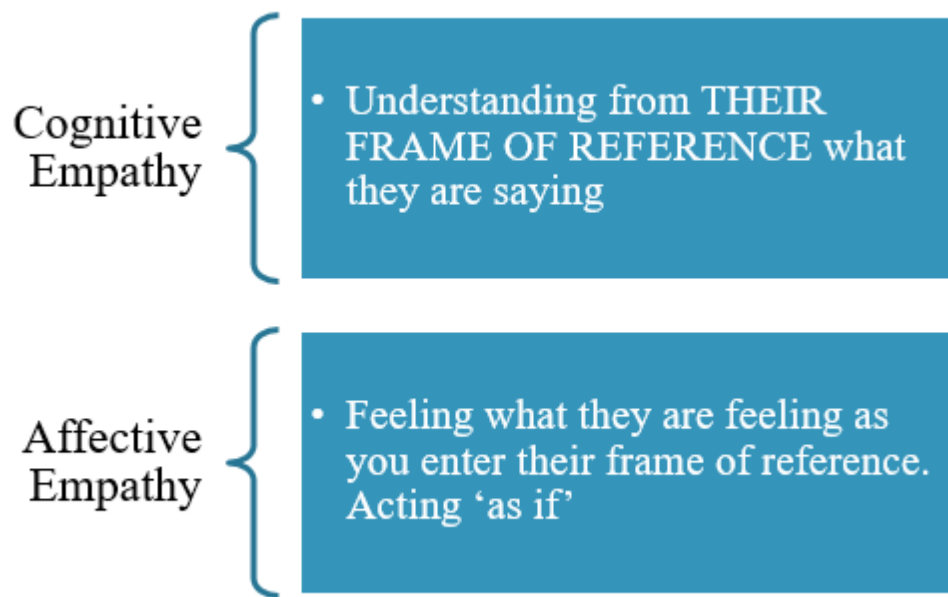
What to AVOID:

- Rehearsing: Thinking about what your response will be while the person is still speaking can distract you from their message.
- Placating: While this can help to defuse a hostile situation, when someone is expressing their emotions, attempting to appease their emotions may minimize their feelings. This does not create alliances or connections.
- Identifying: There will be situations that you may be able to relate to. Bringing in your experience takes away from the person's experience. It is important to be aware of your personal reactions and avoid bringing them into your conversation and guidance.
- Judging: Judgment creates hostility as well as value to the person's actions. The goal is not to place a right or wrong value on what the person is experiencing. Rather listening with an open mind allows for the person to open up. Once they feel comfortable and safe, they will be more accepting of guidance.
- Being right.
- Lecturing: When we hear about people's problems it is easy to get into advice-giving mode. While guidance will be needed at some point, initially the goal is to listen and empathize. When the time for guidance comes, it is important that it be relayed with empathy and genuineness.
- Discomfort with the content of what the client is bringing to you: First responders will potentially hear about many difficult and complicated situations. Check in with yourself before talking with someone so you are ready mentally and emotionally ready.
- A Fiqhi based analysis of the questions: While Islamically informed guidance is the goal for first responders, the initial stages of gathering information and building alliance must be done with an open mind and empathic understanding of the person's situation.

6.02 Empathic Response

Empathy is understanding another person's experience. It fuels connection when you respond to a person's experience with an understanding of their emotions and thoughts. A person will feel heard and understood which will encourage them to open up to you more.

Empathy is NOT sympathy; Sympathy is feeling sorry for someone. When someone is seeking support or guidance, receiving sympathy may make them feel pitied and judged which will hinder them from giving more information.



How Do We Do This?

- Restate or summarize what the client says in your own words that captures:
 - What they are saying (cognitive empathy): Avoid parroting what they are saying. Rather summarize what you are understanding from the content of their message
 - What they are experiencing (affective empathy): This is an attempt at understanding their inner feelings/emotional experience with the particular topic. This can be done by reflecting what they are feeling. For example: “That sounds frustrating” (something they didn’t necessarily say but you felt from them)
- When summarizing, you may need to interrupt them. You can do this in a way that lets the person know you are attempting to understand what they are saying completely and clearly
- Minimize questions: Sometimes questions will be important to get necessary information. However when you reflect a person’s emotional message to them, they naturally provide more information as they feel more understood. Fit questions can be used too. E.g.: “Does that sound right to you? Does what I said seem to fit for you?”
 - Avoid “Why” questions. These questions can be interpreted as judgmental and may break connections. Instead ask “How” or “What” if needed

Empathy is expressed in your tone of voice and non-verbal messages as well. You can create an empathic connection by showing attention and presence in your body language and facial expressions.

6.03 Listening

Active Listening: Listening with all senses. With active listening, you are concentrating and identifying the person’s message based on their words, tone of voice, nonverbal cues (body language, facial expressions) and the emotional meaning of their message. You are not just hearing what they are saying; rather, you are understanding them.

