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Multicultural Psychotherapy Experience: A Grounded Theory Study Among Psychotherapists in Austria

Multikulturell Psychotherapie Erfahrung: Eine Grounded Theory Studie mit Psychotherapeuten in Österreich

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Abstract

The study analysed the psychotherapy experience of multicultural therapists with their diverse Muslim clients. From semi-structured interviews three major categories emerged: 1) resources for clients (family, religion) and therapists (e.g. knowledge, supervisions); 2) challenges (in the lives of clients, therapeutic relationship, therapy setting, and process); 3) coping strategies of therapists (e.g. motivating, psycho-educating, providing time and (in)direct challenge).

Keywords

Multicultural psychotherapy, Muslims, religion and therapy, a grounded theory study, Austria.

Kurzzusammenfassung

Die Studie analysiert die Psychotherapieerfahrung der multikulturellen Therapeuten mit ihren vielfältigen muslimischen Klienten. In semi-strukturierten Interviews haben sich drei Hauptkategorien herauskristallisiert: 1) Ressourcen des Klienten (Familie, Religion) und des Therapeuten (z.B. Kenntnisse, Aufsichten); 2) Herausforderungen (im Leben der Klienten, therapeutische Beziehung, Therapieeinstellung und Prozess); 3) Copingstrategien des Therapeuten (z.B.: .. Zeit geben, indirekte Herausforderung, die Vermeidung und Supervision).

Schlüsselwörter

Multikulturelle Psychotherapie, Muslime, Religion und Therapie, Grounded-Theory-Studie, Österreich.

1. Introduction

Recently, there has been a dramatic interest in the mental health needs, attitudes and practices of Muslims, which has run in parallel to the rising demands of this population in Western countries. Literature in the field has examined diverse aspects of the theme. Studies identified distinct mental illness models in Islamic cultures (Sheikh & Gatrad, 2000). Muslims can attribute the etiology of their emotional problems to multiple sources at the same time (Rahiem & Hamid, 2011). Some examples include stress, test/punishment of God, witchcraft, jinn (spirits), Muslim Personal Law, and a wicked heart (Abdullah, 2007; Al-Adawi et al., 2002; Dein, 2003; Weatherhead & Daiches, 2010).

In comparative studies conducted in multicultural countries (e.g. Israel, Singapore, the UK), Muslims reveal a stronger belief in traditional healing methods (Al-Krenawi, Graham, Dean, & Eltaiba, 2004; Cinnirella & Loewenthal, 1999; Ngab, Nyuntab, & Chiang Ch, 2011). A study conducted in the US indicates a preference of the community to consult religious leaders for their emotional problems (Abdullah, 2007). Hodge (2005) claims that Muslims seek secular services when traditional techniques fail. Abu-Raiyaa and Pargament (2011) trace the mistrust of Muslims towards psychotherapy to the opposition of early analytic founders towards religion, and the concerns of Muslims that psychotherapy may be against their religion. A recent study identified stigma and fear of losing privacy, reputation, and religious image as the leading causes for lower rates of help-seeking behaviour (Scull, Khullar, Al-Awadhi, & Erheim, 2014). Another study among battered Arab women in the USA found shame, language barriers, inadequate knowledge of psychotherapy and the limited availability of services as barriers in help-seeking (Abu-Ras & Wahiba, 2003).

Recent evidence suggests a positive attitude change. In Iran, believers of traditional healing decreased from 40.2 in 1990 to 15.6 in 2000 (Yasamy et al., 2001). A cross-national investigation among Arabs living in Israel, Jordan and the UAE showed a positive correlation between professional help-seeking and education (Al-Krenawi et al., 2004). Furthermore, Maynard (2008) indicated that Muslims tend to consult mental health care for emotional problems when they access appropriate services.

Different views prevail on culturally informed therapy practices. Dwairy (1998) suggests directive counselling similar to the methods of Imams. Masalha (1999) believes professionals should pay attention to confidentiality, appointments, and fees. The adaptability of different psychotherapy approaches to Muslims yield controversial claims. Egyptian psychoanalyst Fayek (2004) argues that the concept of unconsciousness does not fit the Islamic text. Nevertheless, Palestinian psychoanalyst Masalha (1999) reports his successful application of traditional psychoanalytic methods in an Arabic village. Thomas and Ashraf (2011) claim that several principles of Islam like Husn al-Dhun – having a good opinion about God, other people, and future – fit to the concept of maladaptive thoughts in Cognitive Behaviour Therapy (CBT). In Iran, to alter dysfunctional religious schemes for the excuses of obsessive cleanliness, therapists offer another theological reasoning (Khodayarifard & McClenon, 2011).

