

**THE PLACE OF RELIGION IN THE PSYCHOTHERAPY OF MUSLIM
IMMIGRANTS: THE CASE OF FIRST-GENERATION AFGHAN IMMIGRANTS IN
CANADA**

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Abstract

This thesis investigates the place of religion and spirituality in the mental health of Muslim immigrants, focusing specifically on Afghan immigrants residing in Canada. The research explores how pre-migration, migration, and post-migration factors impact the psychological well-being of Afghan immigrants and delves into the role of Islam as both a socio-political identity and a religious practice in therapy. Employing a qualitative research approach, grounded theory methodology is utilized to gain a comprehensive understanding of the experiences of Afghan immigrants. Data is collected through constructivist interviews, and an analytic procedure involving initial coding, focused coding, and theoretical sampling is implemented. The findings underscore the multifaceted nature of religion and spirituality in the lives of Afghan immigrants. The research analyzes perspectives from both clients and clinicians regarding the role of religion and spirituality in the therapeutic process. An emergent model is developed, illustrating the interplay of religion and spirituality within the psychotherapeutic journey from multiple vantage points: the therapist outside the therapy room, the therapist and client in the therapy room, and the client outside the therapy room. The findings offer insights into the experiences of Muslim immigrants in Canada, and implications are outlined for clinicians and researchers, emphasizing the significance of incorporating religious and spiritual dimensions in the psychotherapeutic process and promoting culturally responsive mental health care.

Keywords: Religion, Spirituality, Mental health, Muslim immigrants, Afghan immigrants, Spiritually integrated therapy, Cultural responsiveness

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Chapter One:

1. Introduction

Mental health care is not keeping up with rates of demographic change in Canada. Migration is reported to account for approximately two-thirds of the population growth in Canada and will remain a key driver of growth, with a 19% increase reported between 2011-2016, and could represent up to 34% of the population of Canada by 2041 (Statistics Canada, 2014, 2022). However, studies with immigrant and refugee populations indicate that mainstream mental health care, in many cases, is inconsistent with the values and expectations of immigrants and refugee populations (Fung & Guzder, 2021; Hansson et al., 2009; Marshall et al., 2016). Although symptoms of mental illnesses are similar across cultures, manifestation, descriptions, and interpretations of these symptoms vary across cultures (Byrow et al., 2020; Srivastava, 2009). Culture also influences where people seek help and their preferred treatment (Hassan et al., 2015). The evidence further suggests that when it comes to providing mental health services, one size does not fit all (Mental Health Commission of Canada, 2016). The mental health commission of Canada (2016) highlights the need for more research and exploring the different and distinct needs within the migrant communities and racialized populations and how these differences and distinctions relate to mental health outcomes. Several authors have shed light on the role of mental health professionals (i.e., psychologists, counsellors, social workers, therapists, and medical health professionals) in counselling diverse minority groups and countering the present anti-minority sentiment (Environics Institute, 2016; Schouler-Ocak et al., 2021; Sevunts, 2016). However, even though Muslims are reportedly one of the largest and fastest-growing minority groups in Canada and have grown more than double in the last 20 years (Statistics Canada, 2015, 2022), they are among those who remain misunderstood and understudied in the

mental health field (Qasqas & Jerry, 2014; Tanhan & Young, 2022). Recent literature on multiculturalism in counselling strongly suggests a shift from focusing on mere competence to embracing cultural humility and in-depth cultural understanding as an alternative and more responsive framework for practitioners to address the needs of diverse groups (Fisher-Borne et al., 2015; Hook et al., 2013; Owen et al., 2016; Ratts et al., 2015; Rosenblatt, 2016).

The present research is an effort to address the widely reported gap in mental health literature on Muslim immigrants in Canada and the role of religion in their mental health. The study focuses on first-generation Afghan immigrants due to the community access of the researcher and his positionality as a first-generation Afghan immigrant. Afghan immigrants who continue to seek international protection with prolonged exposure to war are disproportionately affected by mental health problems (Ahmad et al., 2021; Alemi et al., 2014; Hamrah et al., 2021). Previous studies with Afghan immigrants in North America (Alemi et al., 2014; Alemi et al., 2018; Miremadi et al., 2011), Europe (Feldmann et al., 2007; Gerritsen et al., 2006) and Australia (Sulaiman-Hill & Thompson, 2011; Sulaiman-Hill & Thompson, 2012) strongly suggest the need for research on professional help-seeking utilization patterns and culturally relevant strategies for engaging and providing mental health support to Afghan immigrants. Studies further indicate that the help-seeking behaviours of immigrants are closely tied to explanatory models of mental health and culture (Fung & Wong, 2007; Tomasi et al., 2022). Studies with Afghan immigrants show that it is essential for any therapeutic intervention with Afghans to support clients in their religious and spiritual beliefs, yet the place of religion in the therapeutic process of Afghan immigrants has remained an understudied area (Alemi et al., 2014; Garrusi et al., 2022; Mehrabi, 2002; Shirazi et al., 2015). Although studies reported here focus on Afghan immigrants, similar patterns are reported among other Muslim immigrant

communities, which highlights common elements of Muslim immigrant experiences across different cultural and ethnic backgrounds (Czymara & Eisentraut, 2020; Mohamed & Bastug, 2021; Szaflarski & Bauldry, 2019; Tahir & Safdar, 2022).

The present study aims to understand the place of religion and spirituality in the therapeutic process of first-generation Muslim Afghan immigrants in Canada. The research intends to develop an in-depth understanding of the place of religion and spirituality in the therapeutic process by addressing two central questions:

- 1) What role do religion and spirituality play in the lives of Afghan immigrants, and
- 2) What is the place of religion and spirituality in the psychotherapeutic and counselling process of Muslim Afghan immigrants?

Religion and spirituality are the two terms used extensively in this thesis, and it is, therefore, essential to define these terms and highlight their intended use in the context of the present research.

Although the two terms have historically been used interchangeably, modern conceptualizations significantly distinguish between religion and spirituality. ‘Religion’ at its core is adherence to a belief system and unconditional acceptance of the teachings of such belief system (Hill et al., 2000; Paul Victor & Treschuk, 2020), whereas ‘spirituality’ often leans more heavily on direct experience of the soul or divinity and can be defined as a more general feeling of closeness and connectedness to the sacred (Hill et al., 2000; Paul Victor & Treschuk, 2020). Religions are frequently extensively rooted in history, ritual, belief, and doctrine by nature because of their centuries- to millennia-old pasts. Religious organizations adhere to historical precedent and the original interpretations of the founder’s teachings, protecting their traditions and core beliefs. In contrast, spirituality frequently favours an evolving mindset and is less

focused on the rigid traditional approach. This refers to both a more adaptable and flexible attitude towards the basic teachings of the great wisdom traditions and the realization that, as the word implies, spiritual development is a process of evolution.

Many participants of the present study described their belief system as a structured, frequently rule-based construct that, to some degree, governs their behaviour. Such descriptions align with the definition of religion as outlined by many scholars of the field of religion and spirituality (Hill et al., 2000; Jastrzębski, 2020; Koenig et al., 2012; Pargament, 1997; Paul Victor & Treschuk, 2020). However, some participants also referred to their experiences as breaking free from the restrictions and rigid structure sometimes associated with traditional religion. They recognized that they were on a path of self-discovery and were following not a set of external rules but their own inner call to spirit. Such descriptions put them closer to the modern concept of spirituality (Jastrzebski, 2020; Koenig et al., 2012; Pargament, 2007) rather than religion's adherents.

The present study preserves the highlighted distinction between the two terms and uses the term religion and its derivatives within the context of this thesis to participants who adhere to the Islamic religious belief system. The term spirituality and its derivatives within the context of this thesis are conversely used for participants who do not readily dismiss faith in Islam as a religion; however, they often lean more heavily on the direct experience of the soul or divinity. Participants whose spiritual practices such as meditation, yoga, silence, or prayers are outside the bounds of religion claim these practices allow them to make conscious contact with more expanded states of consciousness, thus helping them validate the teachings experientially rather than accepting them on faith alone.

The research is primarily guided by two theoretical models. The first is Pargament's (1997) theory of religious coping, which focuses on "when, why and how religion comes to life" and "why the coping process is so important to the psychological study of religion" (p. 68). The second theoretical model is Levin and Chatters' (1998) proposed models of the interrelationships among religion, mental health, and the possible mediating factors. While each theoretical model is discussed in detail in chapter two, a brief discussion is also provided here to contextualize the study.

Pargament (1997) suggests that people choose the least resistant path in the wake of stressful events. In other words, they tend to choose a strategy that brings the most significant gain and the least loss of significance by using the least resources and accumulating the least burdens. Pargament (1997) argues that the level of stress created by an event is related to how much it threatens, harms, or challenges an individual's sense of significance. Thus, "we are most vulnerable to events that affect the things we care about, for which we perceive the fewest resources and the greatest burdens" (Pargament, 1997, p. 98). Religion offers a framework to create meaning out of life experiences and a way to understand and interpret life events. Pargament (1997) argues that "Any understanding of the human response to extraordinary moments remains incomplete without an appreciation of religion" (p. 4). In addition, this model assumes that the coping process is embedded in the culture. Pargament (1997) also argues that "In the language of coping, culture shapes events, appraisals, orienting systems, coping activities, outcomes, and objects of significance" (p. 117). Hence, the study of the coping process cannot be separated from the cultural milieu, just as it cannot be well understood without the context of a specific stressor. Levin and Chatters' (1998) theory, on the other hand, emphasizes the role of religion in relation to the multifactorial models proposed for the stress-buffering

functions of coping resources for health. Especially applicable are multifactorial theoretical models proposed for the stress-buffering functions of coping resources for health (Wheaton, 1985).

While the religious coping theory proposed by Pargament guides the understanding of the role religion plays in the lives of immigrants, Levin and Chatters' (1998) alternative theoretical models theory guides the present research in understanding the mediating effects of stressful life events and the impact of religious, social, and psychological resources. The alternative theoretical models theory proposes five distinct models: suppressor, distress-deterrent, prevention, moderator, and health effects (Levin & Chatters, 1998). Levin and Chatters (1998) emphasize several alternative ways religion and mental health can potentially relate. The authors further highlight the complexity and meaning of these constructs and relationships and, through their proposed theory, invite researchers and practitioners to arrive at a thorough understanding of the varied connections between religion and mental health (Levin & Chatters, 1998).

This study uses a qualitative design to examine the inclusion of religion in the psychotherapeutic process with its subjects. As Denzin and Lincoln (2011) describe, qualitative research is a situated activity that locates the observer in the world and studies the phenomena in their natural settings to understand them from people's perspectives as they practice them. Thus, further exploring the inner experience, formation, and transformation of the meaning of participants is among the critical reasons for selecting a qualitative research design. The grounded theory research approach, which aims to move beyond description and to "generate or discover a theory" for a process (Creswell & Poth, 2018, p. 82), is selected for the present study. In grounded theory research, the theory is generated from the data gathered from participants as

an effort by the inquirer to generate a general explanation of a process or an interaction guided by the views of several participants (Creswell & Poth, 2018).

The subsequent sections of this thesis begin with a review of the literature and a discussion of the theoretical framework (Chapter Two), followed by a description of the research design and methodology in Chapter Three. Chapter Four presents the results of the study and analysis of the findings. Finally, Chapter Five will conclude with a discussion on the need for further research on integrating religion and spirituality for immigrant clients.

The following chapter of the literature review and theoretical framework draws on three main themes of this research: immigration, religion and spirituality, and integration of religion in the psychotherapeutic process. It will be presented focusing on Muslim immigrants and Afghans in the West. Additionally, the theoretical framework of the thesis is discussed with a focus on integrating religion and spirituality into the psychotherapeutic process.

The first theme presented in the literature review is migration and immigrants, where the process of migration and factors affecting the mental health of immigrants are explored. The second theme explored in the literature is religious and spiritual traditions in immigrant communities, where the role of Islam as a religious practice and socio-political identity is investigated, and evidence of its impact on mental health is reviewed. The third theme explores the integration of religion and spirituality into the therapeutic process of clients with a specific focus on the experiences of immigrants in a therapeutic setting. The theme further draws on clinicians' challenges in integrating religion and spirituality into their therapeutic modalities. Additionally, a brief historical background of Afghanistan and reports on mental health in Afghanistan are discussed. Further evidence of the mental health and help-seeking behaviour of Afghan Immigrants is also gathered in the literature review section.

The research design and methodology chapter gives a brief overview of methodologies in qualitative research, discusses the chosen methodology of grounded theory for this research including how and why it was chosen, and presents relevant criteria and processes for evaluating the research findings. Results and analysis of the findings are presented in chapter four, with an in-depth discussion on the emerging theoretical model of the place of religion in the psychotherapeutic process of Muslim immigrants and its multiple aspects. Theoretical and practical implications of the study for clinicians and clients will also be discussed in Chapter Four. Chapter Four also presents the emergent model of the place of religion and spirituality in the psychotherapeutic process. Chapter Five presents concluding remarks, a discussion on the operationalization of the emerging theoretical model, some limitations of the proposed research, and the author's thoughts on future direction.

Chapter Two:

2. Literature Review and Theoretical Framework

Based on reports and research, this chapter aims to explore the intricate relationship between migration, religion, and mental health, focusing on the experiences of immigrants, particularly Muslim immigrants, in the Western context. The chapter begins by examining the phenomenon of migration and its impact on individuals and societies. It explores immigrants' challenges as they navigate cultural, linguistic, and socio-economic changes in their new homes. The chapter then delves into the significance of religion and spiritual traditions, particularly Islam, for Muslim immigrants. It explores how their religious beliefs, practices, and community engagement influence their mental health, coping mechanisms, and well-being.

Recent immigrants in the West go through unique experiences and challenges from a sociocultural point of view. To highlight these experiences and challenges, the chapter examines the influence of multiple factors, such as cultural adaptation, acculturation processes, and social integration, on the mental health of immigrants. The chapter further highlights the challenges immigrants face as they go through the resettlement process in light of the resources that may be available to them during the resettlement process. The chapter also focuses on the mental health challenges faced by Afghan immigrants. It explores the cultural and contextual factors influencing mental health outcomes and help-seeking behaviours within the Afghan immigrant community. A broader relationship between religion and mental health is examined to understand the potential impact of religious beliefs, practices, and values on psychological well-being, resilience, and coping mechanisms, highlighting the importance of religion for Muslim clients in their therapeutic process.

Furthermore, the chapter explores the integration of religion and spirituality into psychotherapeutic processes. It examines various approaches and models incorporating religious and spiritual dimensions, highlighting the potential benefits and ethical considerations. It also explores strategies and techniques for fostering culturally sensitive and inclusive care that respects clients' religious and spiritual beliefs and delves into the challenges and complexities of fostering an integrative approach in psychotherapy. The chapter also discusses the potential barriers, biases, and ethical dilemmas that arise when addressing religion and spirituality in therapeutic settings. Finally, the chapter examines various theoretical models to understand the relationship between religion, spirituality, and mental health outcomes. It provides a foundation for comprehending the mechanisms through which religious and spiritual dimensions influence psychological well-being.

By addressing these topics, this chapter seeks to contribute to a deeper understanding of the experiences of immigrant populations, particularly Muslim immigrants, and the role of religion and spirituality in their mental health. It underscores the importance of culturally responsive approaches in mental health care and sets the stage for the present study on the integration of religious and spiritual dimensions into the therapeutic processes of Muslim immigrants.

2.1. Migration and Immigrants

The International Organization for Migration (IOM) identifies any person or persons moved or moving from their habitual place of residence within a state or across an international border as a migrant. The IOM defines migration as “a population movement encompassing any kind of movement of people, whatever its length, composition and causes are” (International Organization for Migration [IOM], 2019). This definition disregards legal status, cause of the

movement, length of stay, and whether the move was voluntary or involuntary. It thus encompasses refugees, displaced persons, economic migrants, and persons moving for other purposes.