Verbal

Non-Verbal

☐ **Summarize:** Avoid parroting, paraphrase message that you understand

☐ **Body Language:** Lean in, make appropriate eye contact, be mindful of physical space between you and the person

☐ **Reflect:** reflect the feeling he/she is trying to relay

☐ **Facial Expressions:** mirror their feelings

☐ **Clarify:** Ask open ended questions that will help get more information or "I want to make sure I understand..."

☐ **Tone of voice:** Calm, empathic

6.04 Practice

Respond with an empathic statement that demonstrates understanding of the person's message to each of the following questions. Do not use clarification or questioning for the following statements, the goal is to reflect empathy with the information given:

1. Is it true that a lot of people feel this way? I thought I was the only one with such sinful horrible thoughts?
2. No one can understand this pain. Sometimes I just want to hurt myself.
3. All of these things keep happening and I don't know what to do!
4. Why do I feel so down all the time...like I have no energy? I want this to stop.
5. I don't want anyone to find out I am talking to you. I just don't know what else to do right now. The situation at home...
6. I got diagnosed and then just...didn't want to talk about it. Who's going to care anyway?
7. What do you mean I need professional help? I'm not crazy!
8. I hate everything. School...home...what's the point of it all?
9. He/she (spouse) is taking over my life. I don't know how to handle this anymore.
10. How can I believe in God anymore? Why would God let this happen to me?

6.05 Summary

- A therapeutic alliance is essential in creating a safe space for individuals to discuss their concerns.
- Components of a safe space include: nonjudgmental, unconditional positive regard, and empathy.

- 
- Empathy fosters connection and encourages people to feel more inclined to discuss their dilemmas/concerns.
 - Active listening is an empathic way to show the individual you are present, willing to hear their message, understand their feelings, and provide guidance.
 - Questions and clarification are a way of active listening. However, avoid judgmental questions such as “why?”

Responding To Crisis

7.01 Understanding Crisis

Crisis: An emotional upset, arising from situational, developmental, biological, psychological, socio-cultural and/or spiritual factors. This state of emotional distress results in a temporary inability to cope by means of one's usual resources and coping mechanisms. Unless the stressors that precipitated the crisis are alleviated and/or the coping mechanisms are bolstered, major disorganization may result. It is recognized that a crisis state is subjective and as such may be defined by the individual, the family, or other members of the community (Hoff, 1995; Ontario Ministry of Health and Long-Term Care 1999).

Common Crisis Responses

- Blaming Allah
- Isolating self from loved ones
- Feeling unmotivated
- All or nothing thinking
- Negative thinking

Crisis Intervention: A process that focuses on resolution of the immediate problem through the use of personal, social and environmental resources. The goals of crisis intervention are rapid resolution of the crisis to prevent further deterioration, to achieve at least a pre-crisis level of functioning, to promote growth and effective problem solving, and to recognize danger signs to prevent negative outcomes (RNAO, 2006; Hoff, 1995).

7.02 Crisis Response

1. Develop Rapport : Use empathy, active listening, create trust
2. Identify the problem/crisis. Assess for:
 - a. What is the concern and how is it impacting the person's functionality.
 - b. What is the level of distress?
3. Gather information through Mental Status Exam (MSE)
4. Facilitate individual's understanding of crisis
5. Intervention:
 - a. Explore new ways of problem solving and decision making: What have you done in the past to get through difficult times? What else can you think of to try to get through this?
 - b. Facilitate and mobilize support network
6. Create a crisis plan
 - a. Keep a written record of interventions provided including dates and times
7. Try to form a partnering relationship between family members, the individual in crisis, and yourself
8. Identify support system: Who are the people this individual can turn to in this situation.
 - a. Family members
 - b. Friends
 - c. Imams
 - d. Local support groups

- e. Crisis lines
 - f. Professionals (counselors, doctors, police)
9. Guidance towards next steps of care

7.03 Referral

Barriers:

- Stigma: In collectivistic communities, seeking help can be looked down on. It is even more shameful to discuss personal family matters with outsiders. Understand that the person may have a negative idea about what counseling is.
- Misunderstanding of Counseling: There is a lack of information about what counseling is and how it works. There is an assumption that only “crazy” people seek therapy and it is not necessary for any other types of concerns.
- Fear of Talking to a Professional: Talking to a professional means the problem has become very real. This is a scary thought, especially if you believe the professional will give you medication or fail to understand your religious/cultural background.