Some western researchers focused on Muslim minorities. In a qualitative study, half of the Muslim participants responded positively to having a non-Muslim psychotherapist,

provided professionalism and respect to Islam was demonstrated (Kelly, Aridi, & Bakhtiar, 1996). Some find a person from a dominant culture more competent and safer for confidentiality (Rahiem & Hamid, 2011; Scull et al., 2014). However, professionals report hardships. German psychotherapists find it challenging to cooperate with patriarchal fathers (Fişek, 2011). Likewise, Smith (2011), a British therapist with an atheist and feminist identity, acknowledges feeling uneasy for her lack of knowledge about Islam, and admits her temptation to challenge patriarchy. Moreover, Rahiem and Hamid (2011) argue that due to a therapist's lack of knowledge, they may ask many questions about the faith of the client or may entirely avoid religious subjects. Further, previous friends or a client adhering to Islamic faith may consciously or unconsciously mislead psychotherapists' perceptions of Muslims. Finally, professionals may also feel guilty of the injustices in Western society towards their Muslim clients.

Of the 8.4 million population of Austria, 573,876 belong to the Islamic faith (Aslan, Yıldız, Kolb, & Mattausch-Yıldız, 2014; Statcube Statistical Database, 2014). The Austrian Muslim community is a mosaic of different nations: Turks, Ex-Yugoslavs, Chechens, Egyptians, Syrians, Iraqis, Iranians and Austrian converts (Heine, 2012; Soytürk, 2012). Nonetheless, like many other Western countries, the number of Muslim psychotherapists cannot meet their demands, requiring the assistance of non-Muslim professionals with a limited knowledge of Islam. Application of Western psychotherapy methods to these patients may face challenges. The present study aims to examine possible complications and how psychotherapists overcome them in the field, which can offer insights to clinicians. Most studies in the field of Muslim Mental Health Care tend to focus on attitudes and help-seeking behaviour. Few case studies inform us about the experiences of professionals. Systematic investigations among psychotherapists, who work with Muslim clients, can bring different insights. Research mainly represented clients with Arabic and Iranian ethnic origins. The voices of therapists working mainly with Chechen, Afghan, Turkish and Balkan clients are missing. This study investigates the experiences of therapists from different ethnic, religious and psychotherapy modality backgrounds working with their diverse Muslim clients in Vienna, Austria.

2. Method

2.1 The Setting of the Study

The study took place at Sigmund Freud University of Vienna International Psychotherapy Outpatient Clinic, where international therapists offer services to multicultural clients in different languages. An income-based fee policy ensures the access of refugees/immigrants to services. Muslim clients belong to diverse national backgrounds (e.g. Turks, Slavs, Persian, Arabs, Southeast Asians and Africans). The clinic assigns therapists to clients based on common language and cultural closeness. The major complaints of Muslim clients are depression, anxiety, PTSD and psychosomatic pains. The Muslim author of the article worked as a licensed Systemic Family Therapist (SFT) in the clinic during the study.

2.2 Participants

Purposeful maximum variation sampling provided interviewees representing diverse backgrounds. Respondents are five female non-Muslim psychotherapists from different countries; their average age is 38. They

received training in various therapy approaches with an average of 5.4 years of professional experience. Table 1 presents the psychotherapy orientation, country of origin, affiliated religion and languages that these therapists employ. For confidentiality, the study uses the code of Therapist 1-2-3-4-5. Four participants immigrated to Vienna to pursue a psychotherapy education, while Therapist 4 comes from an immigrant family. Therapist 3 is a licensed psychoanalyst (PA), Therapist 4 is an Individual Psychologist (IP) under supervision (us), and the other three therapists are SFT (two licensed and one (us)).

Table 1
Interviewees of the study

Participants	Therapy modality	Languages used in therapy	Country of origin	Religion
Therapist 1	SFT	English, Russian	Russia	Orthodox Christian
Therapist 2	SFT (us)	English (Albanian, Turkish, Russian, Arabic translators)	Japan	No affiliation
Therapist 3	PA	English, German, Persian	Persia	Atheist (Muslim parents)
Therapist 4	IP (us)	English, German, Turkish	Turkey	No affiliation (Muslim parents)
Therapist 5	SFT	English, German, Russian	Belarus	Evangelical

SFT = Systemic Family Therapy, us = under supervision, PA = psychoanalyst, IP = Individual Psychologist

2.3. Procedure

The author recruited participants through personal contact and conducted interviews in person during home visits in 2012. Semi-structured interviews, lasting from fifty to ninety minutes, explored the experiences of psychotherapists with their Muslim clients. Four subjects preferred to talk in English and Therapist 4 opted for Turkish. The interview protocol included five main categories: a) psychotherapy setting (fee and time); b) therapeutic relationship; c) challenges psychotherapists face in therapy; d) therapy modality-specific issues; e) helpful strategies, techniques, and approaches. The author of the study audiotaped and transcribed interviews verbatim. Data analysis started immediately after the first session, which helped the interview questions to be more explicit with following the participants. Qualitative Data Analysis & Research Software Atlas.ti facilitated grounded theory analysis as outlined by Glaser and Strauss including three coding stages: open, axial, and selective.