Migration is influenced by multiple factors ranging from seeking economic stability and better education, employment, and the betterment of the future to avoiding political and religious persecution to reunification with family (Bhugra, 2004; Bhugra et al., 2010; Bhugra & Gupta, 2010; Schuster, 2016; Tribe, 2010). One of the widely accepted theories of sociological explanation of migration is the push-pull theory. The theory initially proposed by Lee (1966) suggests that migration is governed by both push and pull factors. Lee (1966) identifies economic betterment and educational uplift as the pull factors that attract the individual, whereas push factors are identified as those life situations that give one reason to be dissatisfied with one's present location. These reasons may include political elements, droughts, famine, and natural disasters that may extrude individuals from one culture to another. One of the fundamental distinctions frequently made in migration discussions is between 'voluntary' and 'forced' migration (Bhugra & Gupta, 2010; McColl et al., 2008; Schuster, 2016; Tribe, 2010). Migrants motivated by the pull factors are often reported to be people who 'choose' to migrate for economic betterment and educational endeavours, among many others. In contrast, forced migrants are reported as victims of political persecution, unemployment, natural disasters, drought, and famine (Bhugra & Gupta, 2010; Castelli, 2018; McColl et al., 2008; Schuster, 2016; Tribe, 2010). These categories are often treated as separate 'voluntary economic' and 'forced political' categories. However, migration motivations can be mixed (Bhugra, 2004). In other words, those who immigrate due to conflict, human rights abuse and violation, or persecution, which are significant indicators of forced migration, may also leave economic instability and

poverty. These immigrants may strive to make a more economically stable living once they arrive at a place of safety.

Similarly, those who immigrate in search for economic stability and financial security may be excluded from work or education in their place of origin because of gender, religion, or ethnicity. Those who immigrate voluntarily to work may face forced immigration again due to post-migration stressors, including discrimination in the host country (Schuster, 2016). A clear distinction between migrants, asylum seekers, and refugees is, therefore, difficult and a reality increasingly accepted by migration and asylum experts. Nonetheless, the United Nations High Commission for Refugees (UNHCR, 2006) defines refugees as individuals who, owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, are outside the country of their nationality, and are unable to, or owing to such fear, are unwilling to avail themselves of the protection of that country. On the other hand, an asylum seeker is an individual seeking international protection and sanctuary in a country other than the one of their usual settlements (UNHCR, 2006). In other words, an asylum-seeker is someone whose claim application to take refuge in the host country is submitted but has not yet been finally decided upon (United Nations General Assembly, 1951). Not every asylum-seeker will ultimately be recognized as a refugee, but every refugee is initially an asylum-seeker (UNHCR, 2006). Bhugra (2004), in his review of the literature on migration, acknowledges it as a universal, complex, and highly heterogeneous phenomenon. Although the process can take place individually or in groups, the variety of experiences and range of reasons suggests that the migration process is likely to differ for individuals and groups. The process may be temporary or long-term, occur once in a single generation, or be a continuing migration stream over several generations (Bhugra et al., 2010). Nature, scale, and reasons for migration

determine the complex implications of the process both in terms of biological as well as psychological effects on immigrants who have moved from their habitual place of living to a new environment, people of the host environment to which immigrants moved, as well as people of the home environment from where immigrants have made the journey to their host environment (Bakker et al., 2014; Castaneda et al., 2015; Dancygier & Laitin, 2014; Delara, 2016).

2.1.1. Process of Migration and Factors Affecting the Mental Health of Immigrants

The migration process in recent literature is divided into three stages: pre-migration, migration also known as in-transit, and post-migration (Bhugra, 2004; Bhugra & Gupta, 2010). Pre-migration is when an individual, either singly or as part of a group, decides to migrate and prepares to do so using financial, legal, and political resources. The second stage is in-transit, or the process of migrating and moving across borders and relocating individuals or groups from one site to another. Post-migration is defined as the last stage of the migration process. It is the immigrant's adjustment stage to the new geographic location's social, political, economic, and cultural framework. This adjustment also includes new roles related to gender, employment, and social status, among others (Bhugra & Gupta, 2010). The literature considers each stage in the migration process separate from the others; however, Bhugra and colleagues (1999) argue these stages can overlap. For instance, pre-migration preparations to migrate can continue to and through the migration stage, and the post-migration stage can be prolonged to a considerably long period after migration. Furthermore, Bhugra (2004) describes the process of migration not just as a phase but "a series of events, which are influenced by a number of factors over a prolonged period of time" (p. 244). Bhugra points out that these phases are also under the influence of other social and individual factors, for example, social skills, the concept of self,

psychological, social, and biological vulnerabilities at the pre-migration level, and stress of adaptation, discrimination, economic difficulties, and rootlessness at the post-migration level. In addition, Tseng (2001) emphasizes the influence of the voluntary or forced nature of migration as well. Tseng suggests that the nature of the push-pull factors not only determines the migratory forces but also affects the responses of individuals as well as groups. Migration following wars and political turmoil can result in displacement, which may cause additional or aggravate mental health challenges (Gülşen et al., 2010; Utržan & Wieling, 2020) and negatively affect coping abilities for refugees and asylum seekers (Sim et al., 2023). Individuals can be primary migrants, who are the ones to migrate and then get others to follow over in subsequent waves of secondary migrants. Primary migrants may have different stress experiences than secondary or even tertiary migrants. Primary migrants may experience more stress settling down as they often go through the process of resettlement without additional support often available for secondary migrants offered to them by primary migrants (Bhugra et al., 2014). Recently there have also been waves of group migration to the western countries including Canada (Fransen & De Haas, 2022; Wilkinson, 2021). Such group migrations may provide a sense of social support and create an element of social capital for the individual members of the group, but they may also be a source of stress for some members of the group who must look after the needs of others in the family (Bhugra et al., 2014). Following the pre-migration and migration phases, when migrants begin to settle down, social and economic factors like employment, housing, language, discrimination, and lack of support systems can significantly affect the resettlement process (Bhugra, 2004; Schuster, 2016; Tribe, 2010). Conclusively, social, economic, psychological, physical, and cultural causes influence the mental health of immigrants, especially among vulnerable individuals. In turn, all of these factors can also affect the process and reasons for migration,

although Bhugra (2004) argues that the directional nature of this relationship may not always be entirely clear.

2.1.2. Pre-Migration Factors of Mental Health

Pre-migration factors are described as the pre-existing tendencies to mental disorders associated with vulnerabilities, for instance, perinatal trauma or early childhood adversities, which can, in turn, increase the likelihood of experiencing mental health problems for individuals (Bhugra & Gupta, 2010). Furthermore, individual lifestyle, working conditions, cultural and socio-economic conditions, and community influences are critical indicators of individuals' well-being and health (IOM, 2017). Stompe et al. (2010) further determine that the vulnerability and resiliency of individuals to pre-migration stressors are developed as several biological, environmental, and sociocultural factors interact in forming individual responses. The authors argue that personality factors and past resilience experiences affect how the individual reacts to life events and adjusts to the new environment.

Research further suggests that forced migrants have a higher prevalence of mental health problems compared with residents of the host country or other migrants in the host country. Some studies link the nature of immigration with a predisposition to depression (including major depression), depressive symptoms (Del Amo et al., 2011, Qureshi et al., 2013, Schrier et al., 2010, Steinhausen et al., 2009), anxiety disorders (Del Amo et al., 2011, Steinhausen et al., 2009), and a tendency toward somatization (Del Amo et al., 2011), which are less prevalent in populations of the host countries. Likelihood of experiencing traumatic events in pre-migration is also higher in forced displacement compared to economic migration, which can result in post-traumatic stress disorder (PTSD), depression, psychological distress, and anxiety (Chen, Hall, Ling, & Renzaho, 2017; Fazel, Wheeler, & Danesh, 2005; Heeren et al., 2014).

2.1.3. Migration Phase and its Impact on Mental Health

Reports of the International Organization for Migration suggest that the process of physically migrating in and of itself under normal circumstances is not a risk factor to the mental health of immigrants (IOM, 2017). Similar findings were also reported by Pavli and Maltezos (2017) in their study of the health problems of newly arrived refugees in Europe. However, the conditions surrounding the migration process can increase the vulnerability to adverse health outcomes for the immigrants (Davies et al., 2006). This is particularly true for involuntary immigrants and those fleeing natural or human-made disasters, conflicts, and human rights violations. Davies et al. (2006) report that the physical and socio-economic environment of the migrants in the place of origin (pre-migration stage) determines many of the pre-conditions for the migratory journey; for example, if migrants are in an irregular situation or migrate as refugees and displaced persons, their health can be negatively affected by the migratory journey. Immigrants who migrate through clandestine means or fall into the hands of traffickers and end up in exploitative situations, as well as immigrant workers who lack proper immigration papers, form a large and vulnerable population group (Clapham & Robinson, 2009). Other risk factors include lack of clarity regarding legal status of migrants; limited access to health and social services; experiences of poverty, social exclusion, and discrimination in host countries; lack of education and high levels of stigma towards utilization of mental health services; differences in language and culture; separation from family; and incompatibility of other socio-cultural norms like gender roles.

Research shows that refugees and asylum seekers are severely affected by the factors surrounding the migration phase (Bhugra et al., 2014; Chen et al., 2017; George, 2012; IOM, 2017). They are exposed to intense traumatic and distressful situations during their migratory

journey and typically separated from their families and support systems, creating risks for severe anxiety, depression, and a sense of loss while moving between different countries and refugee camps (George, 2012). These vulnerable groups of immigrants must develop a new sense of hope during the migratory journey, despite remaining in an uncertain state and going through a traumatizing asylum-seeking process and confronting their losses (George, 2012).

2.1.4. Post-Migration Factors of Mental Health

Research in physical and psychological health, as well as global health organizations such as the World Health Organization, have determined material variables as well as interpersonal variables as critical social determinants of health and mental health in members of groups with lower access to power, material resources, policy-making, social and political means (Commission on Social Determinants of Health, 2008; Marmot et al., 2008). Material variables are shaped by broader social and political forces such as lack of access to a safe environment, inadequate food and housing, lack of access to high-quality healthcare, and unemployment; whereas interpersonal variables include experiences of social exclusion, discrimination, and low social status (Commission on Social Determinants of Health, 2008; Marmot et al., 2008). While post-migration factors of mental health are substantially studied in migrants affected by push factors, including refugees and asylum seekers (Crawley et al., 2016; Gonget al., 2011; Ipsos, 2016), there is a significant lack of research on migrants motivated by pull factors. Gong and colleagues (2011) report that non-refugee immigrants to the United States often endure violence during transit, including detention, verbal and physical assaults, and other human rights abuses. While critically reviewing methodologies and results of previously published systematic review studies and primary research on the impact of post-migration conditions, Hynie (2018) attributes the limitation of studies with non-forced immigrant population to how studies classify foreign-

born or migrant groups broadly as ‘immigrants’ and examine disparities between the immigrants and native-born populations without accounting for the critical differences in subgroups of migrants. Hynie (2018) argues that few studies examine the prevalence and impact of trauma experiences after migration to the host country with the non-forced immigrant population. Evidently, more research is needed to shed light on the post-migration factors of non-forced immigrants. However, many immigrants motivated by pull factors share post-migration experiences with those motivated by push factors (Bambra et al., 2010; Braverman & Gottlieb, 2014; World Health Organization, 2014).

Exposure to traumatic experiences before migration and post-migration health conditions put refugees and asylum-seekers at significant risk of poor mental health. The forced nature of migration, post-migration conditions, and the policies and public attitude towards refugees and asylum seekers often place this category of immigrants at the lower end of the social gradient. Some social factors include their membership in groups often stigmatized by the host communities (e.g., minority ethnic, racial, or religious groups), which results in prolonged material deprivation, social exclusion, and uncertainty (Hynie, 2018). Variables that affect the mental health of forced migrants are: income (Allen et al., 2014; Bakker et al., 2014; Braverman & Gottlieb, 2014), employment (Bogic et al., 2012; Momartin et al., 2006; Shishehgar et al., 2017), housing (Allen et al., 2014; Bogic et al., 2012; Hynie et al., 2016), language skills (Hynie, et al., 2016; Kale, & Syed, 2010; Strang et al., 2018;), official processes categorized as asylum seeking processes, which includes preliminary refugee claim acceptance, temporary visas, temporary permission for employment, permanent visas and legal access employment (Bambra et al., 2010; Hainmueller et al., 2016; Momartin et al., 2006; Porter & Haslam, 2005),

social isolation (Allen et al., 2014; Bogic et al., 2015; Bogic et al., 2012; Chen et al., 2017), and discrimination (Beiser & Hou, 2016; Bogic et al., 2012; Shedlin et al., 2014).

2.2. Religion and Spiritual Traditions in Immigrants

Migration can be a traumatizing experience. Immigrants become strangers in the new land and lose familiar sounds, sights, and smells. The expectation of customary behaviour, hearing one's native or more familiar language, and support of family and friends becomes scarce and cannot be taken for granted anymore (Hirschman, 2004). Even the most routine life activities, i.e., shopping for food, working, and leisure time, can become alienating experiences for many new immigrants trying to navigate and be understood (Alba & Nee, 2005). In many cases, however, religious beliefs and practices can serve as a solid foundation for immigrants as they adapt to the new environment in the new land (Hirschman, 2004). Herberg (1983) argues that immigrants must confront the existential question of "Who am I?" in a new social context (p. 12). Immigrants often find meaning and identity by reaffirming their traditional beliefs and the structure of religious faith. The certainty of religious prospects can provide an anchor as immigrants adapt to the changes that their lives must endure in the new land (Hirschman, 2004; Shaw et al., 2019). The long-lasting challenge of migration to a new land is not limited to adaptation. Immigrants struggle to reinvent their lives by absorbing new elements while trying to preserve the old ones (Chiu et al., 2005; O'Mahony et al., 2013). Religious and spiritual beliefs and practices in immigrants resist replacement with the values and beliefs of the dominant host culture. Even those who may have become disdainful or dismissive of the belief system of their home country through acculturation may tend to tap into ancestral beliefs and practices at times of stress and disparity (Falicov, 2009; Kahn, 2015). The tendency to revisit cultural beliefs and rituals has been called ideological ethnicity (Harwood, 1981; Falicov, 2009) and has been

reported as a therapeutic resource for immigrants to utilize practices that enhance belonging, continuity, and moving forward (Walsh, 2009), providing strength to cope with changes and social stresses that the immigrants endure in the host location. Religion can serve as means for the transportability of beliefs and internal continuity of practices both in the private lives of the immigrants and in the public area of religious practices (Falicov, 2007; Falicov, 2009). It also supports the immigrant in adaptation to the new country by providing community involvement and guidance (Haque, 2004). However, religious activities often take a new meaning after migration. Herberg (1983) believes that religious beliefs and attachments have stronger roots after immigration than before, for they provide an experience of emotional connection with others. Scholars have suggested that religious identities become more salient for immigrants in the host country than their home country because of religion's role in preserving ethnic identities (Ajrouch, 2004; Cadge & Davidman, 2006; Kurien, 2001).

Religious institutions and organizations play a significant role in creating community and become a significant source of social and economic assistance for the immigrants in the host country. They can fill the void of extended families and broader communities as a source of a social and spiritual comfort with small and less proximate families in the host country (Hirschman, 2004). Members of the religious community and religious bodies, like family members, do not expect immediate reciprocity as a basis for friendship and social exchange. It is often sufficient for persons to trust and help one another when the idea of a community of shared values is a connecting factor in the relationship (Hirschman, 2004)

Although religion and religious practices can have a positive relationship with the mental health of immigrants, this may vary across cultural groups and by gender (Chappell & Lai, 1998; Jarvis et al., 2005; Whitley et al., 2006). Individual and group identity formation, or how

individuals think of themselves and their relationships to groups of others, is a central theme in research about religion and immigration. Scholars of religion and immigration argue that identity is many-sided and fluid, shaped by historical and social contexts and overlapping (Ajrouch, 2004; Cadge & Davidman, 2006; Hirschman, 2004). In addition to religion and ethnicity, noted scholars of religion and immigration have considered the role of gender in identity construction and maintenance in religious organizations and individuals' lives. It is argued that the work on gender identity suffers from an over-focus on how gender is constructed within religious organizations rather than the various ways that religion and gender might intersect outside of specifically religious settings (Ajrouch, 2004; George, 2012; Hirschman, 2004). Immigration and the condition of diaspora affect the status and position of people of all genders in family, society, and religion (Predelli, 2004). Women can become more marginalized in some areas, whereas they may gain ability and power in other areas. While some immigrant women may lose influence on family life through a lack of language skills, they gain legal rights, which can enhance their position within the same unit (Predelli, 2004).