What You Can Do:

- Clear statements about referral and what it means: State directly and clearly that you believe counseling is a beneficial next step. This individual has sought you out for advice. This most likely means they hold value to what you say. If you have taken the time to develop an alliance and create a safe space, your direction towards counseling will be easier to receive.
- Provide information about counseling: Clear any misconceptions the individual may have about counseling. Address any stigma or fears they express to you. Inform them of what counseling is and how it can be a beneficial source for them.
- Credential your referral using Islam: Oftentimes, patients may be concerned that what they are doing is not Islamic by going to a mental health provider. Or it somehow indicates a spiritual deficiency. Or that the provider is secular, how could they possibly help me? It is important to talk about health and wellness in Islam and how interconnected physical and mental health is to one’s spiritual well-being.
- Clear guidelines about your role (if any) in the referral and treatment process: Make sure the person and you are on the same page when it comes to your continued role in their care. This will differ from case to case. Set these guidelines right away so the person is aware of how you may provide support for them.

Common Misconceptions:

Q: If I talk to a counselor, will my child be taken away?

A: A counselor is mandated to report child abuse or neglect. This means the child is being beaten, or their basic needs of food, clothing, shelter, etc. are not being met and they are in an unsafe environment, or they are being tortured in some way. Talking to a therapist for guidance with parenting or being given a mental illness diagnosis is not grounds for your child to be taken away.

Q: If I talk to a therapist, will my husband (or spouse) be arrested or get in trouble?

A: If you are experiencing domestic abuse and are seeking counseling for support, your therapist cannot report it to the authorities. Confidentiality is an essential part of therapy and your therapist will maintain it. This includes reporting abuse to authorities. In cases where minors are not involved, reporting is not mandated.

Q: Am I crazy if I need counseling?

A: Counseling/therapy is a structured method of receiving care and support when there are struggles and conflict in life. People seek counseling services for many reasons: guidance, additional support, direction, or treatment for mental illness. Having a mental illness does not mean the person is crazy. It means there is a struggle and pain in a person's inner self and it is necessary to address and treat it. Treatment and using the treatment/guidance given by the therapist can add to quality of life.

Q: What if my therapist knows people I know?

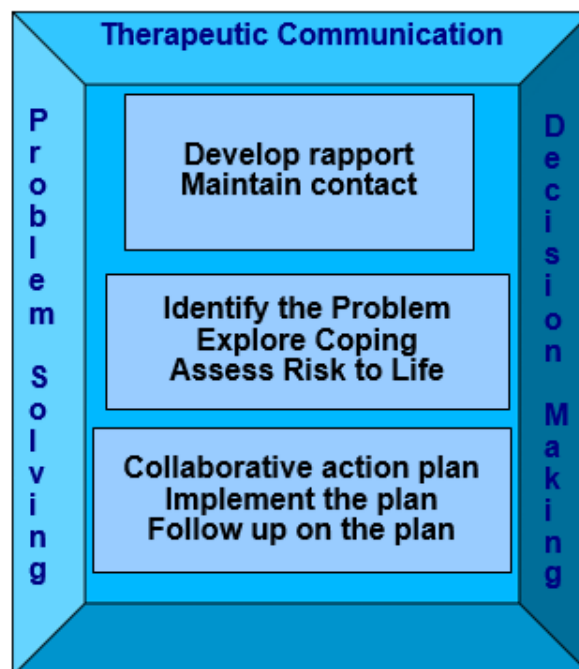
A: Our community is small. If you are going to see a Muslim therapist, this may happen. Therapists are required by law and ethics to maintain their clients' confidentiality. This includes not disclosing their identifying information to anyone. This means even if you run into your therapist in community gatherings, he/she will not acknowledge that they know you.

Q: Does going to therapy mean I need to take medication?

A: A therapist does not provide medication. A psychiatrist does. The therapist may recommend medication based on the severity of symptoms. No one is required to take medication. If psychotropic medication are needed, your therapist will provide you with all the necessary information for you to make an informed decision about your choices. If you choose to take medications, you will do it under the guidance and care of a doctor/psychiatrist, while continuing your therapy.

7.04 Mental Status Exam

Appearance	Age, sex, posture, eye contact, dress, grooming, manner, facial expression
Motor	Retardation, agitation, unusual movements, gait, catatonia
Speech	Rate, rhythm, volume, amount, articulation, spontaneity
Affect	Stability, range, appropriateness, intensity, affect, mood
Thought Content	Suicidal or homicidal ideation, depressive cognition, obsessions, ruminations, phobias, ideas of reference, paranoid ideation, magical ideation, delusions, overvalued ideas, other major themes
Thought Process	Coherence, logic, stream, perseveration, neologism, blocking, attention
Perception	Hallucinations, Illusions, depersonalization
Insight	Awareness of Illness



7.05 Summary

- Crisis is emotional distress that impairs a person's ability to effectively cope with ongoing situations.
- Crisis response is immediate care and guidance towards next steps.
- An MSE is a useful assessment tool to understand the functional level of the individual and identify steps of care.
- Action plans created to address crisis should be collaborative. The person experiencing the crisis should be involved in the plan. A written plan is best practice as it is a concrete reminder of what needs to be done.
- Identifying a support system for the individual is an essential part of the plan. The support system includes: family members, friends, mentors, counselors, Imams, emergency services, doctors, etc. The support system needs to meet various levels of care.