3. Results

The grounded theory study yielded three main categories: 1) resources for the clients & therapists; 2) challenges in conducting psychotherapy with Muslims; 3) coping strategies of psychotherapists

with difficulties of working with Muslim clients.

3.1 Resources

3.1.1 Clients' Resources

Families, living in Vienna and religion, emerge as the most supportive factor in clients' lives (see Table 2). Therapist 5 highlights that "for women it is often children, not the husbands, who contribute to their emotional well-being."

Educational and physical needs of children motivate mothers to integrate into society. Secondly, clients who come from rural areas experience comfort in nature. Thirdly, many clients place a strong faith in medical professionals and psychiatric medications. Lastly, religious beliefs and rituals help to heal past pains, provide acceptance of harsh living conditions and hope for change. However, interviewees have different opinions regarding religion. Therapists adhering to SFT see faith as a possible resource. On the other hand, Therapist 3 (PA) takes religious coping as "a form of obsession and magical thinking." Therapist 4 (IP) argues: "if religion had given them an acceptance, then they would not need therapy."

Table 2
Summary of results

Resources in therapy		
	Clients	Family, nature, medication, religion
	Therapists	Resemblance to own culture, knowledge about Islam, supervisions, techniques from own and other therapy modalities
Challenges		
	Lives of clients	Challenges as an immigrant/refugee, religious stressors, family dynamics
	Setting (money & time)	Dislike of paying just for talking, bargaining, gift bringing, allocating time, fasting during Ramadan
	Therapeutic relationship	Opposite gender, interreligious & intracultural client-therapist relationship
	Psychotherapy process	High/false expectations from therapy, resistance to open up emotionally, therapy modality specific challenges
Coping Strategies of therapists		
	Clients' unrealistic expectations	Motivating, psycho-education, giving time
	Clients' resistance to open up emotionally	Time, (in)direct challenge
	Clients' religious & cultural convictions	Respecting, modifications, provoking, concentrating on constructive aspects of the convictions

3.1.2 Psychotherapists' Resources

Given that the clinic is international, therapists and patients share a global identity. As immigrants, they experience similar integration processes with their clients. Participants observe resemblance between their culture and Islam regarding patriarchy and collectivism. Further, participants with previous knowledge of Islam, and experience with Muslim clients, know vulnerabilities of the culture and possible topics that they can address in therapy. In supervisions, they get ideas about working with resistance, war traumas, and gender issues. Moreover, therapists try different tools that belong to their psychotherapy school with occasional borrowings from different therapy schools. With time, they gain experience and self-esteem in working with this challenging clientele group. However, two therapists view every client as unique and start a new process with each. Finally, Muslim clients accept the authority of their therapists and respect them as a professional.

3.2 Challenges in Conducting Psychotherapy with Muslims

The biggest challenge of working therapeutically with Muslims comes from their harsh living conditions. Therapists observe further complexities in psychotherapy setting (time and money), psychotherapy process and therapeutic relationship (see Table 3).

3.2.1 Challenges in the lives' of clients

Challenges as an Immigrant/Refugee

As immigrants, Muslims in Vienna suffer from a language barrier, isolation and an existential anxiety due to residency permits. A client of Therapist 1 cries, "prostitutes get a visa and I cannot." Further, the lack of a work permit causes financial problems and "questions the role of the man in the family," remarks Therapist 2. Language barriers disadvantage the immigrant clients in residency applications, hospital care, and job seeking. Employment of translators - often children - makes clients dependent. Therapists find it hard to motivate their clients to attend costly German courses. Moreover, a previously poor educational background and problems in concentration, which stem from war flashbacks, make learning a great ordeal. Lastly, lack of language contributes to the isolation of clients. In addition to language, several realities hinder socialization of clients. Firstly, diminished interest in socialization occurs due to depression. Clients might also avoid some people due to regional disputes. Difficult relationships with other refugees in shelters often stem from sharing a small space. Basic refugee housings without separate rooms for different genders hinder hosting friends at home as well. Further, clients who have never built a relationship with people outside of their extended families lack skills in approaching new people. Lastly, Therapist 2 remarks, *"a jealous partner in a homeland controls and restricts socialization of her male client."* The therapist attributes such form of control to *"lack of personal space given in collectivist cultures."*

Furthermore, a discrepancy also occurs between the lifestyle clients are familiar with, their high expectations from Austria, and the reality. To illustrate, clients who come from rural regions are not familiar with an urban lifestyle. Therapist 1 points to a lack of curiosity in her clients, who

"never visit the city and restrict their life to a small district." Moreover, clients from ex-communistic countries bring high expectations in an external source of government. Therapist 1 reports her client screaming, *"I will get a house from the government, you will see."* The therapist finds it challenging to employ a solution-focused approach, mobilizing her clients to take steps towards change.