2.3. Muslim Immigrants and the Role of Islam in their Mental Health

2.3.1. Islam as a Socio-Political Identity of Muslims and its Impact on Mental Health

Muslims worldwide represent around one-quarter of the global population. One-fifth of the world's Muslim population inhabits countries where Islam is not the majority religion, including Western societies where Islam is the principal minority faith and Muslims are the fastest-growing religious groups (The Global Religious Landscape, 2018). The term West and its derivatives in the context of this study primarily refer to the countries and institutions that derived their political, economic, social, religious, and philosophical beliefs primarily from Western European traditions, primarily the UK, France, and Germany, with influences from

Spain and Italy and, further back, Greece. Countries with similar heritage, values, and interests, such as Canada, are also included. Australia and New Zealand are also considered part of the West due to their British heritage, even though they are geographically in the East rather than the West (Ifversen, 2008; McNeill, 1997; The Bill Lane Center for the American West, n.d.). Eid (2014a) in his study of the perceptions about Muslims in Western society, argues that the dominant portrayal of Muslims in the Western mainstream media tends to be negative, despite some efforts to provide a fair and objective representation of Muslims. The dichotomy of the Self and Other between Muslims and Western societies is widely enhanced by the negative portrayal of Muslims, which leads to the characterization of Muslims as exterior to the dominant group (Eid, 2014a). A general imagination of Islam in Western societies is a rigid entity of a global set of adherents (Karim & Eid, 2014), whereas, as a result of global participation in this belief system, Muslims comprise heterogeneous faith groups, demonstrating a wide variety of cultural practices and traditions (Caidi & MacDonald, 2008; Karim, 2009).

However, the overall conception of Muslims in Western societies, particularly North America, is primarily negative. Eid (2014a) argues that racist and discriminatory depictions, discourses, accusations, and generalizations about Muslims in Western societies dehumanize perceptions about Muslims and ultimately deem them inferior to the dominant group in society. Other researchers and authors (e.g. Amri & Bemak, 2012; Delara, 2016; Goforth et al., 2014) found religion as a significant factor that informed discrimination against Muslim immigrants in North America.

Research shows that migration-related stress is intensified with experiences of discrimination and marginalization, and religion was conceptualized as a significant factor informing the discrimination of Muslim immigrants in North America and other western

countries (Castaneda et al., 2015; Shishehgar et al., 2015; Araujo and Borrell, 2006). Muslims in Western societies, particularly in North American society, are found to be in a disadvantaged position in the labour market and workplace, as well as with economic integration (Adida et al., 2010; Akter, 2010; Dancygier & Laitin, 2014). Structural and institutional barriers, on top of the stigma associated with mental health disorders among Muslim populations, prevent their access to healthcare and counselling services, which can influence the lives of several generations (Delara, 2016; Martin, 2015; Gerritsen et al., 2006; Zotova, 2018). However, a significant body of scholarship points to the positive impact of Islam as a religion and religious practice of Muslim immigrants navigating through the new social environment (Abdel-Khalek, 2007; Abu-Ras et al., 2008; Adida et al., 2010; Akter, 2010; Alemi et al., 2014; Aloud & Rathur, 2009; Amri & Bemak, 2012; Ciftci et al., 2013; Demirkaya, 2014; Dwairy, 2006; Haque, 2004; Padela & Zaidi, 2018; Qasqas & Jerry, 2014; Weatherhead & Daiches, 2010; Zotova, 2018).

2.3.2. Islam as a Religious Practice and its Impact on Mental Health

Religion is widely identified as a coping factor and mediator that connects religiousness and mental health outcomes in times of stress (Pargament et al., 2011; Pargament et al., 1998;). Religion creates a sense of belonging and participation in the context of adjustment through networks of mutual support and participation in groups and organizations (Alba & Nee, 1997; Hirschman, 2004; Zotova, 2018).

In the case of Muslim immigrants, religion shelters them from the stresses and difficulties they experience in a new place and creates opportunities for immigrants to connect with the new society (Ebaugh & Chafetz, 2000; Zotova, 2018).

Islam, as a religion, provides Muslims with a code of behaviour, ethics, and social values. These values are essential in the development of coping strategies to deal with stressful life

events for Muslims. Islam teaches them the harmonious way of living together. The Quran¹ in surah 28, verse 77 states:

وَابْتَغِ فِيمَا آتَاكَ اللَّهُ الدَّارَ الْآخِرَةَ وَلَا تَنْسَ نَصِيبَكَ مِنَ الدُّنْيَا وَأَحْسِنْ كَمَا أَحْسَنَ اللَّهُ إِلَيْكَ وَلَا تَبْغِ الْفُسَادَ فِي
الْأَرْضِ إِنَّ اللَّهَ لَا يُحِبُّ الْمُفْسِدِينَ

Seek the life to come by means of what God has granted you, but do not neglect your rightful share in this world. Do good to others as God has done good to you. Do not seek to spread corruption in the land, for God does not love those who do this. (Quran 28:7, Oxford World's Classics edition)

Islam provides Muslims with guidelines for two types of interactions: interactions of humans with God and interactions among humans (Sabry & Vohra, 2013). There is an emphasis on maintaining good health in Islam as Muslims believe that body and soul belong to Allah² and will be returning to Him. Thus, the need to ensure physical and spiritual well-being is emphasized by Islam. The Qur'an speaks of healing for the illness of the human heart, and the Prophet is reported to have exhorted treatment of the sick and various means for cleansing the heart through meditation, prayer, and good deeds.

Maryam Gazorpour and Nasrin Barkhordar (2003; as translated and cited in Hamidi et al., 2010), in their study of mental health in the Quran, concluded that while the Quran does not use the word mental health, it provides practical teachings, each in its own way, in maintaining mental balance and providing hope and dignity to human beings. Islam addressed many concepts

¹ The Quran, also transliterated from Arabic as Koran or Qur'an, is the book composed of sacred writings accepted by Muslims as revelations made to Muhammad by God through the archangel Gabriel (Merriam-Webster's collegiate dictionary, 2016).

² Allah, used in Islam, refers to God: the supreme or ultimate reality, the Being perfect in power, wisdom, and goodness who is worshipped (as in Judaism, Christianity, Islam, and Hinduism) as Creator and ruler of the universe (Merriam-Webster's collegiate dictionary, 2016).

related to the mental health of the believer, i.e., hope, belief in the hereafter, self-knowledge and self-development, unity of personality, anger, patience, and willpower.

Despite the emphasis Islam puts on health and well-being and the role of the believers in maintaining good health, literature in healthcare suggests that the religious practices of Muslims can both enable and hinder good health (Padela & Zaidi, 2018). Studies suggest that Muslims who view Allah as the controller of health and illness, as well as the only ultimate provider of cures, may, in some cases, be led to fatalism (Johnson et al., 1999; Padela et al., 2012; Shah et al., 2008). In such cases, the emphasis is put on ritual prayers, supplication, and reading of the Qur'an as a primary or secondary way to solicit health benefits and be healed (Carroll et al., 2007; Odunukan et al., 2015). Weatherhead and Daiches (2010), in their study of a heterogeneous sample of Muslims, found that the Muslims found peace of mind in religious practices and identified religion as a place to which they could refer in times of disparity and problem. Weatherhead and Daiches (2010) further identify the belief of Muslims that religion provides them with psychological relief and helps them by teaching them the importance of submitting to Allah. Studies suggest that some adherents of Islam perceive the need for professional psychological assistance and seeking services as less relevant, based on the central belief that only God can help (Weatherhead & Daiches, 2010). However, where therapy is seen as relevant, religion is considered an integral part of the therapeutic process of Muslims (Haque, 2004; Mehrabi, 2002; Youssef & Deane, 2006; Ypinazar & Margolis, 2006; Zotova, 2018).

As highlighted, religious practices and beliefs about health and illness have contextual differences and commonalities across Muslim groups. A fundamental tenet of Islam, shared by all groups, is that there is one God (Allah), and Allah causes everything, including illness. Some religious leaders consider illness as a method of connection with Allah and do not consider it as

alien but rather an agent of cleansing and purifying the body and the soul, creating a balance of the physical, emotional, mental, and spiritual aspects of the individual (Rassol, 2000). Multiple studies on the Muslim perspective of psychical and mental illness reflect this core belief (DeShaw, 2006; Padela et al., 2012; Shah et al., 2008; Ypinazar & Margolis, 2006). Mental illness may also be perceived as a test or punishment from God (Abu-Ras et al., 2008; Rassool, 2000). It is implied by the punishment that only those who have not been faithful to God will fall victim to psychological disturbances (Amri & Bemak, 2012). This belief stands at the root of the social stigma that perceives those with psychological conditions as detached from God, a situation considered “shameful” not only for the individual but for the family of the individual as well (Aloud & Rathur, 2009; Demirkaya, 2014; Erickson & Al-Timimi, 2001; Youssef & Deane, 2006). Muslim families are reported to experience stigma due to mental illnesses and the unwillingness of other community members to marry into a family with a member experiencing mental illness (Abu-Ras, 2003; Shibre et al., 2001). Although consideration of intersectional stigma in the context of Muslim mental health is a critical issue in addressing the mental health needs of Muslims, socio-cultural aspects of Muslim immigrants in the West are an exacerbating factor.

2.4. Socio-Cultural Aspects of the Immigrant Experience in the West

Data reported by international organizations indicate that the extensive globalization process during the past 15 to 20 years has led to the migration of millions of persons from their places of origin worldwide (IOM, 2016). In hopes and aspirations for an improvement in their socio-economic conditions, these migrants bring with them their heritage, language, religion, and traditions, that is, their culture, as well as their racial and ethnic characteristics and manifestations (Ruiz & Bhugra, 2010). On many occasions, these migrants are refugees and

asylum seekers migrating because of political and military conflicts in many parts of the world. Intrinsic in these migratory processes is the 'stress' produced by the interaction of the majority culture of the host society and the minority culture of the migrant groups (Ruiz, 2004).

Ruiz (2004) identifies the stress produced by the migratory process as 'acculturative stress,' and the process is known as the acculturation process. Migrant groups, in the context of acculturation, tend to 'integrate' with the majority culture in the host society; 'assimilate' into the majority culture and accept the differences; 'reject' the majority culture; or 'marginalize' themselves within the host society or the majority culture (Ruiz 2004).

A series of variables may impact the acculturation process represented by integration, assimilation, rejection, and marginalization. These factors include sociodemographic variables (i.e., sex, marital status, education level, race, ethnicity, religion, and economic condition); societal variables (i.e., pluralistic, tolerant, or racist nature of the majority culture); migrant group variables (i.e., nature of the migration process); sociological and psychological variables (i.e., coping and adaptation style of the migratory group and previous experiences of conflict in the migrant group); and behavioural variables (i.e., use of drugs and alcohol, abuse, and criminal tendency). These variables, accompanied by the final mood of the acculturation process, will determine the degree of positive and negative outcomes when resolving the impact of acculturative stress (Ruiz, 2004; Ruiz & Bhugra, 2010).

Confronting the sociodemographic variables, immigration, including identity, religion, and culture, are particularly challenging for Muslim immigrants. Openness to identifying with the host society and culture while having a strong sense of connection to the original identity can be an obstacle to the acculturation process in the host society. Coupled with experiences of marginalization and othering, Muslim immigrants are disadvantaged in the acculturation process.

2.4.1. Muslim Immigrants in North America

The Muslim population arguably increased dramatically in North America during the twentieth century. In 2012, nearly 130,000 people from Islamic countries became legal residents of the United States (Pew Research Center, 2012). However, it is widely reported that Muslims and other people of faith are often singled out in a prejudicial manner (Hodge et al., 2016). Prejudice against Muslims may have been exacerbated by the terrorist attacks of September 11, 2001 (9/11), as researchers have documented a spike in discrimination and hate crimes directed toward Muslims after 9/11 in the United States (Hodge et al., 2016). This increase in discrimination is not only reported in the United States, but several community surveys, focus groups, and polls in Canada also suggest that there has been an increase in discrimination against Muslims post-9/11 (Chung, 2011; Helly, 2004).

Muslims are reported to be the fastest-growing religious minority in Canada (Moghissi & Ghorashi, 2016). According to Statistics Canada and the National Household Survey (Statistics Canada, 2016), the growth rate of the Muslim population is exceeding other religions. Meanwhile, Muslims in Canada are reported not to enjoy acceptance like other religious minorities. Moha Ennaji (2016) argues that the problem for Muslim diaspora stems from a lack of proper understanding of the Muslim community by other Canadians, whose impressions are formed through stereotypes and negative characterizations (i.e., men as terrorists, a widespread acceptance of honour killings).

The role of media in othering Muslims in Western societies is also echoed by Mahmoud Eid (2014b). Eid argues that Western societies tend to consider minorities as ‘Others’ who should either be tolerated by the majority or are expected to assimilate with the majority culture. Eid emphasizes the role of entities such as the media in perpetuating negative stereotypes about

Muslims resulting in distorted public perception of the religion and its followers. These misperceptions in Western society have amplified racism also referred to as religio-racism by Weisenfeld (2018), discrimination, and dehumanization of Muslims (Eid, 2014a). However, the significant lack of literature on the effects of these misconceptions on the mental health of immigrants highlights the need for research on all groups of Muslim immigrants in North America, specifically in Canada (Adamuti-Trache et al., 2018; Amri & Bemak, 2012; Moghissi et al., 2009; Youssef & Deane, 2006). Among these groups, there is an especially large gap in research on Afghan immigrants (Alemi et al., 2018; Alemi & Stempel, 2018; Bronstein et al., 2012; Gerritsen et al., 2006; Lipson & Omidian, 1992; Lipson & Omidian, 1997; Mehrabi, 2002).

Afghans immigrants are reported to be significantly affected by psychological distress, including posttraumatic stress disorder and depressive symptomology, anxiety, grief-related disorders, psychosomatic disorders, and existential meaning crisis (Fazel et al., 2005; Gerritsen et al., 2006; Laban et al., 2004). However, findings from studies with other refugee populations suggest that pervasive mental health problems experienced by Afghan immigrants are also reported by other immigrant populations (Alemi et al., 2014; Fazel et al., 2005).

2.4.2. Afghan Immigrants in Canada

Afghanistan has been one of the top ten source countries of immigration to Canada since 2010 (Immigration and Refugee Board of Canada, 2018). Data from the Canada Census 2016 recorded 83,995 people of Afghan origin living in Canada. Afghan refugees began migrating to Canada in significant numbers in the late 1980s. The majority of the Afghans living in Canada (i.e., 60,065 people) are first-generation immigrants (Statistics Canada, 2016). Because more

than five million Afghan refugees fled Afghanistan to neighbouring countries of Pakistan, Iran, and India, most Afghan refugees came to Canada by way of a third country (Norquay, 2004).

The census data also reports that most Afghans in Canada reside in the southwestern region of Ontario and the Greater Toronto Area. Significant communities of Afghans in Canada are present in Toronto, Montreal, Vancouver, Calgary, Ottawa, Hamilton, Kitchener, Edmonton, and Guelph (Statistics Canada, 2016).

Afghan immigrants have various challenges in adapting to life in Canada, such as critical post-migration mental health stressors like labour market challenges, linguistic barriers, and discrimination (Wilson et al., 2010). Cross-sectional studies with Afghan refugees show elevated levels of depression and post-traumatic stress disorder (Alemi et al., 2016).