Understanding and Responding to Suicide

8.01 Understanding Suicide

The American Foundation for Suicide Prevention reports that Suicide is the 10th leading cause of death in America. While women are more likely to attempt suicide, men are more likely to attempt and complete suicide.

The National Institute of Mental Health reports:

- Over the last 15 years, suicide rates have increased by 24%
- Suicide completion rates are about four times higher in males while females have higher attempts.
- In 2015 there were twice as many suicides than homicides in the United States

When working with suicide cases, it is important to be aware of personal attitudes and beliefs about suicide. Bringing your personal attitudes/beliefs in your response and care of this person can be harmful to the individual and hinder any plan of action to help guide the person away from suicide.

Signs	Verbalizations	Feelings
- Change in behaviors (eating, sleeping, social interaction) - Significant change in appearance (weight, hygiene) - Isolation	- "It will all end soon" - "I'm done" - "I can't do this anymore" - "No one can help me"	- Worthlessness - Guilt - Sad/lonely - Hopeless - Helpless - Desperation - Anger

8.02 Concepts

Suicidal Ideation	Thoughts about suicide, death, or wanting to quit life. Hopelessness and isolation accompany this
Suicidal Behavior	Actions done before suiciding. Examples: saying goodbyes, giving away possessions, loss of interest in activities/daily routine
Plans	The person has a specific plan of how they want to suicide
Means	Tools to suicide
Previous Attempts	The person has attempted suicide in the past but failed
Wall of Safety	People, accomplishments, goals, beliefs, hobbies and passions that will protect individual from suiciding

8.03 Active versus Passive

If a suicide case is identified, it is important to assess what stage the person is at in their suicidal thoughts:

Category	Description		What to do
	Harm to Self	Harm to Others	
Passive Thoughts or Ideations	Individual says “sometimes I feel done!” or expresses that at times they don’t want to live- ASK QUESTIONS. You need to assess to see if they are actively suicidal. If they are not and they appear to be in distress	If the individual is angry with someone and says “I wish I could hurt them...” ASK QUESTIONS- assess the situation. If they are just talking through their feelings- give them the time they need. Provide empathy and support.	- You will ask them to make an appointment with a therapist and get them in for a session ASAP. - If they appear to be in extreme distress but are not actively suicidal or homicidal give them information about getting to a hospital and recommend they do this or make first responder referral - You will recommend relaxation techniques
Active Thoughts Without a Plan or Means	The individual says they are suicidal. However, they have no specific plans or tools to go through with it. You can tell they are distressed.	The individual says they want to hurt someone. They have no means or plans. It feels like they are blowing off steam. Use calming statements/relaxation techniques	- You will be empathic and give them space to talk - You will ask them to get to the hospital - You will ask them if they need an ambulance - If you feel that they are in extreme distress you will call 911 - You will stay on the phone until help arrives - Use calming statements/relaxation techniques

Active Thoughts Without a Plan or Means (continued)			Harm to Others - You will ask questions to get more information to make sure they will not harm anyone. - You will get them to a place where you are sure they will not harm someone - If this is not happening you will call 911 and stay on the line
Active Thoughts with Plan/Mean	The individual says they are actively suicidal. They have a plan in mind and have the means to do it (ex- they have a knife/blade and they say- "I am going to cut my wrist")	The individual says they want to harm someone (I am going to kill... or set fire to.) They have a specific plan and they have the tools to do so. You identify that this person is going through with their plan	- You will call 911 - You will get callers/chatters location - You will stay on the line with them and talk to them until help arrives - Use calming statements

8.04 Response and Intervention

1. Ask Questions! If you suspect someone is ready to suicide or is having thoughts, explore this with them.
2. Do not be afraid to use the word suicide.
3. Listen and use empathy to connect with their story.
4. Find a point in their story that you can use to bring them away from suicidal thoughts.
5. CALL 911 if thoughts are active or the person has means/plans to suicide.
6. If thoughts are passive or person has no plans/means, create a safety plan or "No Harm Contract."
7. Create a Wall of Safety: This includes everything that motivates a person to live and reject suicide.

8.05 Wall of Safety

The following are areas to assess to gauge a person's support network as well as to guide them away from suicidal behaviors/thoughts:

- People I love
- People who love me
- My spiritual/religious beliefs
- What I value
- People I can turn to for help
- Things I love to do
- Things I want to try

8.06 No Harm Contract

A No Harm Contract is a safety tool you can use in cases where individuals have suicidal ideation but no plans/means. IF there is a plan or means, hospitalization and emergency services are required.

The No Harm Contract is a pledge from the person to you that they will not suicide. If they have suicidal ideation they will seek out services. You will add multiple services for them to seek out. It also includes the Wall of Safety. The more specific it is the more beneficial it is. The No Harm Contract does NOT guarantee the individual will reject suicide. It is a tool that can be used in hopes to prevent them from suiciding.