Religious Stressors

Participants describe their Muslim clients as conservative based on their garments, praying regularly, and narrations. With systemic family therapists, the topic inevitably arises through resource seeking questions of *"what helps/helped you."* All therapists remain respectful and neutral when clients bring religious values.

The therapists identified several Islamic practices as negative for mental health. These are feeling guilty for not being able to show acceptance to harsh living circumstances, conceptualizing mental illness as punishment for sins, and passively accepting God-given conditions and obsessions/hallucinations that occur in the context of religion. To illustrate, some clients worry if they have performed religious rituals correctly, or experience illusions of hearing the prophet or the last Imam. Further, Therapist 2's client believes *"suffering from grief is OK, but being depressed is from the devil."*

Challenges in Family Dynamics

Clients often bring family disputes to therapy. Typical burdens brought to therapy regarding families are elderly care, gossip, coming between a spouse and the family of origin, ending harmful partnerships, and violence. To illustrate, a client of Therapist 2 marries according to the wishes of his family and suffer the consequences. She believes her Muslim clients *"have to be that way due to family or community."* They employ *"I and we interchangeably"* hardly distinguishing between their own wishes and their family's wishes. Therapist 1's young client cannot visit her friend's house, as her family fears premarital sex. Therapist 3 claims that parents restrict *"particular pleasure possibilities,"* such as dancing and going to parties.

Therapists have different experiences regarding family violence. One of the female clients of Therapist 5 deals with her anger management problems in therapy. Therapist 1 had one client who had divorced from her abusive husband. She believes such cases exist in all cultures. Therapist 4 *"never experienced a client, who continues to remain in a violent relationship."* She emphasizes; *"violence is violence"* and *"it cannot be cultural."* Therapist 3, on the other hand, believes *"family violence tends to be more in Muslim culture."* She has clients, who say, *"it is God's will; I am married to that man, so I have to live with him no matter what."* Finally, therapists believe that female but not male clients would bring the issue of violence to therapy if it occurs. Therapist 3 believes men take *"the power for granted."*

Migration experience puts fixed gender and generational roles governing families to test. Wives often complain about their husbands' unwillingness to help with household chores. Nonetheless, Therapist 2 observes diversity among different ethnicities. Her male Afghan client suffers since he cannot fulfil his role as a father while suffering emotionally, whereas her

Albanian and Turkish male clients are very distant fathers.

Concerning generational roles, aged immigrants, who acculturate less to Austria, feel dependent on children due to language barriers and emotional problems. Consequently, they lose a part of their patriarchal authority. An elderly client of Therapist 2 feels humiliated for his dependence on children and tries to remain the *"top of the family."* According to clients' culture, young adults must take care of parents, which is rather challenging in a foreign country when they have limited social and financial resources.

3.2.2 Challenges in Psychotherapy Setting

Therapists often have an easy relationship with clients regarding money due to *"the reasonable price request of the clinic."* Therapist 3, on the other hand, experiences dislike of paying *"just for talking."* It is also crucial for clients that claiming money does not matter in the beginning. However, non-educated clients might bargain afterwards. Refugee clients, who are exempt from a therapy fee, tend to bring presents. Therapists find it *"hard to reject"* gifts in the form of traditional homemade food. Hence, participants bring this issue to their supervisions and sometimes allow them.

Concerning time, Therapist 3 observes that *"some of her Muslim clients are strict, and others are rather easy-going."* However, female clients often cancel therapy sessions due to their children. Clients rarely ask for the option of a different time to suit their prayer time. Finally, during holy Ramadan, many clients take a break. For clients who continue psychotherapy therapists take into account that they have less energy while they fast.