Symptoms of these elevated conditions are related to war, traumas, older age, loss of social support, loss of identity, discrimination, poor language skills, and lower employment and education opportunities (Alemi et al., 2016). Social disadvantages are linked to asylum status challenges observed in newly resettled Afghan youth and adults (Bronstein, Montgomery, & Dobrowolski, 2012). Mental health symptoms of the majority of Afghan immigrants may improve over time and as they get settled, but ongoing daily psychological stressors constitute a significant risk factor for Afghan immigrants long after resettlement (Alemi et al., 2016).

Wilson et al. (2010), in their study of pre- and post-migration determinants of the mental health of newly arrived refugees in Toronto, discuss that newly arrived refugees face pre-migration stressors, including war, violence, torture, and persecution, and these determinants exacerbate the post-migration stressors that refugees face in the post-migration period. Studies indicate that religion has been a critical source of inner comfort and social connectedness in Afghan immigrant communities. For example, Mehrabi (2002) reports that reciting verses from

the Quran and performing regular prayers gave Afghan immigrants a sense of purity and cleanliness. More specifically, rape victims found this a valuable way of cleaning their bodies from what they perceived as the impurity of rape (Mehrabi, 2002). The use of religious parables as well as reading the life story of the Prophet Muhammad and the Surahs (verses) from the Quran and Hadith (sayings of the prophet Muhammad) are reported comforting while at the same time providing the basis for social connection in religious entities (Mehrabi, 2002).

In their study on religious identity and practice among Afghan males and females in Canada, Moghissi et al. (2009) found that 71% of males and 77% of females identify themselves as “Muslim” (Moghissi et al., 2009). These authors also report that, contrary to stereotypes that all peoples of Muslim background are very religious and that their communities are similar in terms of the strength of religious belief and practice, their research shows that within the Afghan community in Canada, individuals show different degrees and kinds of religious affiliation. About 31% of Afghans surveyed in their study are reported to be high in religious identity and high in religious practice, typed by researchers as “strongly committed,” and 30% of Afghans surveyed in their study are reported to be low in religious identity and religious practice categorized by researchers as “tending to be secular.” While the number of Afghans on both extremes is close, the researchers report that 17% of Afghans surveyed were very high or high in religious identity and low or medium in religious practice, typed as “virtual religious,” and 22% of Afghans surveyed were low or medium in religious identity and very high or high in religious practice, typed as “ritual practitioners” (Moghissi et al., 2009, p. 93).

2.5. Afghanistan: A Brief Historical Background

Afghanistan is a landlocked country in South Asia (Runion, 2017). The National Statistical and Information Authority of Afghanistan (NISA, 2019) estimates the total population

of Afghanistan to be 31.6 million. However, varying reports of the estimated total population between 34.9 million (CIA, 2018) and 37.17 million (World Bank, 2018) are widely reported in the literature. The country arguably served as a buffer between the British and Soviet empires until its independence from Britain in 1919 (Central Intelligence Agency, 2018). Afghanistan is dotted with high mountains and deep and narrow valleys that may separate people of different cultures and lifestyles (Emadi, 2005).

Afghanistan's inhabitants are reported to be diverse and full of contrast (Emadi, 2005). Each ethnic community is said to have its own culture and history and speak its own language (Emadi, 2005). Afghanistan has two official languages, Pashtu and Dari (Runion, 2017). However, it is estimated that as many as 49 languages are spoken in Afghanistan (Runion, 2017). Afghans, despite their cultural diversity and many ethnic groups, arguably have remained united as a country and have defended themselves against foreign invaders (Runion, 2017).

A significant development in Afghanistan's history is reported as its Islamization by Muslim armies in 652 C.E. (Emadi, 2005). Runion (2017) states that Afghanistan has faced turmoil since the dawn of humankind and throughout history, immersing its history in conflict, distress, and social crisis, but it is also reported to offer a wide range of diverse narratives (Runion, 2017). The International Organization (2016) defines mobility as an essential aspect of Afghan history, which includes migration for seasonal and permanent employment and seeking refuge.

Records show that Afghans have been fleeing the violence in their country to neighbouring countries of Pakistan and Iran in large numbers since the 1970s when the communist regime took power, and subsequently in the aftermath of Soviet Union's invasion of Afghanistan in 1979 (Runion, 2017). Although the greatest number of Afghan immigrant fled to

the neighbouring countries of Pakistan and Iran, there has been a significant number of immigrants fleeing to countries in the European Union, Australia, and North America (Marchand et al., 2014).

It is widely reported that the Soviet invasion in 1979 caused the first large wave of migration of Afghans (IOM 2016). Data shows that it was during this period that the Afghan population was reduced by half due to migration (IMO, 2016). The number of Afghan refugees in 1990 increased to more than 6 million (Marchand et al., 2014).

The second large wave of Afghan migration reportedly occurred after the victory of the Mujahedeen in 1992 (IOM, 2016). At this time, many, especially the urban and educated middle class, began to flee from Afghanistan and continued to do so during the regime of the Taliban in 1994. These movements continued until the year 2000, when over 300,000 Afghans fled to neighbouring countries and other continents (Marchand et al., 2014).

The third wave of Afghan migration is reportedly caused by the war and associated bombings between the Taliban and the Allied Coalition forces led by the United States in 2001 (Marchand et al., 2014). The United Nations High Commission for Refugees' (UNHCR) report on Forced Displacement indicated that as many as 2.5 million Afghan refugees were registered in 2016 (Kasmani, 2017).

The fourth and most recent wave of Afghan immigrants started in August of 2021 after the withdrawal of the United States from Afghanistan and the takeover of Afghanistan by the Taliban for a second time (UNHCR, n.d.). The Taliban, as a de-facto governing authority, imposed a harsh interpretation of Islamic law despite pledges to respect the rights of women and religious and ethnic minority communities. Meanwhile, as they have transitioned from an insurgent group to a de-facto government, the Taliban have struggled to provide Afghans with

adequate food supplies and economic opportunities. People of Afghanistan, particularly women and girls, face significant challenges under the rule of the Taliban, including widespread food insecurity, soaring inflation, and high economic instability, which are also exacerbated by sanctions and loss of aid, limited livelihoods, and more frequent and severe climate shocks. UNHCR (n.d.) has recorded over 1 million internally displaced people. Furthermore, in the events leading up to the Taliban's takeover of Afghanistan in August 2021, neighbouring countries Pakistan and Iran saw the highest numbers of Afghanistan's refugees and asylum seekers. Almost 1.5 million Afghans fled to Pakistan, while Iran received 780,000, according to UNHCR (n.d.).

In the immediate aftermath of the Taliban's return to power, the United States military evacuated more than 124,000 individuals from Afghanistan. More than 77,000 evacuees were admitted into the United States and offered a two-year entry permit (Dawi, 2023). The Canadian Government announced resettling 40,000 vulnerable Afghans in addition to an earlier initiative to resettle thousands of Afghans who had worked for the Canadian Government, such as interpreters, embassy employees, and their families. As of May 2023, over 30,000 Afghan refugees had migrated to Canada post-Taliban takeover of Afghanistan in August 2021 (Immigration, Refugees and Citizenship Canada. 2023).

2.6. Reports on Mental Health and Help-Seeking in Afghanistan

Institute for Health Metrics and Evaluation (2017) at Washington University reported that more than a million Afghans suffer from depressive disorders, and more than 1.2 million suffer from anxiety disorders. The institute identified the nearly four decades of political violence, rising number of people affected by social problems, violent conflicts, civil wars, displacements, and disasters among some of the causes.

The dire situation of Afghan mental health is arguably a hidden consequence of the war and is often overshadowed by the loss of life and the ruins of the country (Alemi et al., 2018). Furthermore, there is a significant lack of research and authorship on Afghan views of mental health and what Afghans see as being helpful in addressing their mental health needs and problems, which further aggravates the ongoing stressful social condition (Alemi et al., 2016; Miller et al., 2008). Studies show that similar to people from many other conflict-affected countries, mental health help-seeking resources for Afghans are limited to help from professionals of the medical sector, traditional healers, and drawing on faith and family support systems (i.e., Imams³ and close family members) (Alemi et al., 2016; Saxena et al., 2007). A household survey of mental health and social functioning in postwar Afghanistan shows that Afghans rely on traditional healers like clergy ‘Imams’ and practitioners of herbalism ‘Tabibs’ (Cardozo et al., 2004).

Additionally, Scholte et al. (2004) report that Afghans draw extensively on assets of cultural resiliency such as family, friends, and remaining engaged in religious activities. Other reports show that Afghans cope by self-medicating with psycho-pharmacological drugs (i.e., anti-depressants, mood stabilizers), seeking refuge in religious shrines, and distracting or keeping themselves busy (van de Put, 2002; Ventevogel et al., 2002; Wildt et al., 2017). Alemi et al. (2018), in their examination of help-seeking patterns of Afghans, found that Afghans rely heavily on religion and religious activities as well as the support of family and friends. The authors report that some Afghans also seek the help of medical professionals and traditional healers. However, they are influenced by higher severity of distress symptoms.

³ Imam, Arabic imām (“leader,” “model”), in a general sense, one who leads Muslim worshippers in prayer (Zeidan, 2022)

2.7. Mental Health and Help-Seeking Behaviour of Afghan Immigrants

Studies show that the vulnerability of Afghan immigrants to psychological distress is rooted in traumas encountered in their homeland and subsequently fleeing their homeland (Alemi et al., 2014). Studies conclude that many Afghan immigrants have experienced observing atrocities, loss of members of their families, and stressful escape and transit journeys (Alemi et al., 2014; Fazel et al., 2005; Keyes, 2000; Lipson, 1991; Lipson & Omidian, 1992; Lipson, & Omidian, 1997). Recent studies suggest that memories of traumatic war experiences are rekindled through current reminders, associated with the rumination, linked with isolation and loneliness, which in turn affect many even after long-term resettlement (Feldmann et al., 2007; Sulaiman-Hill, & Thompson, 2012).

While studies assessing the extent of trauma are limited, research indicates that traumas encountered by Afghans may not be as distinguishable compared to other refugee groups that also face political violence. For example, the impact of losing family due to displacement and death may be similar among various Muslim refugee groups, including Afghans, who value the institution of family as an integral facet of their culture (Lipson & Omidian, 1992; Alemi, James, & Montgomery, 2016).

Additionally, studies with Afghan refugees suggest that mental health problems may be amplified due to eroding cultural values that dictate family affairs, for example, the lack of respect children show towards elders, their indifference to the culture, and their newfound sense of identity and independence in the host country's culture (Lipson, 1993; Lipson, & Omidian, 1997, Alemi et al., 2016). Studies with Afghan immigrants further highlight that the elderly are perhaps the most vulnerable to a deep sense of being up-rooted. The overall burden of mental

health problems across all age groups appears to be mediated by cultural barriers, notably language barriers.

Mental health symptoms of the majority of Afghan immigrants may improve over time and as they get settled in host countries, but ongoing daily psychological stressors constitute a significant risk factor for Afghan immigrants long after resettlement (Alemi et al., 2015). Wilson et al. (2010), in their study of pre- and post-migration determinants of the mental health of newly arrived refugees in Toronto, discuss that newly arrived refugees face pre-migration stressors, including war, violence, torture and persecution, and these determinants exacerbate the post-migration stressors that refugees face in the post-migration period.

Studies across all age groups show that Afghan immigrants' mental health problems appear to be mediated by cultural barriers, particularly language barriers. In general, language barriers between Afghan immigrants and health service providers are partly responsible for the low mental health care utilization (Alemi et al., 2014). Other significant factors of low utilization of services include the stigma among Afghan immigrants regarding mental health, distrust of Western medical assistance methods, and perceptions of psychotherapy as a Western phenomenon (Miller & Rasco, 2004).

Although there is a significant lack of research about utilizing mental health services, some qualitative studies show unique help-seeking experiences of Afghan immigrants. These experiences include religious activities, seeking support from members of family and friends, and expressing gratitude for one's situation (Alemi et al., 2014). Some studies also observed Afghan immigrants resorting to alcohol abuse to cope with stressors associated with the acculturation process (Haasen et al., 2008).

Literature not only emphasizes the need for improved access to mental health services for the immigrant population but urges mental health professionals to increase their awareness of Afghans' responses to stressors, their support systems, and coping strategies, all of which may be shaped by religion and cultural norms (Alemi et al., 2014)

2.8. Religion and Mental Health

Religion is defined as “beliefs, practices, relationships or experiences having to do with the sacred that are explicitly and historically rooted in established institutionalized systems” (Pargament, Exline, & Jones, 2013). Pargament (1997) uses the term sacred inclusively to refer not only to concepts of God and higher powers but also to other aspects of life that are perceived to be manifestations of the divine or infused with divineline qualities. These include transcendence, immanence, boundlessness, and ultimacy. Pargament and Mahoney (2005) further elaborate that any part of life, whether positive or negative, including beliefs, practices, experiences, relationships, motivations, nature, art, and war, can be endowed with the sacred status. Conclusively, Pargament (2007) defines sacred as “concepts of God, the divine, and transcendent reality, as well as other aspects of life that take on divine character and significance by virtue of their association with, or representation of, divinity” (p. 32). Mahoney (2010) argues that religion occurs in the broader context of established institutions and traditions with a primary goal and a process for facilitating spirituality.

Theoretical and empirical studies clarify that religion and spirituality have multiple dimensions and constructs and are made of numerous thoughts, feelings, actions, experiences, relationships, and psychological responses. Understanding the formation of religious and spiritual pathways requires looking at the forming factors and the interconnection of those factors. Meanwhile, it is critical to note that people do not follow religious and spiritual

pathways in isolation from the social and cultural forces (i.e., social or religious groups, cultural forces like age, ethnicity, family, and community); instead, these forces shape the nature of the individual's religious and spiritual journey over their lifespan (Pargament, Mahoney, & Shafranske, 2013).

Another central theme in the study of religion and spirituality is the integration of multiple valences. Perhaps the most controversial question in the field of psychology is whether religion and spirituality are right or bad for health and well-being. Taking one position or the other has been seen in both the academic and non-academic literature (Pargament et al., 2013; Pargament, 1997), and arguably, there may be a degree of truth to each of the sides. Pargament (1997) argues that the oversimplification of these constructs could prove to be misleading. Although stressful situations generally rush religious impulses, a significant number of individuals remain atheists before, during, and after intense life experiences. While some people turn to their faith in search of support or use it as a way of avoiding confrontation with reality, in many cases, religion and spirituality encourage active coping rather than passive coping (Koenig et al., 2012; Pargament, 1997; Pargament, 2002). Furthermore, religious groups can indeed promote intergroup conflict and terrorism; however, religious groups also sponsor peace, reconciliation, and social justice moves (Fallot & Blanch, 2013; Jones, 2008; Pargament et al., 2013; Stern, 2003; Silberman et al., 2005; Waller, 2013).

Research on the correlation between religion and mental health has shown a positive correlation, negative correlation, and absence of correlation (Loewenthal, 2007; Malinakova, 2020). Meta-analyses of studies on religion report that religion has an overall beneficial relation to mental health (Garssen et al., 2021; Hackney & Sanders, 2003). On the other hand, studies also indicate that extrinsic religious orientation is associated with negative characteristics such as

prejudice and fear of death (Doane et al., 2014; Khan et al., 2019; Donahue, 1985). Reporting the absence of a correlation, Payne, and colleagues (1991), in their review of religion and mental health, did not find evidence for a connection between religiosity and the prevention of major clinical mental health disorders. Gartner and colleagues (1991) report an ambiguous correlation between anxiety, sexual disorders, psychosis, prejudice, self-esteem, intelligence, and religion. However, such results are not observed in other studies including meta-analyses on correlation between religion and mental health.

Dein (2006), in a review of the literature on religion and depression from 1996 to 2006, reports that religious people have a lower incidence of depressive symptoms/depression. Dein further reports increased recovery speed from depressive disorder among religious individuals compared to non-religious individuals. However, the researcher indicates that this protective effect is less clear-cut for psychotic depression. Although research results that suggest religion is negatively correlated to depression, anxiety and the adverse effects of multiple stressors cannot be ignored; there is ample research that reports on positive correlation between religion and mental health. Lesniak et al. (2006), in their study of psychological distress and religiosity among young African American adults, show that intrinsic religiosity reduces distress and depression. Similar findings are reported by Goodman and Dyer (2023) in their study with families in the United States. Watlington and Murphy (2006) report that African American women with greater religious involvement reported fewer depressive symptoms and posttraumatic stress symptoms in the aftermath of domestic violence. Furthermore, cross-cultural research suggests a positive correlation between religiosity and life satisfaction among college students (Gauthier et al., 2006), lower levels of suicide in church attendees (Kay & Francis, 2006), a positive association between religiosity, happiness, and mental health and a negative

association of religiosity with depression and anxiety among Kuwaiti adolescents (Abdel-Khalek, 2007).