Use your judgment! If the individual is giving you signs of active thoughts, guide them towards emergency services!

8.07 Summary

- Suicide is one of the leading causes of death in America.
- A person generally experiences extreme psychological and emotional distress when thinking of suicide.
- Be mindful of your reactions. Do not bring in your personal beliefs.
- There are some common signs that indicate suicidal behavior such as giving away possessions, statements of hopelessness, or extreme changes in daily behavior/appearance.
- It is IMPORTANT to ask questions and explore suicidal thoughts with someone presenting with suicidal ideation.
- It is IMPORTANT to seek emergency services when needed (active thoughts or plans/means).
- Do not be afraid to use the word suicide.
- A Wall of Safety provides a written reminder of why a person can reject suicide. Ask questions and explore to create the Wall of Safety.
- A No Harm Contract is a written tool in which an individual commits to reject suicide. It is NOT a guarantee that they will reject suicide.

8.08 No Harm Contract Sample

I _____ make a commitment to living. I will reject suicidal thoughts and harmful behaviors that can lead me towards suicide. I will not attempt suicide or any self-harming behaviors.

If I have suicidal thoughts I will reach out to:

The crisis line I will call is _____

People in my life I can turn to for support are:

Name: _____ Phone Number: _____

Name: _____ Phone Number: _____

Name: _____ Phone Number: _____

Things I can do to feel better:

My values are:

People I love:

Signature: _____

Witness signature: _____

A Collaborative Care Approach

Collaborative care includes attending to the client or person's need in a holistic manner with the guidance of experts from different modalities. Our goal in collaborative care is to have our religious leaders and scholars as well as psychologists and mental health experts involved in care and guidance. This collaboration can include other professionals if the situation warrants it such as: lawyers, doctors, crisis experts, law enforcement officials, etc.

When creating a team it is imperative to determine a common goal. In mental health care, the goal will be facilitating behavioral and psychological change in a supportive, empathic, and clinically beneficial environment.

9.01 Roles

Always practice within your scope of expertise. It is vital to remember to stay in your role. Each professional will have a specific role and everyone must adhere to:

- Imams/scholars/religious community leaders: These individuals are qualified and learned in the Islamic sciences. They are able to provide religious guidance, religious rulings, and spiritual guidance/support- based on the needs of the situation.
- Therapists/counselors: Professionals who have completed their education in their respective fields and are licensed to practice as psychologists or mental health professionals. They provide evidenced based therapy techniques to people with mental illness or people struggling with family/social issues etc.
- First responders: These individuals have been trained to respond to individuals or communities/groups in crisis. They have the training to respond to the initial needs and direct people towards appropriate services. First responders who also have religious education and training will be able to provide spiritual guidance and Islamic direction as well.

9.02 A Collaborative Care Model for Adjudicating Legal Cases between Practitioners and Clergy

In determining the application of any ruling (obligation, dispensation, prohibition, etc.) to a specific case, jurists seek to identify the existence of authoritative religious statements (Qur'ān or ḥadīth) that speak to the issue and can form the basis for a ruling. As mentioned previously, after the jurist uncovers the relevant legal rulings and realizes that such rulings are contingent upon the mental status of the subject, the psychological expert may be called upon to clarify the applicability of the ruling to the subject. Specifically, they may be consulted to determine whether the subject's psychological functioning or clinical symptomology could have impaired any of the relevant legal criterion to rule some as legally insane or any one of its subtypes. Therefore, it is necessary for the jurist to translate these expert findings or assessments into Islamic legal terms.

For example, the fear of loss of mental capacity (*khawf dhahāb al-ʿaql*) is a classical legal consideration in lifting normative legal restrictions in Islamic law, such as in the case of a widow who is mandated to pass her



mourning period (*‘iddah*) in her marital home unless she finds herself in such solitude that, beyond mental discomfort, it is feared she will lose her mind (*dhahāb al-‘aql*), in which case she may choose a separate residence (Ibn ‘Ābidīn, *Radd al-Muḥtār*). By analogy, the permissibility for abortion may be sought within Islamic law for a woman that may endure overwhelming psychological harm by pregnancy or birth. However, what constitutes significant distress and how this condition would be operationalized within the law is unclear. Hence the Islamic jurist could be assisted by an expert in gathering the necessary psychological variables and in performing psychological assessments, as is the role of a forensic psychologist, to prove overwhelming psychological harm (*ḍarar*) or the likelihood of the loss of mental capacity (*dhahāb al-‘aql*). Mental health experts can thus play a critical part of the judicial process in that their expertise may assist jurists in deciphering the actual context of the legal ruling (*ḥukm*) and help identify whether any of the clinical indicators of psychopathology fit one of the legal categories of insanity and its subtypes. In essence, arriving at conclusions with the aid of psychological or cognitive assessments can have implications about the legal status of the individual, thereby impacting even healthcare decision-making such as the patient’s autonomous ability to provide consent for treatment or enter into a treatment contract.