Table 3

Challenges in conducting psychotherapy with Muslims

Areas that challenges occur	Specific challenges
Clients' living conditions	Being immigrant/refugee, religious stressors, family conflicts
Therapy setting	Dislike of paying just for talking, bargaining, gift bringing, loss of energy during Ramadan, allocating time as a parent
Therapeutic relationship	Opposite gender, interreligious & intracultural client-therapist relationship
Therapy process	High/false expectations from therapy, resistance to open up emotionally, therapy modality specific challenges

3.2.3 Challenges in Therapeutic Relationship

Opposite gender Client – Psychotherapist Dynamics

In respect to Islamic boundaries set between genders, in particular, issues of eye gazes and handshakes, concern the therapeutic relationship. Therapist 4 realizes the discomfort of her conservative male clients when she wears a miniskirt, hence dresses humbly not to attract attention and to feel personally comfortable. She also adopts "L" style

seating arrangement and avoids eye gazes. Therapist 3, in contrast, continues eye contact until her patients became habituated. Two therapists wait for male clients to offer a handshake. Further, Therapist 2 recognizes that it is hard for male clients to discuss emotions with a young woman. Therapist 5 and Therapist 1 argue that their male clients "enjoy having young female therapists," at times asking if their therapist is single. As in the case of their other male clients, participants hinder any confusion through setting clear boundaries.

Inter-religious & Intracultural Client-Psychotherapist Relationship

The chief obstacle in inter-religious psychotherapy (when therapist and client represent different religious faiths) is their lack of knowledge about Islam. Therapist 1 admits that she does not know *"the perspective of Islam on drugs and alcohol."* As a result, therapists develop a hypothesis based on their limited contextual knowledge. To illustrate, Therapist 2 knows the existence of polygamy in Islam, but not the custom of gender segregated sitting arrangements in the home. Hence, when her client complains that he cannot invite any male friends to a single-room shelter, she misinterprets it as a wish to have an extra room for a second wife.

Participants do not observe any difficulty in establishing trust in interreligious psychotherapy. According to Therapist 5, trust can develop through showing respect. However, due to regional ethnic conflicts and post-traumatic stress some refugee clients *"suspect her to be a spy."*

Turning now to an intracultural therapist-client relationship, concern for confidentiality in a small community of immigrants exists. Therapist 4, who belongs to Turkish immigrant circles, asks her family members never to bring any *"personal information to her related to clients and vice versa." Further*, clients may wish to get very close to a therapist, who is a member of their culture, by employing pronouns used among friends or inviting therapists to their home.

3.2.4 Challenges in Psychotherapy Process

Therapists indicate that the psychotherapy process with Muslim clients who have acculturated to Austria is very similar to European clients. However conservative clients hardly show a willingness to change in therapy. Therapists express the diversity of their clients as follows:

"Educated man from Turkey is like a cultured man in Europe. I cannot compare it with Chechen farmers." Therapist 1 **– clients are diverse-**

"Clients are different. Turkish and Balkan students are more knowledgeable about western lifestyle, and my Afghan clients are not like that." Therapist 2 **–clients are diverse-**

Clients' expectations from psychotherapy

Due to lack of knowledge and familiarity with psychotherapy many Muslim clients come with unrealistic anticipations: high hopes, direct consultation, document requests, only complaining or sharing secrets without any intention to change.

"Especially my elderly clients put me up like God, saying save me, heal me. It is difficult to find resources inside, and they turn to

external sources." Therapist 2 **–high expectations–**

"My client complains saying you are just talking to me. Tell me what to do." Therapist 1 **–request for direct consultation-**

"Some of my clients bring their emotional garbage, just to complain." Therapist 5 **– therapy as a place to complain-**

"I have male clients, who cannot share personal problems in the family as a father figure. They come therapy to share secrets." Therapist 2 **–therapy as a place to share secrets–**

Further, client referrals occur through psychiatrists, social workers, and families, mainly for PTSD patients. In the beginning, some of these clients are cautious about psychotherapy.

"My clients believe symptoms are a natural cause of war and immigration. They cannot disappear. Healing power just belongs to God, and therapy can only help to survive a daily life." Therapist 1 **– scepticism towards therapy–**

"Clients think a young therapist cannot help them to solve serious problems." Therapist 5 **-scepticism towards therapist-**

Clients' resistance

Therapists agree that their Muslim clients concentrate on symptoms and complications within a family but avoid talking about their emotions. Therapist 2 believes her male Muslim clients resemble those of non-Muslims, though *"they carry a thicker armour." "My biggest problem is to show that they are not just religious people, but they are people with emotions,"* says Therapist 5. Therapists identify the inability to recognize emotions, limited self-reflection, collectivism, suppression, dissociation, religious convictions, shame, and pride as underlying reasons behind their *"thick armour."* Resistance occurs especially on topics of sexuality, suicide, and religion.