Koenig and colleagues (2012) highlight that although many published studies are conducted in Western nations involving Christian populations, the number of studies on Muslim populations from Middle Eastern countries is increasing. However, the authors stress the need to understand the similarities and differences between these faith traditions to better understand the research from the two areas of the world. The authors argue that despite the similarities and differences, three primary bonding beliefs of the two faith traditions, Christianity and Islam, set the stage for the similar influence of these religions on the mental health of their followers. Koenig and colleagues identify the three primary bonding beliefs as (1) the worship of and surrender to one God; (2) almost identical moral values and many similar practices; and (3) the desire to follow the teachings of their respective prophets (Jesus and Muhammad) whose teachings despite being in different cultures, times, and circumstances in history are very similar.

Koenig and colleagues (2012) further report that among the studies published on religion and mental health in Western countries with predominantly Christian populations, 256 studies (79%) found greater happiness, satisfaction with life, or well-being in the more religious and spiritual participants; additionally, 26 out of 32 studies (81%) found greater optimism as well. The authors report that among 45 studies that examined the relationship between meaning and purpose in life with religion and spirituality, 42 studies (93%) found greater meaning or purpose among the more religious and spiritual (Koenig et al., 2012). Self-esteem is reported to be significantly high among religious and spiritual participants in 42 out of 69 studies (61%) (Koenig et al., 2012). The authors report positive effects of religion and spirituality on internal locus of control in 62% of the studies, on depression and faster remission from depression, or

reduction in depression severity in 61% of the studies, significant inverse relationships between religion and spirituality and suicide (completed suicide, attempted suicide, attitudes toward suicide) in 75% of studies, and inverse relationships between religion and spirituality and anxiety in 49% of studies (Koenig et al., 2012, p. 181).

Although compared to studies in Western countries, there have been fewer studies reported from Middle Eastern countries (including Pakistan, Afghanistan, Malaysia, Egypt, and Bangladesh) with predominantly Muslim populations (Koenig et al., 2012), the reported findings of the studies in comparison to those conducted in the Western countries are not very far from each other. A positive association of religion and spirituality with well-being is reported in 12 (72%) of the 18 studies (five from Israel, five from Kuwait, two from Malaysia, and one from Pakistan) published between 1887 and 2010 (Koenig et al., 2012, p. 180).. Among four studies conducted in Iraq, Iran, Pakistan, and Malaysia, positive associations between religion and self-esteem were found in Iraqi and Iranian participants, and no association between religion and self-esteem was reported among participants from Pakistan and Malaysia (Koenig et al., 2012). On the other hand, studies with participants from Malaysia, Israel, Palestine, Lebanon, Egypt, Kuwait, Iran, Afghanistan, Pakistan, and Turkey reported positive, negative, and no association between religiosity and psychological distress (Koenig et al., 2012).

Pargament and Raiya (2007), in their summary of recent advances in research in religion and coping, report that despite the growth in scholarship achieved in the past two decades, the focus has almost exclusively remained on the Christian population. Pargament and Abu-Raiya argue that other traditional faiths, particularly Islam, have remained mainly neglected from systematic, rigorous, and large-scale scientific research inquiry. Further highlighting the gaps in the study of the psychology of Islam, Abu-Raiya and Pargament (2011) call attention to the lack

of assessment and measurement tools that can lead to an incomplete and imprecise understanding of Islam. The authors note that instruments used in studies with the Muslim population are rooted in a different cultural climate and are based on Western Christian assumptions about religion. Furthermore, Abu-Raiya and Pargament (2011) argue that the definitions and application of existing psychological theories of religion are developed mainly within Western cultural contexts. Therefore, they might be biased about Islam, culturally insensitive, or even ethnocentric and may not fully capture the uniqueness of this religion. Purely Western measures of religiousness may, for instance, overlook salient aspects of Islam (e.g., pilgrimage, specific ethical conduct), might be offensive to some Muslims, and some of the items of these measures might be irrelevant to Muslims. Although there is a significant scarcity of literature that offers an in-depth perspective on Islam and its links to health and well-being, recently, several attempts have been made to develop scales of this nature (Abu-Raiya & Pargament, 2011). Despite the instruments' shortcomings, this emerging body of research has shed light on critical Islamic dimensions and identified some connections between Islamic beliefs and practices and the well-being of Muslims. Specifically, two major substantial conclusions can be derived from this body of research. First, the findings of this body of research lend support to the multidimensionality of Islam, where the most recurrent factors found in studies were *beliefs* and *practices* testifying to the centrality of these two dimensions to the lives of Muslims (Abu-Raiya & Pargament, 2011). Second, this body of research has begun to demonstrate connections between different aspects of Islamic religiousness and well-being and health indicators, for example, the association between the effects of extrinsic and intrinsic forms of religious commitment with the perception of nearness to God, anxiety, death anxiety, and depression or prediction of multiple well-being indices (e.g. satisfaction with life, physical health, optimism) with the two factors (i.e. Religious

Practices, Religious Altruism) of the Islamic Religiosity Scale developed by Tiliouine and colleagues (2009).

2.9. Integration of Religion and Spirituality into Psychotherapeutic Processes

The fabric of many people's lives is woven with religious and spiritual beliefs and practices. Extensive research has demonstrated a positive relationship between religion and spirituality and physical and psychological health (Koenig et al., 2012). For many immigrants, religion and spirituality can foster increased social belonging, connection, and support; adjustment to stressors through meaning-making, coping, and resilience; and grounding of one's identity through noteworthy beliefs and values (Akbas et al., 2022; Chaze et al., 2015; Paloutzian & Park, 2014). Nevertheless, for some people, religion and spirituality can be a source of conflict and confusion or defence against unresolved psychological conflicts (Exline & Rose, 2014). The incorporation of a client's religious and spiritual identity into psychotherapy has the potential to influence both change processes and treatment outcomes.

Meanwhile, personal beliefs, values, and presumptive frameworks are inherent to the clinical practice of mental health professionals and interact with professional ethical considerations. These personal beliefs and values often reflect or are associated with religious or spiritual presumptive frameworks (Hope et al., 2019; Yarhouse & Johnson, 2013). The professions that provide mental health support can be conceptualized as value-laden professions with inherent values that motivate clinical practice. These values influence and inform various aspects of the therapeutic relationship, such as informed consent, self-disclosure, assessment and diagnosis, the conceptualization of client issues, and therapeutic intervention (Yarhouse & Johnson, 2013). As a result, religious and spiritual value conflicts and ethical dilemmas are among the factors that affect the course of treatment, and these issues can be especially

challenging to navigate. When a client's religious or spiritual beliefs, commitments, or practices manifest as clinically significant attributes, the paths become even more complicated and ethically challenging (Frunza et al., 2019).

The complexity is attributable mainly to the fact that psychology, religion, and spirituality approach meaning from vastly distinct perspectives. Divergent worldviews and presumptive meaning-understanding frameworks may be the root of such complexity.

2.9.1. Differing Approaches of Psychology and Religion and Spirituality to Meaning

Psychological, religious, and spiritual perspectives on meaning are distinct. The predominant worldview of psychology is naturalism, whereas most mainstream religions and spiritual traditions adhere to theistic or existential worldviews. Different worldviews entail different assumptive frameworks, epistemological bases, language, and values, which can generate friction in therapeutic relationships, leading some to question whether Religious and psychological approaches are incompatible (Slife & Reber, 2009).

Different assumption-based frameworks and commitments can result in a division that appears insurmountable. Some clinical theorists, for instance, advocate a polarizing approach to psychological and religious or spiritual roles (Gonsiorek et al., 2009; Plante, 2009). In other words, mental health professionals must operate exclusively within a naturalistic worldview and may only speak from scientific knowledge. Others argue that this dichotomy is false (Edwards, 2013; Magnusson, 2000). A mental health professional with a theistic worldview may view all of life as religious or spiritual and infuse their role with their religious or spiritual understanding. It may be undesirable or impossible for that professional to renounce their convictions when assuming a professional position (Yarhouse & Johnson, 2013). When different assumption-based frameworks are available, it is easy to recognize the dilemmas that arise. Personal beliefs and

values may conflict even within similar frameworks of assumption among professionals and between professionals and those they serve. Although the division appears irreconcilable, it must be resolved (Yarhouse & Johnson, 2013). For instance, a psychotherapist may work with a woman suffering from an anxiety disorder who feels compelled to pray repeatedly before going to bed to alleviate her dread of dying in her sleep. A therapist could treat her obsessive-compulsive symptoms without considering the role of prayer in her life or her beliefs about the sacred and about God, who she thinks cares about her and answers her prayers. In addition to treating the obsessive-compulsive symptoms, a second therapist with a theistic or spiritual worldview could help the same client retain the ability to pray in meaningful ways to nurture her relationship with the sacred.

When professionals approach their work from a naturalistic worldview, even though those receiving services operate from a theistic or spiritual worldview, or vice versa, language can become a source of confusion. For instance, a researcher who has integrated psychology, religion, or spirituality might include queries on a survey about 'sacrifice' to assess the relationship between sacrifice and religious or spiritual beliefs with the implicit recognition that sacrifice is intrinsically positive and essential for flourishing relationships. Respondents with feminist perspectives may support the items with the understanding that sacrifice is inherently harmful, and an artifact of oppression perpetrated by patriarchy. These responses may be misinterpreted and devalued when analyzing the data and drawing conclusions. Mental health professionals and researchers use language to develop, measure, and communicate constructs, but language also contains embedded values (Frunza et al., 2019).

Those who advocate a separation between the discipline's scientific, religious, and spiritual aspects have cited epistemological differences as the primary reason for this

separation (American Psychological Association [APA], 2007; Gonsiorek et al., 2009). Religious and spiritual realities are based on a classical realist method of knowledge acquisition, which is informed by tradition, experience, and revelation (Coe & Hall, 2010). While practitioners of the field of psychology provide the public with scientific knowledge that has been objectively tested and can be rationally understood, their methods do not admit religious and spiritual knowledge because such understanding cannot be objectively known or empirically demonstrated (Yarhouse & Johnson, 2013).

When stated in this manner, it is reasonable to assume that such knowledge cannot be studied and, consequently, should not be explored within psychology. Each epistemological approach, whether the modern scientific approach or religious and spiritual approaches based on classical realism, has limitations; therefore, a functional model is required to use each approach effectively and to the client's advantage (Duckham & Schreiber, 2016).

In addition to the impact of differing worldviews on the complexity of value and ethical issues, there are significant differences of opinion regarding how psychology and religion should be integrated into professional practice. This query is difficult to answer because there are multiple integration philosophies and models and different categories of these philosophies and models (Carter & Narramore, 1979; Eck, 1996; Johnson & Jones, 2000).

Carter and Narramore offered four broad approaches in one of the earliest attempts to classify the relationship between psychology and theology. To broaden the discussion, Yarhouse and Johnson (2013) characterize these as the relationship between psychology and religion or spirituality to include traditions that lack an explicit theological component.

The four approaches and their subtypes are the following:

1. The *Against* model represents a conflict between psychology and religion or spirituality. From an epistemological perspective, the secular version of this model views realism and empiricism as the only valid means to truth. It finds religious or spiritual revelations to conflict with the findings and methods of the science of psychology. The secular version believes that religion and spirituality are detrimental to emotional balance. However, the sacred version of this model considers revelations to be the only source of truth, as opposed to reason or scientific investigation. Religious and spiritual individuals adhering to the against model not only consider revelation the only truth, but they also view other truth claims and their work in therapy as harmful to their mental and emotional health.
2. The *Of* model seeks to identify positive psychological principles within a religion or the psychology of religion. In other terms, it is the psychological study of religion. This model's secular version minimizes religious concepts' religious nature or content and denies the supernatural. The revelations in this model's secular alternative omit supernatural and historical elements. They are interpreted as expressions of humanity's universal struggle to be genuinely human and rise above dependency's limitations. Revelations and spiritual perspectives are imbued with a specific psychological meaning and, as a result, serve as a vehicle for the expression of psychological truth. In contrast, proponents of the sacred variation of this model emphasize the universal nature of revelation and spiritual perspectives rather than the supernatural and redemptive aspects. They draw attention to compassion, liberty, accountability, and the need for personal development.

3. The *Parallel* model, or the view that psychology, religion, and spirituality are all significant and valid but that they exist in parallel and cannot be integrated. The secular version of this model adopts an isolationist stance in which the primary reliance should be on the scientific method. However, it acknowledges that philosophy and religion also have their appropriate domain of activities outside of science. The proponents of the sacred version of this model emphasize both scripture and spiritual perspectives as well as science. However, they presume the two do not interact deeply, explicitly, or implicitly. According to the sacred version of the parallel model, there can be no conflict between religion, spirituality, and psychology because they are independent and disconnected.
4. The *Integrate* model investigates the compatibility between religion and spirituality and psychology, as both pursue truth and presume there is a unity that defines truth. Secular theorists of the integrated model may view religion as an integrative force in personal life and emphasize religion's contributions to personal adjustment and development. Despite their contributions, they are limited because they lack understanding of and commitment to the authoritative nature of theistic revelations and spiritual views. In contrast, despite the development of literature on psychology and religious scripture, few scholarly works discuss the integration of psychology and theological perspectives in a comprehensive and in-depth manner, as the purpose of many writings is to promote religious and spiritual practices rather than conceptual understandings of the relationship.

More modern categorizations consider similar factors and widen the discussion to some extent (Johnson, 2010). However, there seems to be much rarity of discussion, let alone

agreement, about which models are the most ethically sound. This has to do with how theistic and psychological views of what it means to be human and healthy can be combined while still upholding the aspirational principles of the psychological field, such as promoting beneficence; relating to others and practising with fidelity, integrity, and justice; and showing respect for people's rights and dignity (American Counselling Association [ACA], 2014; American Psychological Association [APA], 2002; Canadian Psychological Association [CPA], 2017; American Psychological Association [APA], 2017). Some approaches may be better suited than others to adhering to these principles. For instance, mental health professionals who follow an approach that integrates psychotherapeutic processes with religion and spirituality may be more likely to maintain their professional competencies and excellence than those who assume a conflict between psychology and religious and spiritual belief (ACA, 2014; APA, 2002; CPA, 2017; CRPO, 2011; OCSWSSW, 2018). For example, the mental health professional who frames the relationship between religion and psychology as one in which religion is against psychology may feel justified in foregoing informed consent for the use of prayer or the use of sacred texts in therapy (Yarhouse & Johnson, 2013). In contrast, the mental health professional integrating psychology with religion and spirituality may be more likely to examine empirical research on the benefits of prayer or reading sacred texts during the informed consent process for religiously accommodating treatment. In addition, a mental health professional integrating psychology with religion and spirituality may be more likely to research the benefits of prayer or reading sacred texts when getting informed consent for religiously accommodating treatment.

Realizing the profound nature of religious and spiritual convictions makes resolving value conflicts exponentially more difficult. Discussing a cultural value difference, such as the pre-eminence of the community versus the individual, it suffices to recognize the difference and

its implications. However, differences in religious and spiritual beliefs and values can have moral and even life-or-death consequences (Maximo, 2019). Given the importance of belief and value commitments to human motivation and behaviour, it is crucial to comprehend how to respect value differences at the intersection of psychology, religion, and spirituality.

Pargament (2009) wrote, “Dealing with religious and spiritual issues in psychotherapy is inherently messy. Why? In part because religion and science are not totally separable” (p. 391). Religion and science, in the form of psychology, are interested in helping people live better lives. The applied aspect of psychology makes assumptions about how individuals should live in light of various personality theories. Similar to how religious and spiritual beliefs reflect values, efforts to enhance people’s lives also reflect values. The inherent disarray necessitates an explicit discussion of values and value conflicts for the field and its clinicians to proceed ethically.