Legal and Ethical Privileges and Responsibilities

Working for the community comes with the responsibility of safety, for the service provider, individuals seeking service, and the community as a whole. Legal and ethical responsibilities encompass various aspects of the interaction between provider and community member including: confidentiality, defining reportable situations, defining role of the provider, and limitations it may come with. There are two categories to consider: Legal responsibilities and ethical responsibilities.

Legal Responsibilities: Responsibilities, boundaries, and limitations set in place by your local government which may vary state to state. While there are some general laws that have to be adhered to, even across state lines, the parameters of that law may look different in different states.

Ethical Responsibilities: Role and limitations defined by the profession. These rules create the standard for how the provider interacts with community members when working. They also create a standard for decision making in these settings as well as limitations in the role the provider may have in given situations.

As Muslim providers, we adhere to both the legal and ethical responsibilities set by our laws and professions. We also adhere to the religious responsibilities and guidelines given to us by Allah, which come with working for our fellow brothers and sisters in Islam.

Service Providers:

- Psy.D or PHD in Clinical Psychology
- Psychiatrist or MD
- Social Workers – LSW, LCSW
- Counseling – LPC, LCPC, LPCC
- Marital and Family Therapist – LMFT
- Pastoral Counselor: Can be certified by American Association of Pastoral Counselors (AAPC)
*Requires CPE's
- Chaplain: Board of Chaplaincy Certification

Counseling is not a protected term. However professional counseling is. Hence, for professional counseling, state licensure is needed. However, pastoral counselors are not required to be licensed. Therefore, the two services have variances in their guidelines. Below are the legal and ethical considerations for pastoral counseling.

10.01 Confidentiality

Q: Does your Masjid have to comply with HIPAA?

A: Mosjids that self-administer health plans and have over 50 participants are subject to the privacy-protection rules of HIPAA.



Masjids that are subject to HIPAA will need to create, document, and implement a privacy plan to ensure they keep employees' private medical information confidential. This written plan needs to include:

- Designation of a certain employee as the plan's "Privacy Official" to administer the plan.
- Creation of a privacy-training program.
- Creation of internal guidelines and procedures to ensure that they protect private health information by making sure no unauthorized persons see it.

Confidentiality with Community Members:

There is a moral and legal responsibility to keep information about community members confidential. This includes ALL identifying information and specifics about the case. If consultation is needed, it is best practice to let the individual know you will be consulting with a colleague without giving away any personal or identifying information.

Clergy-penitent privilege: the legal mechanism that prevents clergy or counselors from being required to disclose confidential communications in a court proceedings.

- The purpose of the clergy-penitent privilege, as articulated by the United States Supreme Court, is the recognition of "the human need to disclose to a spiritual counselor, in total and absolute confidence, what are believed to be flawed acts or thoughts and to receive priestly consolation and guidance in return.
- Only six jurisdictions have expressly abrogated the privilege with regard to mandatory reporting laws (New Hampshire, North Carolina, Rhode Island, Tennessee, Texas and West Virginia). The remaining jurisdictions do not specify whether the privilege continues to apply in these situations, leaving clergy members in limbo as to their duties under the law in such situations.

10.02 Mandated reporting

This term is typically in reference to reporting child abuse or neglect. Mandated reporters will call their state's Department of Children and Family Services (DCFS) (or equivalent) to report cases of physical/sexual abuse, or harm and neglect of a minor (0-17 years old in most states). The parameters of what constitutes as child abuse or neglect may differ from state to state.

"The Child Abuse and Prevention Treatment Act defines child abuse and neglect or child maltreatment as:

Any recent act or failure to act on the part of a parent or caretaker, which results in death, serious physical or emotional harm, sexual abuse or exploitation, or an act or failure to act which presents an imminent risk of serious harm.

- Neglect is a failure to meet the child's basic needs, e.g., not providing enough food, shelter or basic supervision, necessary medical or mental health treatment, adequate education or emotional comfort

- Physical abuse refers to the injury of a child on purpose, e.g., striking, kicking, beating, biting or any action that leads to physical injury.
- Sexual abuse is the use, persuasion or forcing of a child to engage in sexual acts or imitation of such acts.”

Criteria:

- Alleged victim is a child under the age of 18 (minor).
- Alleged perpetrator is a parent, guardian, foster parents, relative caregiver, paramour, any individual residing in the same home, any person responsible for the child’s welfare at the time of the alleged abuse or neglect, or any person who came to know the child through an official capacity or position of trust in settings where children may be subject to abuse and neglect.

Reporting: Best Practices

If the situation presented meets the guidelines defined in the Child Abuse Prevention Treatment Act call DCFS and file a report. **This can be done anonymously.**

IF THE CHILD/MINOR IS IN IMMEDIATE DANGER CALL 911.