"I reach the topic of sexuality with my clients only after establishing trust in about eighty sessions." Therapist 4 **–resistance sexuality–**

"Conservative clients do not talk about suicide directly. They wish to sleep and never wake up. They don't take responsibility; God should decide for them." Therapist 2 **–resistance suicide–**

"Clients talk about faith only after they begin to trust. They employ religious greeting or expression to test my reaction first." Therapist 4 **–resistance religion–**

"My refugee client was angry with an Evangelist missionary, who tried to convert him. It is a sign of openness and trust that he tells it to me." Therapist 1 **–religion, trust–**Psychotherapy School-Specific Issues.

Interviews also reveal psychotherapy modality-specific difficulties. To begin with, PA clients rarely accept couch therapy associating it with sexuality. Secondly, according to Therapist 3, Muslims tend to be "less insightful, how significant the childhood experience could be." Hence, they tend to bring their adulthood traumas. Moreover, clients, overwhelm therapists when they come with relatives and friends. A twenty-year-old client of Therapist 4 attends all analytic sessions with his mother based on a common agreement. She further receives calls from families of her young adult

Turkish clients who want to request information disregarding privacy.

Turning now to SFT, employment of the miracle question with Muslims proves futile. Clients find it hard to imagine a positive future due to hard living conditions, and reserve miracles only to religious figures. Furthermore, some clients do not accept nonverbal tools such as "family board and drawing." They prefer verbal communication instead. Interviewees also cannot incorporate children into the therapy process, because clients control their children by telling, "just take a toy and play." What's more, employment of a reflective team makes it hard, at times, for their clients to verbalize intimate subjects. Therapist 2 also remarks that her Muslim clients sometimes "give more value to the opinion of a male member of the team, disregarding her." Lastly, therapists find it hard to mobilize their clients with solution-focused questions for change since they expect help from external resources such as God, family, government, and medication.

3.3 Coping strategies of psychotherapists

Table 4 shows the difficulties that occur in conducting psychotherapy with Muslim clients and how professionals cope with these challenges. Therapists meet clients' unrealistic expectations, resistance to open up emotionally, religious and culture convictions by employing different strategies. These are: giving motivation, psychoeducation, allowing time, (in)directly challenging, making modifications, provoking and concentrating on positive.

3.3.1 Coping with unrealistic expectations of clients

Psychotherapists employ various coping strategies in order to overcome different challenges. Respondents, on account of clients' naive expectations from therapy, emphasize the importance of psychoeducation and giving time. Metaphors serve as a useful tool for familiarization of psychotherapeutic concepts such as an active role of the client and a limited facilitative role of the therapist (The Flowchart 1). To exemplify, Therapist 4 likens her role as a therapist to somebody *"with a light that makes the road clearer for a client."* Given sufficient time, clients familiarize with the therapeutic setting, see positive changes, and feel accepted. Thus, their scepticism turns to trust. If these interventions fail therapists request help in supervision hours and sometimes end the psychotherapy process.

"In the first session, my client brought Turkish kebab, hugged me and asked my well-being. He then said, "OK make us tea so that we talk. You should also come to my home next time." With time, he learned, how therapy works." Therapist 4 **–overcoming unrealistic expectations with time–**

"Slowly my client said, "I was very sceptical, what did you do with me? I normally never speak so much. I feel better now." Therapist 1 **–overcoming scepticism with time-**

"With some, an anticipation of a miracle or a prescription of a solution does not alter. With them, we end the therapy." Therapist 4 **–unrealistic expectation, ending therapy–**

Some clients visit the clinic because therapy confirmation provides them with advantages such as sick leave or refugee status. Therapists in the first session clearly present their limitations and try to gain cooperation. Being disappointed, some clients leave therapy; however, in following periods they might return with a more cooperative attitude.

Table 4
Coping strategies of psychotherapists

Challenges	Specific coping strategies
Clients' unrealistic expectations	Motivating, psycho-education, giving time
Clients' resistance to open up emotionally	Time, (in)direct challenge
Clients' religious & cultural convictions	Respect, modifications, provocation, concentration on constructive aspects

3.3.2 Coping with clients' resistance

Facing their clients' resistance to open up emotionally, therapists employ different strategies. Firstly, they provide time for them to overcome their defences. Secondly, especially analytic therapists, in particular, might raise the topic directly after feeling it in countertransference. Thirdly, therapists approach indirectly beginning with broad themes, circular questions, feedbacks, and symbols.