Jones (1994) brings this argument to its logical conclusion, asserting that “psychology could be enriched by a more explicit exploration of the interface of religion [and spirituality] with its scientific and applied activities” (p. 197) and eloquently highlighting the need for an inclusive perspective on understanding the interface between psychology, religion, and spirituality.

2.9.2. Integrative Paradigm of Religion and Spirituality in Psychotherapeutic Process

Pargament and colleagues (2013) refer to their proposed organizing perspective as the integrative paradigm for the psychology of religion and spirituality in the APA Handbook of Psychology, Religion, and Spirituality. This paradigm is based on a profound appreciation for diversity and integration in religion, spirituality, and psychology. Mental health professionals cannot rely solely on a single set of theoretical, methodological, or practical instruments to comprehend the extraordinary extent and depth of religion and spirituality (Pargament et al.,

2013). Instead, multiple concepts and procedures are required. To create coherence and wholeness, however, it is equally important to identify points of connection and interaction, explore possibilities for convergence and synthesis, and answer unanticipated questions and challenges that can only arise from dialogue and exchange within the field.

The present study relies heavily on some of the main themes discussed by Pargament et al. (2013), i.e., religion and spirituality as multidimensional, multi-level, and multivalence within the context of psychotherapeutic processes for immigrants, as discussed in the following section.

A. Religion and Spirituality as Multidimensional. Theoretical and empirical research demonstrates that religion and spirituality are multidimensional constructs comprising many thoughts, emotions, actions, experiences, relationships, and physiological responses that serve various functions and produce various outcomes (Glock, 1962; Idler et al., 2003). However, the extraordinary multiplicity and diversity of religion and spirituality make it even more difficult to comprehend these processes. How can we make this task easier? The metaphor of the journey, which consists of pathways and destinations (Pargament, 1997, 2007), is particularly beneficial. Consider a person entering the world and beginning a journey.

A religious and spiritual journey that, over time, leads them down multiple paths. Religious and spiritual paths reveal much about an individual's character; no two people's life paths are identical. Virtually every prominent religious tradition describes life as a journey and provides its adherents with a map of the paths they should follow. The Pillars of Islam, for instance, define the central path of life as submission to Allah's will. Others, however, prefer to construct their own paths through their spiritual views and practices (Pargament et al., 2013). While some individuals may follow the 'preconstructed' paths made available to them by their

religious traditions, others prefer to construct their own paths through their spiritual views and practices.

Paths defining life's journeys also lead to specific destinations (Pargament, 2007). Social scientists have articulated a variety of religious and spiritual destinations, or to use their terminology, religious and spiritual functions, over the years. Religion and spirituality serve functions ranging from impulse control and anxiety reduction to meaning formation and evolutionary adaptation (Garssen et al., 2021; Levin & Chatters, 1998; Lucchetti et al., 2021; Rosmarin & Koenig, 2020; Weber & Pargament, 2014).

B. Religion and Spirituality as Multilevel. People do not follow their religious and spiritual paths in isolation. They navigate within a larger field of social and cultural forces, such as religious affiliation, age, ethnicity, family, community, and culture. Religion and spirituality are multidimensional constructs and multilevel phenomena (Ciftci et al., 2013; Pargament et al., 2013). These forces influence the essence of an individual's religious and spiritual journey throughout their lifetime. As essential as the individual level of analysis is to religious and spiritual study and practice, other levels of analysis are also relevant foci.

Recent research has tried to clarify the difference between a conscious, explicit level of religiosity, spirituality, and personal belief and a less conscious, implicit level of religious understanding (Hall et al. 2013; Mahoney 2013). Researchers and practitioners have begun to cast new light on the manifestations of religion and spirituality within intimate relationships, families, institutions, communities, and cultures. Religion derives from the concept of tying, or, as Guntrip (1969) stated, "religion is relationship to the nth degree" (p. 324).

C. Multiple Valences of Religion and Spirituality. Are religious and spiritual beliefs beneficial or detrimental to health and well-being? This is possibly the most contentious matter

in the field. The arguments about whether religion and spirituality are helpful, or damaging are ultimately misguided because they are based on the idea that there is an all-or-nothing answer; religion and spirituality are either good or bad, in simple, black-and-white terms (Pargament et al., 2013). In contrast, the psychology of religion and spirituality makes it evident that these phenomena are multidimensional and can be beneficial and harmful.

The crucial question is not whether religion and spirituality are positive or negative but when, how, and why they assume constructive or harmful forms (Pargament, 1997, 2007; Pargament et al., 2013). Alternatively, to pose the issue more scientifically: “How helpful or detrimental are specific religious and spiritual expressions for specific people coping with specific situations in specific social contexts based on specific criteria for helpfulness and harmfulness?” (Pargament, 2002, p. 178). This question more accurately reflects a fundamental truth: religion and spirituality can be good or bad. Moreover, the complexity of this topic indicates the need for a vast corpus of research to unravel the intricate connections between religion, spirituality, and human functioning.

2.10. The Rationale for Integration of Religion and Spirituality in the Psychotherapeutic Process of Immigrants

Similar to the biological, psychological, and social dimensions of existence, spirituality and religion are associated with the mental health and well-being of immigrants (Alemi et al., 2016; Khan et al., 2018; Koenig et al., 2012; Rosenberg et al., 2022; Tomasi et al., 2022; Wilson et al., 2010). Consequently, assessing religion and spirituality as part of a more extensive biopsychosocial–spiritual assessment provides a more comprehensive, holistic comprehension of the existential circumstances of clients (Hodge, 2013). The biopsychosocial-spiritual viewpoint encompasses the recognition of the multifaceted nature of client problems, including biological,

psychological, social, and spiritual components (Bakal, 1999). Hodge (2001) defines religious and spiritual assessment as the process of collecting, analyzing, and synthesizing information about these two interrelated constructs into a framework that informs practice decisions. The procedure is structured around comprehending how religion and spirituality influence functioning (Shafranske, 2005). In other words, the purpose of the evaluation procedure is not to determine the validity of clients' beliefs, values, and practices but rather how they impact client-related functioning. For instance, understanding how religion improves psychological coping can provide the foundation for subsequent practice strategies intended to alleviate problems.

According to Pargament (2007), religion and spirituality are considered normal, natural, and distinct aspects of existence. By conceptualizing these constructs in a manner congruent with the lived realities of their clients, mental health practitioners implicitly communicate respect for their clients. For many individuals, their experience of the sacred is fundamental to their sense of self. Other aspects of diversity (e.g., ethnicity, gender, class) define and influence the expression of the search for the sacred.

The following aspects of clinical practice in the context of the mental health of immigrants serve as a foundation for assessing religion and spirituality in practice: professional ethics, client autonomy, knowledge of clients' worldviews, identification of religious and spiritual strengths, and identification of religious and spiritual problems. The underlying rationales in each of these fields of study often intersect and strengthen one another.

2.10.1. Professional Ethics

A primary function of professional ethics codes is to guide practitioners' conduct (Freeman, 2000; Hathaway & Ripley, 2009; Yarhouse & Johnson, 2013; Hathaway & Ripley, 2009). Clinicians and mental health professionals who employ the Ethics Codes pertinent to their

field of expertise should assess spirituality and religion as part of their routine practice in light of the shared principles of respect, dignity, and excellence in professional practice by multiple governing bodies of mental health and psychological service provision (ACA, 2014; APA, 2002; CPA, 2017; CRPO, 2011; Hodge, 2004; OCSWSSW, 2018). These principles emphasize the idea that everyone deserves to be valued for who they are as a person without regard to external characteristics or circumstances. It also entails understanding the client in the context of their life and considering physical, psychological, social, and spiritual factors. This type of evaluation provides the information required to ensure ethical compliance (Hodge, 2013; Plante, 2009). It is essential, for instance, to learn about clients' religious backgrounds to consider their beliefs when providing services. Similarly, to avoid inadvertently discriminating against or degrading religious clients, it is often necessary to know their religious and spiritual narratives (Richards & Bergin, 2000; Van Hook et al., 2001). In conclusion, a practitioner's ability to adhere to professional ethics is greatly aided by undertaking a spiritual and religious examination.

2.10.2. Client Autonomy

Therapy works best when it is conducted in a safe, non-threatening environment where patients feel comfortable sharing their values and desires (Richards & Bergen, 2005). Many individuals desire to incorporate their spiritual and religious values into the therapeutic dialogue. Studies have demonstrated that clients from various cultural, religious, and spiritual backgrounds prefer to have their religious and spiritual values and beliefs incorporated into the counselling process (Arnold et al., 2002; Larimore et al., 2002; Mathai & North, 2003; Rose et al., 2001, 2008; Solhkhah et al., 2008). In their scoping review, Chaze and colleagues (2015) note the emergence of similar perspectives in studies of various immigrant populations in Canada. In studies reviewed by Chaze and colleagues (2015), most clients desire to incorporate their

religious and spiritual values into therapy. Additionally, according to the American Psychological Association (APA) and the APA Presidential Task Force on Evidence-Based Practice (2006), mental health professionals are ethically responsible for accommodating patients' requests to include their spiritual and religious beliefs in treatment.

2.10.3. Knowledge of Clients' Worldviews

Therapists' knowledge of their client's cultural worldviews is increasingly recognized as crucial to successful therapy (Sue & Sue, 2008). Understanding how clients perceive reality facilitates the development of therapeutic rapport, using culturally sensitive interventions that are more likely to be adopted and avoiding interactions that could jeopardize the therapeutic relationship. Client buy-in and success can be improved through interactions consistent with clients' worldviews (Cross, 2002; Gone, 2007). Religion provides an interpretive framework for comprehending reality that informs adherents of who they are and how they ought to live for many individuals (Pargament, 2007). These religious worldviews can influence attitudes regarding animals, burial practices, childcare, communication styles, coping behaviours, death, diet, finances, bereavement, marital relations, medical care, military participation, recreation, and education (Hodge, 2004b). In other words, the search for the sacred is expressed in diverse religious cultures by many individuals (Koenig, 1998; Richards & Bergin, 2000; Van Hook et al., 2001). By suggesting interventions consistent with and even resonating with clients' spiritual worldviews, clients' sense of ownership increases, thereby increasing the likelihood that clients will implement and adhere to treatment recommendations and processes (Sue & Sue, 2008; Wolf, 1978). The likelihood of this dynamic occurring may increase if therapies are built around the client's religious and spiritual qualities.

2.10.4. Identifying Religious and Spiritual Strengths

Determining ‘what works’ is often essential to promoting well-being (Lopez & Snyder, 2003). The resources necessary to alleviate difficulties can be made more easily accessible by building on areas of strength. Religion and spirituality are frequently prominent qualities in the lives of clients. Religion and spirituality are associated with a variety of favourable health outcomes, according to a large and growing body of research (Ano & Vasconcelles, 2005; Koenig et al., 2001; Koenig et al., 2012; Pargament & Raiya, 2007; Gall & Guirguis-Younger, 2013). Moreover, studies have examined the outcomes of interventions incorporating clients’ spiritual and religious values into therapy (e.g., spiritually oriented cognitive–behavioural therapy [SO-CBT] modified to incorporate clients’ spiritual beliefs and practices; Jastrzębski, 2023).

2.10.5. Identifying Problems Related to Religion and Spirituality

In most cases, spirituality and religion can be deemed beneficial, but this is not always true. Religious and spiritual practices might sometimes create more issues than they solve (Koenig et al., 2001; Zinnbauer, 2013). Instead of providing support and assistance, congregations can be sources of conflict and tension (Exline & Rose, 2005). Rather than being beneficial, coping styles can be detrimental (Pargament, 2007). Religion and spirituality can be sources of conflict and anxiety (Bockrath, 2022). For better client care, it is crucial to have a firm grasp of the interplay between clients’ religious and spiritual backgrounds and their current difficulties.

2.11. Addressing Religion and Spirituality in Psychotherapeutic Process

Religion can be integrated into the clinical practice of psychotherapy in various methods. However, a distinction is made between implicit and explicit approaches to this type of

integration. In the implicit approach, the clinician's values are the focal point. For instance, a Christian mental health professional could bring their value of agape (the nonsexual version of compassionate love) into the session (Yatim et al., 2015). The clinician's own embrace of this value could lead them to demonstrate more compassion toward their clients. When religion and spirituality are explicitly integrated into psychotherapy, they are used as an active force in the healing process through spiritually integrated or spiritually oriented therapy (Jastrzbski, 2023; Priester et al., 2009).

Spiritually integrated or spiritually oriented psychotherapy refers to various psychotherapeutic approaches attuned to human life's spiritual dimension (Jastrzbski, 2023; Pargament, 2007). To distinguish it from pastoral counselling and spiritual direction, Pearce and colleagues (2019) suggest calling it "spiritually competent care" (p. 537). This approach treats mental health issues in a holistic manner, drawing from spiritual resources but not limiting itself to any one belief system. In an integrative framework of psychotherapy, religious and spiritual interventions such as meditation and prayer are practised, and collaboration with religious and spiritual leaders is also encouraged (Sperry, 2001).

Spiritually integrated therapy aims to assist individuals in developing a coherent narrative of their spiritual journey by fostering a greater comprehension of the events that have influenced their spiritual beliefs, values, practices, and identity. The client's views reflect the recurring themes that have been a part of their relational history.

Psychotherapy frequently provides the means to initiate a client's spiritual quest because, in specific contexts, it addresses fundamental existential issues, such as a sense of meaninglessness, dissatisfaction, and emptiness, as well as matters of faith, such as the desire for a more intentional spiritual practice (Sperry & Shafranske, 2005). To help them work through

their spiritual problems, some people seek the counsel of a pastor, rabbi, Imam, spiritual director, or even a therapist specializing in the spiritual realm.

Most people seek assistance because they are dealing with personal issues, some connected to spiritual yearnings or concerns. On the other hand, harmful religious or spiritual convictions can act as a catalyst when they get in the way of a person's life objectives or spiritual commitments, whether such convictions are conscious or unconscious. It is common for people to seek out a therapist or spiritual advisor in order to find solace from their pain, get clarity in times of uncertainty, and support them on their path to inner growth and change (Rizzuto, 2005).

2.11.1. Proposed Model to Integrate Spiritual Issues into Counseling

There is a rising need for incorporating religious and spiritual themes and processes into a secular form of therapy, in addition to more conventional forms of spiritual care like spiritual direction or, more recently, pastoral counselling. As therapy progresses, mental health professionals may use specific interventions to address the client's religious and spiritual issues and experiences. In situations like this, incorporating religious and spiritual content into the therapeutic process would respond to concerns brought up by the client (Piedmont & Wilkins, 2020). According to Sperry (2012), most clients expect this from their therapists and mental health professionals.

Andrzej Jastrzębski (2021, 2023) proposes new approaches for the inclusion of religious and spiritual content in the therapeutic process and proposes distinct options concerning the presence of religious and spiritual issues found in the therapeutic process:

- *Exclusively Spiritual Therapy*, often known as pastoral counselling, focuses solely on spiritual matters.

- *Spiritual Process* occurs within the context of problem-focused treatment when there is a period of time designated for spiritual processing.
- A *Spiritual Episode* in therapy is when someone is going through treatment at the same time as they have a spiritual awakening due to a spiritual awakening, insight, or challenge occurring in their life.
- *Spiritual Intervention* is when spiritual interventions are offered to a client to address a specific obstruction that prevents the client from fully healing from their condition. This may require the assistance of a spiritual guide.
- *Spiritual Objective* is when an individual's search for the ultimate meaning of life has become the central focus of counselling.
- *Spiritual Perspective/Understanding* refers to when the therapist is the only one with an understanding of the spiritual issues, paths, and processes at play in the client's life.

Jastrzbski (2021, 2023) further elaborates on these modes of presentation and emphasizes that the first option represents a spiritually focused approach. Both the practitioner and the client are aware of this dynamic and agree to work predominantly with this dimension of human existence that is imbued with religiousness, spirituality, or faith.