If a situation is presented in which the decision to report or not is unclear some steps to take are:

1. Call DCFS anonymously and inquire if the situation is reportable.
2. Identify the ethical dilemma and the presenting problem. What are the barriers stopping you from making a decision?
3. Consult with a professional or colleague to talk through the decision.

What Information is Needed?

1. Names, birth dates (or approximate ages), races, genders, etc. for all adult and child subjects.
2. Addresses for all victims and perpetrators, including current location.
3. Information about siblings or other family members, if available.
4. Specific information about the abusive incident or the circumstances contributing to risk of harm—when the incident occurred, extent of injuries, how the child says it happened, etc.

Procedures for Organizations/Agencies: Best Practices

Your organization should have written policies and procedures in place for reporting.

Your reporting policy and procedure should:

- Identify what types of information and behaviors must be reported
- Specify a timeline for reporting
- List who is in the reporting chain—who you report to—and what decisions each person has to make

- Identify the authorities to receive the report, their contact information, and the type of information to be reported
- Include protocols about notifying parents/guardians
- Include an incident report form for the reporter to complete

Create a report template for documenting the necessary information.

- Often both verbal and written reports are required. Having the information organized will make the verbal report easier.
 - Most written reports require the same basic information: the youth's name, age, and address; the name(s) and address(es) of parent(s); the name and address of the alleged abuser; and an explanation of why it is believed that abuse has occurred
- Create a checklist for staff to use to ensure all requirements have been met:
 - Local law enforcement numbers and child protective services numbers
 - Hotline numbers (to use if needed)
 - Parameters needed for reporting to be mandated (Example: Is the person a minor? Is there immediate harm? Etc.)
 - Policies specific to the organization in regards to reporting
 - Instructions to call 911 or other appropriate authorities if staff are concerned about immediate safety and a supervisor or designated, trained medical or mental health professional is unavailable

10.03 Cultural Considerations

In most collectivistic cultures, corrective discipline is common practice. It is important to be mindful of these cultural practices as spanking and equivalent practices do not meet requirements for reporting.

The "operational definitions" section of the DCF Policy Manual provides some useful examples of injuries that may result from physical abuse:

- head injuries
- bruises, cuts or lacerations
- internal injuries
- burns, scalds (reddening or blistering of the tissue through application of heat by fire, chemical substances, cigarettes, matches, electricity, scalding water, friction, etc.)
- Injuries to bone, muscle, cartilage, ligaments (fractures, dislocations, sprains, strains, displacements, hematomas, etc.)
- death

As a first responder and community leader, you may give guidance towards better disciplinary practices, if the situation calls for it.

10.04 Suicide and Mandated Reporting

- There is no Federal law that mandates reporting for suicide risk and thus each state has their own laws with regard to whether reporting is required, who is required to report and what the process is for reporting.
- Some professions may have rules that govern their licenses and thus are required to report—again this varies by state—but may include medical professionals, mental health professionals, teachers/schools, law enforcement, among others.
- Confidentiality laws also vary by state in terms of when parental consent must be attained; imminent risk waves parental consent in most states.

Some states like Washington and Texas are mandating suicide prevention programs in schools.

As Clergy you are NOT a mandated reporter in cases of suicide. However, it is imperative to refer these cases ASAP! You may be held liable. You can also call crisis hotlines for guidance for yourself or for the individual in crisis. The Hotline worker will determine if the information given by the reporter meets the legal requirements to initiate an investigation.

Illinois Child Abuse Hotline 1-800-25-ABUSE (1-800-252-2873) or Your Local State Hotline

Khalil Center Hotline 1-855- 5HELPHC (1-855-543-5752)

10.05 Summary

- Legal responsibilities are assigned by state policies and requirements while ethical responsibilities are assigned by professional guidelines. It is imperative to know both and adhere to both.
- Clergy are required to maintain confidentiality of their community members. By law, they do not have to disclose certain information based on the state they are in.
- Mandated reporting is used when a minor (as defined by the state law) is experiencing child abuse or neglect.
- The Child Abuse Prevention Act states abuse to be serious physical, emotional, sexual abuse in which there is risk and harm to the child from the parent or caretaker. And Neglect is defined as failure to meet basic needs such as food and clothes.
- As clergy, in most states, you are mandated to report child abuse/neglect. Your state will have guidelines. Familiarize yourself with these guidelines.
- It is best practice to have your agency/organization have a protocol in place for reporting.
- Having a written system will provide for less opportunities of error. Make sure all staff is aware of the written system and adheres to it.
- Be mindful of cultural implications in regards to corrective discipline.
- If you are unsure about reporting, you can call and inquire anonymously. You can also call a hotline to talk through a situation. Consultations with professionals and colleagues is also a useful option.
- You are not mandated to report suicidal intent or actions. However, it is best practice to refer these cases as you can be held liable. Crisis hotlines are beneficial resources for guidance.