"I do not start with sexuality. If I feel it in countertransference, I bring it up indirectly," starting with relationships between men and women." Therapist 4 **–indirectly challenging–**

"When I feel it in countertransference I bring topics professionally, but directly. I explain that their general relationship might suffer if they do not overcome sexual problems." Therapist 3 **–directly challenging–**

3.3.3 Coping with religious and cultural convictions in therapy process

Therapists' attitude towards the religious and the cultural values of their clients varies as either negative or positive. Therapists adhering to SFT but not PA tend to evaluate them positive and employ reinforcement. *"I asked them. Tell me, what good can your God bring to you? Sometimes valuable resources come."* Therapist 1 **–evaluation positive, reinforcing–**

"*They get power from the faith because I think all the religions aim to fulfil the life not suffering. When a person heals the past pain, it makes them and also their God happier.*" Therapist 2 **–evaluation positive, reinforcing–**

"If religion could help them, they would not be in therapy in the first place." Therapist 4 **–evaluation negative–**

Therapists employ a palette of different strategies for so-called negative aspects of religion and culture such as patriarchy.

These are avoidance, provoking, adjusting and concentrating on positive aspects.

"Through circular questions, I provoke my clients at appropriate times. If it irritates them, I apologize … I ask, "*What would God say that your wife suffers while you do not help her and wish more children?*"" Therapist 1 **–evaluation negative, provoking–**

"I found these religious coping strategies more or less sick. They are magical thinking. To strengthen their ego, I avoid them. Only in suicide, I let them suppose that God would punish them." Therapist 3 **–evaluation negative, concentrating on positive aspects–**

"Women have two priorities in life; God and husband. They are like two rocks in the forest. I cannot move them. I just play and dance around." Therapist 1 **–evaluation negative, avoidance–**

Therapists tend to avoid certain subjects such as religion and sexuality in sessions. Hindering factors are a lack of knowledge about Islam, fearing to intimidate clients or to strengthen their religious defences. The following quotations reveal these attitudes: *"I do not want hot discussions about beliefs because they sometimes protect personal development with religion."* Therapist 1 **–avoidance not to strengthen religious defences–**

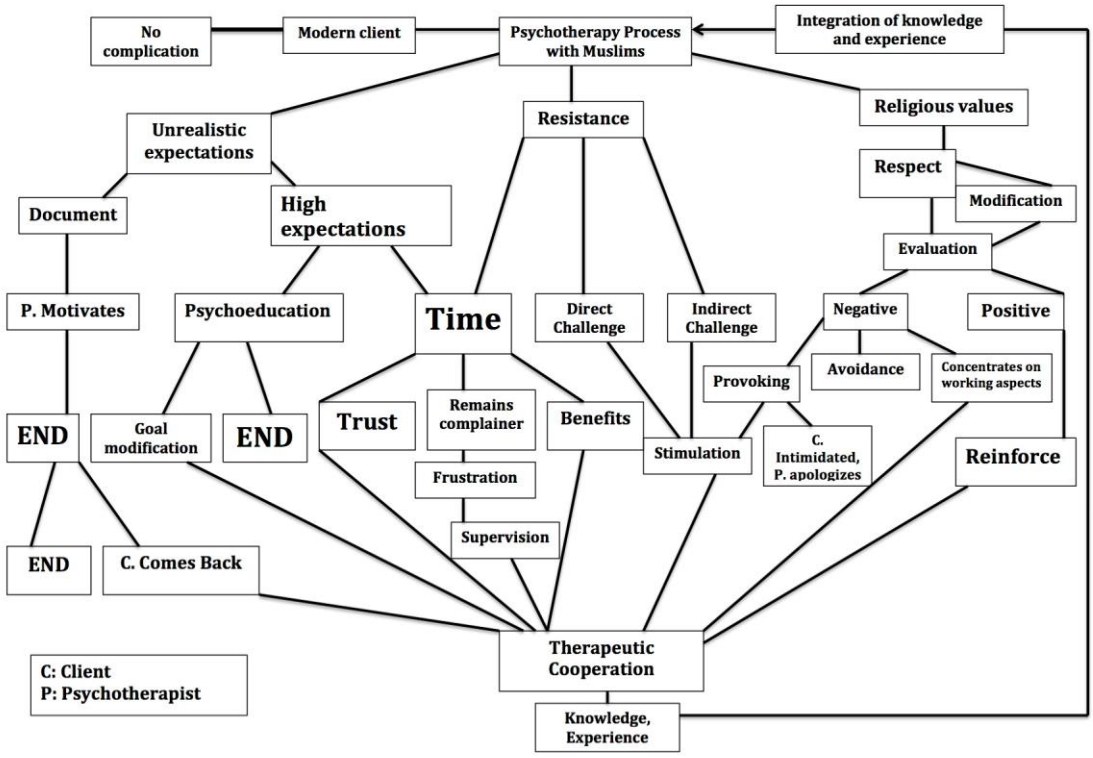
"It is so humiliating to talk about sex with them. I do not touch." Therapist 2 **– avoidance to hinder intimidation–**

"There are various Muslim groups, and I am afraid to touch their politics. It is absolutely not my world." Therapist 2 **– avoidance due to lack of knowledge–**