The spiritual process may be an unanticipated development in a problem-focused therapy that is otherwise routine. In this context, both practitioner and client recognize that a significant life event, such as the untimely demise of a loved one, must be promptly integrated into therapy because it presents a pressing issue that must be addressed in the present. For instance, working through a spirituality-based bereavement process could take five to eight sessions.

The spiritual episode is a similar therapeutic phenomenon, but it is less intense and less time-consuming, typically requiring only two to three sessions. A sudden spiritual discovery, revelation, or insight that must be integrated into the client's life illustrates this.

Spiritual intervention is the fourth choice. Regular therapeutic work may address trauma, but a spiritual doubt or obstruction impedes the process's progression. Therefore, the therapist recognizes this as a spiritual or religious intervention to aid the process, even though the aim or focus of therapy or the intervention may not be religious or spiritual per se. In this case, resolving this spiritual issue may open the door to additional healing. To do so, the practitioner must either be well-grounded in the spiritual tradition of the client or recommend that the client seek additional support from an experienced spiritual guide. The fifth choice is a spiritual objective. It implies that the client, the therapist, or both are aware that the entire therapy is ultimately religiously or spiritually oriented. Spiritual issues, such as discovering the fundamental meaning of existence, are not directly discussed during the therapeutic process. The final option is the therapist's spiritual perspective or understanding alone. This means the therapist is spiritually attuned and active but will never reveal this to the client because they do not address this issue in therapy. Nevertheless, according to Jastrzębski (2023), a spiritually sensitive therapist will identify spiritual issues, paths, and processes in the client's life and attempt to aid them indirectly. A spiritually sensitive practitioner's ultimate spiritual horizon may be their faith, which they may exhibit by praying for clients outside of the session without their knowledge. The proposed model can also be used to comprehend the psychological issues that arise during the spiritual direction process. Presently, it seems almost inevitable that individuals seeking spiritual direction will also carry psychological issues and wish to discuss them occasionally or in greater depth with spiritual directors. For this to be successful, the therapist

must be fundamentally receptive to this type of approach and aware of their professional limitations and when a referral would be more beneficial for the client.

2.11.2. Multicultural Orientation Framework

According to Owen (2013), the foundation of the multicultural orientation framework consists of three primary pillars: cultural humility, cultural opportunity, and cultural comfort. These three pillars encompass attitudes, motives, behaviours, and reactions, both inside and outside of the treatment environment.

A. Cultural Humility. Cultural humility incorporates the intrapersonal and interpersonal ethos inherent in the framework for multicultural orientation. This component of the multicultural orientation framework serves as the foundational concept that propels the development of the other two significant aspects of the model: cultural opportunities and cultural comfort. Culturally humble therapists can accurately perceive their own cultural values and maintain an other-oriented perspective (Davis et al., 2010; Hook et al., 2013). This involves respect, a lack of superiority, and self-awareness regarding their own cultural beliefs and values.

The ability of therapists to evaluate themselves culturally, including their biases, strengths, limits, opportunities for improvement, beliefs, values, attitudes, and assumptions, is an example of the intrapersonal component of cultural humility. In order to do this, culturally humble therapists should maintain an openness to receiving feedback from clients and other stakeholders. It is normal practice to include feedback from clinical supervisors, peers, and clients through professional development initiatives. The defining characteristic of intrapersonal humility is the capacity to integrate this knowledge while maintaining a non-defensive and receptive position.

The interpersonal component of cultural humility refers to a manner of relating to others that is open to and interested in other people's cultural ideas and values rather than arrogant or presumptive (Davis et al., 2010; Hook et al., 2013). However, being accepting of other people's views and identities does not imply unconditional acceptance. The interpersonal aspect of cultural humility involves engaging with beliefs and values distinct from one's own.

B. Cultural Opportunities. Cultural opportunities are markers that arise in treatment in which the client's cultural beliefs, values, or other facets of the client's cultural identity might be investigated (Owen, 2013; Owen et al., 2017). Cultural opportunities help clients explore their cultural beliefs, values, and other aspects of their cultural identity in the therapeutic context. There are usually many opportunities to explore and incorporate a client's cultural background into the treatment process, but unfortunately, most of these opportunities are not taken advantage of. Cultural opportunities and humility work together during therapy sessions to achieve optimal results. For instance, Owen and colleagues (2016) discovered that clients who indicated that their therapists missed cultural opportunities reported having less favourable results from their therapies. The clients' perception of the therapist's level of cultural humility had a significant role in determining the extent to which these unfavourable effects were moderated. It can be safely argued that retaining a culturally humble position might help counterbalance the effects of some cultural errors or slip-ups.

When a client brings up a cultural belief, value, or any other facet of their cultural history, opportunities to learn about their culture present themselves. These opportunities present themselves naturally, allowing the therapist to smoothly transition into a more in-depth investigation of the client's cultural identity. In other instances, the therapist may be the one to initiate possibilities for cultural engagement. For instance, during a session in which a client is

discussing the suicide death of a family member, the therapist may comment: “Sometimes when people face tragedy, they turn to religion or spirituality to cope. I am curious to know if it is the case for you.” In this particular case, the therapist draws on prior knowledge of loss and bereavement to open the door to cultural exploration.

B. 1. Cultural Comfort. Cultural comfort refers to the feelings that come before, during, and after culturally relevant dialogues in sessions between the therapist and the client. These sentiments may arise at any point in the discourse. Being mentally and emotionally at ease, open, peaceful, and relaxed are defining characteristics of a comfortable culture. Some therapists can feel awkward or tense while discussing culturally sensitive topics with their clients. These topics can sometimes feel difficult and unpleasant to address. Therapists with a high level of cultural comfort can limit their apprehension when conducting cultural discussions and instead engage the client in a collected, comfortable, and connected manner. According to the findings of Owen et al. (2017), therapists’ levels of cultural comfort helped explain the racial and ethnic variations in treatment dropout among their caseloads. In other words, certain therapists were more successful at maintaining their White clients than their racial or ethnic minority clients, while other therapists demonstrated the reverse tendency. Those therapists who struggled to find common ground with their racial or ethnic minority clients had a higher rate of dissatisfaction among their racial or ethnic minority clients compared to that of their White clients. It is challenging to be culturally humble if one is not at ease expressing interest in or asking questions about a client’s cultural background; hence cultural comfort and cultural humility are related concepts.

C. Cultural Humility in Therapeutic Process. Integration of cultural humility takes place from start to end of the therapeutic process, including intake, diagnosis and case conceptualization and on-going therapeutic relationship.

Intake processes occur at the initial appointment with a client or, at times, during the first few sessions. There are several ways to carry out an intake session. A specific protocol may require the therapist to acquire certain information during the intake depending on the kind of facility or institution (e.g., community mental health centre, university counselling centre, private practice, hospital). The range of methods for conducting an intake session is outside the purview of this chapter (for more information, read: Finn & Tonsager, 1997; Hilsenroth & Cromer, 2007); however, typical objectives of the intake are to (a) establish a rapport between the client and the therapist, (b) evaluate the client's current concerns (such as symptoms or characterological patterns), (c) comprehend background information (such as family history, psychological history, and education), (d) gather information about current contexts (such as family, friends, social networks, work or school, legal concerns), and (e) establish an initial sense of the agreed-upon treatment goals.

An important additional goal of a culturally humble intake should be to obtain information about the client's prominent cultural identities, how these identities intersect with the client's presenting problem, and how the client might want their cultural identities to be incorporated into the therapy process. This information can be obtained by asking the client questions about how they would like to receive therapy. Although the tone of the therapeutic relationship is usually determined in the first session between the therapist and the client, it may have begun to take shape earlier. The first impressions a client has of a therapist can be influenced by several things, including (a) how the therapist presents themselves in ads or on

their website, (b) how the waiting area and office are decorated, and (c) whether the client feels the intake forms are culturally appropriate. The opening remarks and therapeutic stance taken during the intake session might also impact the therapeutic process. The initial intake session sets the tone for how therapists and clients interact. These initial impressions can also assist clients in determining if the therapist and treatment environment constitute a culturally safe space (Frank & Frank, 1991; Wampold & Imel, 2015).

Clients also assess a therapist's overall expertise and cultural knowledge throughout the intake process. They also evaluate how well they think the therapist can relate their cultural narrative to their issue.

The client and therapist collaborate on the therapeutic relationship. Therapists cannot come out as neutral or unconcerned with values. Instead, clients and their therapists must contribute their cultural beliefs and experiences to the therapeutic process; these beliefs and experiences can then influence the development and upkeep of the therapeutic relationship.

Using theory to conceptualize a client's presenting problem and translating that conceptualization into a meaningful treatment plan and treatments in session is one of the most difficult tasks for a therapist. Understanding the client's most important cultural identities can help therapists better understand the client's presenting issues. Determining which cultural identities the client values most (Hook et al., 2017) is critical. Understanding a client's cultural identity may also provide therapists insight into their values and ideas. Clients who grew up in a certain tradition are likely to have picked up certain attitudes, morals, behaviours, and customs. The therapist's theoretical framework for conceptualization might then incorporate these ideas and values and their relative existence and absence.

The therapist's conception of the client should also consider who they are as a person. The client and the therapist jointly develop therapy as a two-person process. Therefore, the therapist's cultural values and beliefs influence the extent to which the client is comprehended.

2.11.3. Collaborative Model of Treatment

Although the relationship between psychology and religion has been contentious historically, over the past 20 years, the need for effective collaboration between psychologists and spiritual leaders has become increasingly evident for three primary reasons: the extent to which clients espouse religious and spiritual affiliations, continually emerging literature detailing the benefits of positive religious coping and religious and spiritual engagement, and recognition of religion as an area of diversity requiring clinical competence by regulatory authorities in the field of psychology and mental health care.

Breuninger and colleagues (2014) capitalize on the noted reasons and present a collaborative treatment model for practitioners who engage with religious and spiritual clients while working from a secular theoretical orientation. Their proposed collaborative model allows the client's religion and spirituality to be utilized for positively influencing therapy.

Clinicians must go beyond passive acceptance when dealing with religious and spiritual difficulties. In-depth descriptions of successful and unsuccessful collaborations and extrapolation of guidelines for managing collaborative partnerships have occupied a sizable amount of the literature on collaborative work with other professionals (Benes et al., 2000; Budd, 1999; Budd & Newton, 2003; Chappelle, 2006; Edwards et al., 1999; McMinn et al., 2003; McMinn & Dominguez, 2005; McMinn et al., 2010; McRay et al., 2001; Milstein et al., 2008; Milstein et al., 2010; Plante, 2009; Richards & Bergin, 2005).

These collaborative models and principles aim to establish bidirectional relationships between religious professionals (i.e., Imams, clergy, and spiritual counsellors) and mental health professionals (i.e., psychologists, psychotherapists, and counsellors) for purposes of consultation and referral. However, the model proposed by Breuninger, and colleagues (2014) differs from all of those mentioned above in that it is specifically a collaborative treatment model.

Collaboration between the mental health professionals and religious or spiritual professionals in the model presented by Breuninger and colleagues (2014) aims to develop a single treatment composed of separate, simultaneous interventions functioning cooperatively. Therefore, the model uses the term intervention to describe a specific activity ordered toward the client's mental or emotional well-being employed by either the mental health or religious or spiritual professional. Treatment in the context of the collaborative model refers to the overall process of client healing, composed of the distinct but cooperative activities of mental health professionals and religious or spiritual professionals (Breuninger et al., 2014).

Breuninger and colleagues (2014) note that the effectiveness of the collaborative treatment model rests on the presence of four essential prerequisites: 1) the clinicians and religious professional must possess the ability to collaborate, 2) they must have shared values, 3) they must offer cooperative but distinct interventions, and 4) the clinicians must utilize a cognitive-behavioural therapy framework.

The authors further assert that the clinician and religious professional must be able to work together successfully. The effectiveness of this relationship according to Breuninger and colleagues (2014) depends on essential elements of effective collaboration and qualities like good communication, respect, and trust. The clinicians and religious professionals must also have shared values. While the clinician and religious professional may not have the same or

similar religious beliefs, they must share overall values. This means that the clinician or religious professional may have to put aside personal beliefs for broader values, such as a common desire to see an individual heal and flourish or help a client achieve their therapeutic goal. Trusting relationships based on communication and respect can often allow clinicians and religious professionals with differing personal beliefs to find a common understanding and shared ground to treat the client collaboratively.

Breuninger and colleagues (2014) further elaborate that utilization of a cognitive-behavioural therapy framework by clinicians is deemed essential because of the ease with which religious concepts can be conceptualized, at least broadly, in cognitive-behavioural terms. However, other approaches like psychodynamic, humanistic, or any other approach can also be used with the collaborative model. According to the authors, the causal chain of events in the cognitive-behavioural therapy framework follows a consistent pattern, and there is usually an activating event that the individual perceives. The individual's appraisal of the event gives rise to beliefs or cognitions, and these cognitions or beliefs subsequently result in feelings or behaviours from the individual. These feelings or behaviours can become activating events in themselves or cause events to ensue in one's environment, giving rise to other activating events. Similarly, the authors report that for religious clients, events in one's environment activate religious beliefs and cognitions. These beliefs and cognitions can lead to feelings and behaviours that can become activating events or influence one's environment in ways that give rise to other activating events that elicit subsequent religious beliefs or cognitions.

Both cognitive-behavioural therapy framework and religion concern themselves with individuals' beliefs and behaviours, and both systems also recognize the reciprocal relationship of thoughts and behaviours (Breuninger et al., 2014). Cognitive-behavioural therapy framework,

therefore, allows for both psychological and spiritual concepts to be readily identified and conceptualized by their lowest common denominator—beliefs and behaviours (Breuninger et al., 2014). It also permits clinicians and religious professionals to see how a maladaptive automatic thought might be treated with a spiritual coping thought or how maladaptive spiritual behaviours might be decreased by recognizing the thought errors that drive them (Breuninger et al., 2014).

Breuninger and colleagues (2014) also find it essential for respective interventions to remain distinct. According to the authors, clinicians must perform psychotherapeutic interventions and refrain from engaging in theological debate. Similarly, religious professionals must focus solely on religious content and help clients foster positive religious coping strategies. The intervention of religious professionals should be strictly religious or spiritual in nature. Nonetheless, despite the encouraged use of cognitive-behavioural therapeutic techniques, it is acceptable and even encouraged that the clinician's intervention touch on and remain open to the influence of religious themes that have been collaboratively discussed with the religious professional (e.g., encouraging engagement in religious activities and utilizing religiously themed reality testing, coping thoughts, and rational responses; Breuninger et al., 2014).

2.12. Challenges in Fostering an Integrative Approach in Psychotherapy

2.12.1. Competency and Education

Most mental health professionals have positive dispositions and are open to discussing clients' religious and spiritual beliefs and practices, and most clients report positive experiences (Adams et al., 2015; Post & Wade, 2009). In addition, the Association for Spiritual, Ethical, and Religious Values in Counselling (ASERVIC) has over 4,000 members. It promotes "free intellectual inquiry into the spiritual, ethical, religious, and value domains of counselling" (ASERVIC, n.d.). In response to this mission, ASERVIC leaders compiled a list of competencies

(Cashwell & Watts, 2010) deemed “essential for training counsellors to work effectively with client’s religious and spiritual concerns” (Young et al., 2007, p. 48). Despite favourable attitudes toward religion and spirituality and a desire for training in religion and spirituality (Souza, 2002; Young et al., 2007), the majority of mental health practitioners report rarely discussing religion and spirituality in their educational experiences (Chiang et al., 2020; Moffatt & Oxhandler, 2018; Plum, 2011; Walker et al., 2004). Researchers have demonstrated that counselling and psychotherapy training programs address religion and spirituality minimally or inconsistently (Adams et al., 2015; Cashwell & Young, 2004; Dobmeier & Reiner, 2012; Hage et al., 2006; Post & Wade, 2009; Walker et al., 2004; Young et al., 2002; Young et al., 2007). Thus, counselling students may be inadequate or unfamiliar with the ASERVIC competencies (Robertson, 2010; Dobmeier & Reiner, 2012).