Scenarios: What Would You Do?

Questions to ask yourself:

- What feelings do you experience?
- What do you want to do?
- What are your options?
- What do you think you should do?
- If there are things you want to do but don't, why do you reject these options?
- What are your legal and ethical obligations?
- Are there any contradictions between your legal responsibilities/constraints and what you believe is ethical?
- To what extent do you believe your education and training have prepared you to deal with this situation

What Would You Do?

Scenario 1:

Aliyah has been coming to your Islamic center for the past four months. You feel that you have a good relationship with her and she sees you as her mentor. However, you do notice that she seems to be very depressed, isolated and appears not to have a lot of hope in her life, expressing a desire for Allah to take her life away. Before the time that she is scheduled to come into the center for a program that she is a part of, you check your answering machine and find this message from her: "I want to thank you for trying to help me, but now I realize that nothing will do me any good. I won't be seeing you or anyone else ever again. I didn't leave any notes because there really isn't anything to say. Thank you again for trying to help. Goodbye." You have to begin the program in the next two minutes and won't be free again until four hours later.

What would you do?

Scenario 2:

Sister Nasreen calls you at 2 A.M. and asks if you could come over because her husband was abusive to her and she is very anxious.

What would you do?

Scenario 3:

A 48 year old woman is an Iraqi refugee. She has been coming to your Islamic center's social service office regularly to receive zakat and clothes. She calls you at 2 A.M. Thursday, saying she just got into an argument with her husband and is very upset.

What would you do?

Scenario 4:

You have been mentoring a 17 year old youth/student that sometimes comes in and has some family meetings with you. They are a mother and father and their three adolescent children that come to the center. After the fourth meeting with the family, you find that one of the children has left a note on your desk. Here is what the note says: "My father has molested me for the last 2 years. He has threatened to kill my mother and me if anyone else finds out. I could not take it if you told anyone else. If you do, I will find a way to kill myself."

What would you do?

Scenario 5:

Abdul Haleem was sexually molested by his Qur'an teacher as a 10-year-old in an Islamic boarding school. His parents found out about this and removed him from the school. He is now 25 years old and is not actively practicing Islam. He feels a spiritual void in his heart so he comes to see you. He discloses his previous trauma and reports that he has never touched the Qur'an since his trauma and he is angry at God and cannot understand why God would allow this to occur. He is struggling to embrace his faith and religion has become associated with his trauma.

What would you do?

Scenario 6:

Sister Ayesha is working on addressing her history of sexual trauma. It has adversely affected her life over the years. She cannot reconcile her trauma with her faith, feels abandoned by God and thus has abandoned Him by becoming religiously inactive. She goes to meet with the Imam who begins to explain to her the benefits of trials and tribulations. Ayesha shuts off and disconnects.

What would you do?

Scenario 7:



Malik Smith is pacing at the back of the masjid. You go over and ask him how he is doing. He says to you that he has recently been fired from his job, his wife left him and the kids and his parents have abandoned him since his conversion to Islam several years ago. He says that things keep going downhill for him and he is feeling totally isolated. He does not know where to turn. Additionally, he discloses to you that in his adolescent years he was part of gang and he participated in some horrific activities that haunt him to this day. He is feeling hopeless and feeling intense internal pain and isolation. He discloses to you that he has been "seriously considering killing himself to put himself out of his misery."

How might you respond to elicit more information from him? What are you looking for in your suicidal assessment? How might you respond to this situation?

What would you do?

Scenario 8:

You've been working with a moderately depressed person for four months. You feel that you have a good rapport but the he's not getting better. One day, he leaves you the following voicemail: "I want to thank you for trying to help me, but now I realize that nothing will do me any good. I won't be seeing you or anyone else ever again. I didn't leave any notes because there really isn't anything to say. Thank you again for trying to help. Goodbye."

What would you do?

Common Questions: How Do You Respond?

Below are a few questions commonly asked by community members. With all of the tools/skills learned today, answer the questions.

- Be aware of personal opinions and beliefs.
- Remember: Empathy, active listening, unconditional positive regard, and safe space.
- If you are having a difficult time with some of these questions, explore your reasons. Understand where your thoughts are. The goal is not to change your beliefs or thoughts. Rather, it is to be aware of them so you can manage them appropriately when responding to community members or in crises situations.

Q1: Is Suicide Haram? Will I be punished for suicidal thoughts?

Q2: How do I convince myself to start praying again?

Q3: My parent is physically abusive. I cannot maintain a relationship with them. It stresses me out to the point of panic attacks. What do I do?

Q4: I think I'm gay. I have not told anyone. I hate myself! I feel alone and gross. Am I going to hell? What do I do?

Q5: I do not want to wear Hijab but my parent/spouse is forcing me too. It just feels burdensome and now I'm angry all the time. What do I do?