"Being a top of a family as a father is crucial for my Albanian, Turkish and Afghan clients. That is why I treat them very respectfully as a female therapist." Therapist 2 **–adaptation–**

"I select religious concepts and vocabulary that give them trust like; this body of us as created by God can have connections with our feelings." Therapist 4 **–adaptation–**

Flowchart 1
Coping Strategies of Therapists in Working with Muslim Clients



4. Discussion

The study adds to a growing body of literature on the multicultural psychotherapy experience of the Muslim population by providing an example in the Austrian context. It is unique in providing experiences of working with previously underrepresented clientele groups like Turks, Chechens, Afghans, and Balkan Muslims; unlike earlier research that concentrated mainly on Arabic and Iranian populations. Furthermore, the research is one of the few studies that give voice to non-Muslim professionals' experience in this field. The findings enhance our understanding of possible challenges and resources in a therapeutic setting, process, and relationship. The investigation revealed that the difficulties faced in the lives of clients challenge the psychotherapy process. Psychotherapists find it hard to work with solution-focused techniques or childhood traumas in the face of existential fears of clients. Further, the psychotherapeutic background provided a reliable predictor of participants' attitudes toward Muslim clients. Systemic therapists view religion as a possible resource and try to benefit from it. However, psychodynamic therapists respect, analyse, but do not reinforce religious coping in therapy.

Current study produced results that support the findings of some of the previous work in this field. Firstly, previous studies among different Muslim populations demonstrated the effectiveness of religious coping strategies such as praying, going on pilgrimage,

taking prophets' lives as reference points for coping with PTSD, adversity, and grief (Aflakseir & Coleman, 2009; Mehraby, 2003; Vasegh, 2011; Williams, 2006). Respondents in this study observed religious coping strategies of their clients as well. Secondly, in line with the observations of Masalha (1999), this investigation confirms the family orientation of patients and importance of this topic in therapy. Furthermore, therapists do not observe the employment of friends as a social coping strategy, which agrees with the findings of Hall and Livingston (2006). Thirdly, the high frequency of arranged marriages, distinct gender roles and restrictions put on women confirms Abudabbeh's (1998) observation with American Muslims. Nevertheless, the findings show that limitations in socialization like visiting a friend pertain mostly to single girls not to married women. The difference might be due to the strong emphasis given to virginity. Further, young individuals with a higher acculturation level might claim more rights than their mothers. Fourthly, in parallel to the conclusions of Dwairy (2009), who advocates the employment of metaphors in psychotherapy with Muslims, participants employed them especially in providing psychoeducation. Lastly, the findings of the current study are consistent with those of Rahiem and Hamid (2011) that discussions on sexuality, suicide and religion are difficult among Muslim clients.

Previous studies reached a different conclusion in various areas. The literature demonstrates a firm conviction in the traditional etiology of mental illnesses among Muslims (Al-Adawi et al., 2002). Nonetheless, in the current study, only two interviewees had few patients who made attributions to Jinni (spirit) and demons. A possible explanation for this might be that clients, who do not believe in secular explanations, are less likely to apply to the clinic. Besides, in the context of established mental health care in Austria, Muslims might be better informed. In contrast to earlier findings, no evidence of help-seeking with Imams was detected. A major source of difference might lie in the fact that most of the Imams only speak the language of the biggest Muslim population group of Turks in Austria. Therefore, clients, who speak other languages cannot access this clerical aid.

The present project set out to explore how psychotherapy is conducted with the Muslim population in an Austrian context by psychotherapists from diverse schools and cultural backgrounds. The study traced resources and challenges in the lives of clients that influence the therapeutic setting, process, and relationship. The study further investigated the strategies of therapists in overcoming these challenges and their resources in working with these patients.

We found several limitations of the present work. One is that data represented only female therapists' perspectives. Hence, evaluation of female client's interaction with opposite gender professionals is missing. A second limitation is that the clinic welcomes clients mainly from low and middle classes. A greater depth of information may have been obtained by combining the perspective of therapists, who offer services in their private offices for higher fees, to more informed and educated clients.

Based on findings of this study, clinicians are urged to provide psycho-education at initial sessions through metaphors. Giving time can enable patients to overcome their resistance and familiarize them with the setting. Clinicians can further motivate their clients to open up through direct and indirect methods, rather than avoiding topics such as sexuality and religion.

These findings can serve as a basis for future studies that can focus on other psychotherapy methodologies applied to Muslims. It would also be interesting to see the perspectives of clients. This study can offer a paradigm for the intercultural psychotherapist-client relationship, and conducting psychotherapy with clients who have strong religious convictions.

5. References

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