Given the inconsistent curriculum or lack of integration of religion and spirituality in the training of mental health professionals, it is not surprising that students in mental health professions express discomfort in addressing these issues with clients (Adams, 2012; Souza, 2002) and that clinicians attend inconsistently to religion and spirituality in psychotherapeutic processes (Adams et al., 2015; Post & Wade, 2009; Walker et al., 2004). Clinicians may avoid discussing religion and spirituality due to perplexity regarding these concepts, ambiguity regarding how to address them, and potential legal and ethical concerns (Gonsiorek et al., 2009). This lack of attentiveness may impact client outcomes. Some evidence suggests that clinicians may pathologize religious or spiritual beliefs with which they are unfamiliar (O’Connor & Vandenberg, 2005), which may lead to misdiagnosis and inappropriate treatment objectives.

In response to the potential negative impact on client outcomes and the gap between clinician attitudes and practices, a vast amount of conceptual literature has been published on the

need to better integrate religion and spirituality into the education of mental health professionals (Briggs & Rayle, 2005; Gonsiorek et al., 2009; Hagedorn & Gutierrez, 2009; Pate & Hall, 2005).

When provided with religious and spiritual training, students reported positive responses and demonstrated increased competency in integrating religion and spirituality into the therapeutic process (Adams, 2012, 2015; Baggs et al., 2011; Dobmeier & Reiner, 2012; Robertson, 2010; Souza, 2002). However, it remains unclear why training in religion and spirituality has not been more formally and consistently integrated into educational programs, particularly given the need for and benefits of such training.

2.12.2. The Rarity of Research on Religiously and Spiritually Accommodating Interventions

Literature indicates that highly committed religious individuals, particularly those associated with more conservative branches of their religious tradition, frequently request religiously or spiritually accommodating interventions (Hodge, 2013; Worthington et al., 1996; Worthington et al., 2013). The clientele appears to be basing these requests on two assumptions. Firstly, they believe they have the right to receive psychotherapy that respects their values and does not undermine their faith. Second, they believe such an approach to treatment will produce psychological and spiritual outcomes that are at least comparable and possibly preferable (Worthington et al., 2013). Creating a body of scientific evidence demonstrating that accommodating secular remedies to religious clients is undeniably advantageous has proved challenging (Worthington et al., 2011).

The development of a research foundation for religiously and spiritually accommodating interventions comparable in scope, breadth, and sophistication to secular research on outcomes faces numerous obstacles (Worthington et al., 2013). In numerous ways, the infrastructure

inhibits the achievement of this objective. Clients prefer personalized treatments, whereas practitioners and scientists favour treatments with broad applicability.

The difference in perspective restricts research by focusing it more narrowly than what experts deem effective. Historically, religiously and spiritually accommodating interventions have been more influenced by client-driven concerns (i.e., demand-side pressure) than scientific concerns (i.e., theorist-centred supply-side structure). For example, practitioners began incorporating religion into psychotherapy in response to the demand of theologically conservative (mostly evangelical Christian) clients (Worthington, 2011). Several researchers subsequently began investigating the practice.

Many methodological issues also remain unresolved. For example, there is no consensus on the number and categories of religious and spiritual accommodations required for a treatment to qualify as religiously and spiritually accommodative interventions (Worthington et al., 2013). It is unclear why accommodating religious and spiritual preferences would be preferable to a secular approach. There are many different markers of spiritual transformation, ranging from subtle to overt in their presentation. It is unclear how religious and spiritual accommodations ought to influence specific measures (Worthington et al., 2013). It is generally agreed upon in the research that interventions sensitive to people's religious and spiritual backgrounds are effective (Hook et al., 2010; McCullough, 1999; Smith et al., 2007; Worthington & Sandage, 2001; Worthington et al., 2011). However, the analyses cited here also identify methodological flaws such as small sample sizes, failure to report attrition, absence of a treatment manual or fixed protocol, failure to perform a long-term follow-up, and failure to include clients from a greater variety of religious, spiritual, racial, or ethnic, and cultural backgrounds in the research on

religiously and spiritually accommodating interventions among many others must be addressed in future studies.

2.13. Theoretical Models of Religion, Spirituality and Mental Health

Priester, Khalili, and Luvathingal (2009) argue that the philosophy of science has shown that science and a scientific method that is neutral and empirical does not exist, which is an idea of critical importance in the study of human behaviour. The authors argue that changing political and sociocultural factors have contributed significantly to an unclear resolution of the role of religion in mental health treatment. The authors further note that despite the unclarity and differences of views in theoretical models, the association between religion and mental health has received extensive attention and mixed responses.

Psychological theories of the last century and more recent developments highlight religion's role, see religion as an integral part of the human experience, and attempt to describe the place of religion in light of respective philosophies of psychological theories. The biological psychology model sees religion and religious experiences as having a biological base caused by biological agents (Churchland, 2002). For example, mystical experiences are interpreted as results of frontal lobe epilepsy or attributed to neurochemical imbalances (Churchland, 2002).

The psychodynamic model assumes that projections and unconscious processes determine religious motivations (Fuller, 1994). For example, some psychodynamic theories explain religiosity as an archetypal occurring in the person, religion as an elusive intermediate space between inner and outside reality, and recent object-relations and attachment theories see religion as the result of projection processes (Fuller, 1994; Priester et al., 2009; Winnicott, 1993).

The behaviourist model describes religion as a reality-inconsistent learned behaviour (Fuller, 2008). In contrast, the cognitive model explains religion as cognitive schemata in terms

of an irrational, organized cognitive structure developed based on earlier experiences (McCallister, 1995). The sociocultural model views religion and religious behaviour as being formed and shaped by the family context and sociocultural factors (Fuller, 1994).

This research will focus on the religious coping theory (Pargament, 1997) to understand the challenging relationship between religion and coping with life stressors of the immigrant population. The research will further incorporate Jeffery S. Levin and Linda M. Chatters' (1998) theory of alternative theoretical orientations to understand the role of mediating factors concerning the health status of the immigrant population.

Pargament's (1997) theory of religious coping is based on two assumptions about the prediction of coping. The first assumption of Pargament's prediction of coping is that all humans encounter trials and transitions that push them beyond their own capabilities. Pargament (2002) argues that this encounter triggers a dynamic coping process.

Pargament's (1997) second assumption of prediction of coping rests on an individual's ability to proactively engage in multiple possibilities and choices. Pargament (1997) further argues that coping with challenges often incorporates a religious dimension when its "available" and "accessible" (p. 144). The author further argues that multiple factors like personal, situational, and social factors shape the availability of religion.

Religion is more significant in coping when it becomes a prominent and integral part of the individual's orienting system (Pargament, 1997). However, according to Pargament (1997), an individual's "turning to religion in coping" does not refer to the spontaneous generation of religion from a vacuum (p. 147). The author argues that a closer analysis of situations where religion seemingly has come out of nowhere reveals evidence of the availability of religion.

Pargament further attributes two strategies to the function of religious coping: a conservation strategy and a transformation strategy. The conservation strategy in the coping process helps maintain feelings of meaning, mastery, and spiritual connection during a life crisis. However, the transformation religious coping method is employed when there is a need to abandon old hopes and dreams for life to move forward. The significance of transformation is maximized when the search for new meanings begins and attempts to change the significance are initiated.

Cummings and Pargament (2010) suggest that with a microanalytic approach toward religion, it is evident that religion can be helpful, harmful, or irrelevant to adjustment. Pargament (1997) identifies two broad groups of positive and negative religious coping methods in his religious coping theory. Positive coping method expresses a secure relationship with the transcendent force, for example: interpreting the stressor as salutary, treating God as the partner, and seeking and appreciating God's love and care (Pargament, 1997; Pargament et al., 2011). Positive religious coping further gives the individual a sense of spiritual connectedness with others and a benevolent worldview (Pargament et al., 2011).

A negative religious coping strategy, however, often mirrors the underlying spiritual tensions and struggles within oneself, with others, and with the divine, for example: reinterpreting the stressor as a punishment given by God, passively depending on God to resolve the stressor, and attempting to cope on one's own without relying on God's help, which is more likely to have deleterious effects (Pargament et al., 2011). Understanding the functions of religious resources people call upon in stressful times is central to Pargament's (1997) theory of religious coping. Cummings and Pargament (2010) emphasize understanding the function of religious coping in the wake of stressful situations more than what form religious coping may

take. This implies that it is not enough to know that an individual prays multiple times a day, attends religious services, or considers themselves highly religious, but the content of prayers, the types of support sought from faith communities, and the perspectives about what the stressor means bears more importance (Cummings & Pargament, 2010). Pargament (1997) argues that the function of religion may vary across people performing the same religious behaviours or even within the same person in connection with different stressors; therefore, researchers should assess how patients use religious coping to deal with a particular stressor.

In contrast to Pargament's (1997) religious coping theory, other theories may simply engage with religious behaviour with an assumption that global variables capture the coping dynamic. Global variables in this context refer to the overarching theories humans use to orchestrate their lives, the way the world works, and the individual's place in it (Park & Folkman, 1997). According to the authors, one feature of global meaning is the assumption that events generally unfold in the world in an orderly, predictable manner. Moreover, people usually expect positive outcomes to occur more than negative ones and that the nature of a person's circumstances corresponds to their quality of character; in other words, bad things happen to bad, incompetent people, and good things happen to good, competent people (Park & Folkman, 1997). Another component of global meaning is the sense that one is purposefully pursuing worthwhile ends (Park & Folkman, 1997). It is argued that since these variables are more distant from the function of religion as a coping strategy, they may exhibit weaker but similar relationships to measures of religious coping assessment in particular situations.

Pargament's theory of religious coping provides a possible explanation for how religion affects mental health, including health-related behaviours, social support, optimism, and hope. The present research additionally turns to the "alternative theoretical models of religion and

mental health” proposed by Jeffery Levin and Linda Chatters to understand the interrelation of the mediating factors of religion with mental health (Levin & Chatters, 1998, p. 42).

The interrelationship between religion, mental health, and mediating factors theory proposed by Levin and Chatters (1998) derives from similar models developed for sociomedical research. Levin and Chatters refer to the multifactorial theoretical models proposed by Wheaton (1985) for the stress-buffering functions of coping. The authors further refer to the proposed model of Krause and Tran (1989) to understand the role of religion as a coping resource that enhances self-esteem and mastery.

Based on extensive research, Levin and Chatters (1998) propose five alternative theoretical models to understand how the effects of religion and mental health are impacted by health status and mediating factors (Idler, 1987) like promotion of social cohesion (i.e., socially supportive resources which buffer the impact of stress), theodicy (i.e., a context of meaning for coping with suffering), coherence (i.e., cognitive perceptions, such as optimism, which serve to reduce uncertainty), and health-related behaviour (i.e., discouragement of known behavioural risk factors, such as smoking and drinking):

1. Suppressor model
2. Distress-deterrent model
3. Prevention model
4. Moderator model, and
5. Health effects model

The suppressor model defines the overall relationship between religion and mental health as fully recursive from a sociological point of view and as an indirect effect association from an epidemiological perspective. In this model, poor health, or general stressors, leads to increased religious activity and other social, psychological, and behavioural coping responses, often engendered by religion. This relationship, in turn, serves

to suppress or reduce the deleterious effects of the stressors on the mental health of the individual (Levin & Chatters, 1998).

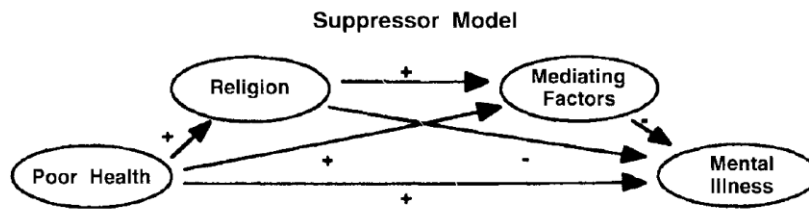


Figure 1. The suppressor model. Adapted from *Research on religion and mental health: An overview of empirical findings and theoretical issues* (p. 43), by J. S. Levin, and L. M. Chatters, 1998. In H. G. Koenig (Ed), *Handbook of Religion and Mental Health*. Burlington: Academic Press.

The distress-deterrent model defines the overall relationship as an independent effect association in epidemiological terms. In this model, poor mental health, general stress, and religion have independent and opposite effects on mental health. Poor health does not engender either greater religiosity or psychological coping response. The model is also known as the counterbalancing model (Krause & Tran, 1989)

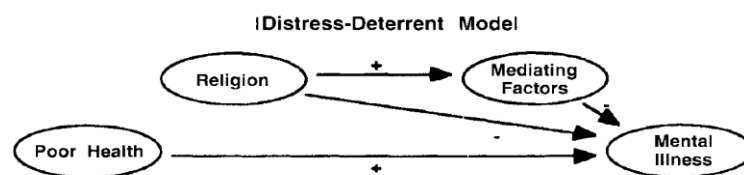


Figure 2. The distress-deterrent model. Adapted from *Research on religion and mental health: An overview of empirical findings and theoretical issues* (p. 43), by J. S. Levin, and L. M. Chatters, 1998. In H. G. Koenig (Ed), *Handbook of Religion and Mental Health*. Burlington: Academic Press.

In the prevention model, religion, in epidemiological terms, exerts both direct and indirect protective effects on mental health. In light of this model, mental health benefits from religious involvement and psychosocial mediation by preventing physical morbidity, which itself is a psychological risk factor. This model is consistent with the epidemiologic

literature on the primary preventive effects of religion on physical health (Levin, 1996; Levin & Schiller, 1987; Levin & Vanderpool, 1992)

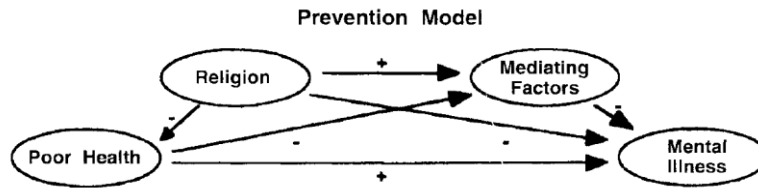


Figure 3. The prevention model. Adapted from *Research on religion and mental health: An overview of empirical findings and theoretical issues* (p. 43), by J. S. Levin, and L. M. Chatters, 1998. In H. G. Koenig (Ed), *Handbook of Religion and Mental Health*. Burlington: Academic Press.

The moderator model defines the relationship between religion and mental health as interactive in sociological terms and as an effect-modifying association in epidemiological terms. In this model, through the various degrees of religious involvement, poor health or general stress interacts with religion and other mediating factors, such as the deleterious effects of religion on mental health. This model is consistent with findings from health-related studies primarily done in clinical populations, where respondents of the research are symptomatic or at more advanced stages of the natural history of the disease (Idler, 1987; Koenig & Futterman, 1995).

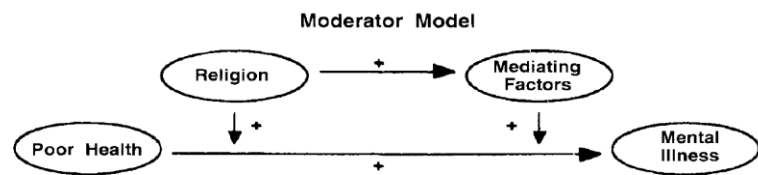


Figure 4. The moderator model. Adapted from *Research on religion and mental health: An overview of empirical findings and theoretical issues* (p. 43), by J. S. Levin, and L. M. Chatters, 1998. In H. G. Koenig (Ed), *Handbook of Religion and Mental Health*. Burlington: Academic Press.

The health effects model defines the relationship between religion and mental health similarly to the suppressor model; however, the direction of effect in this model is opposite to the suppressor model. Poor health or general stressors (typically age-related declines in functional activity) act as suppressors and prevent an individual from performing certain types of religious activity (i.e., organized religious involvement) and may exert adverse psychosocial effects in terms of competing for mediating factors (i.e., lead to harmful health-related behaviour, increase social isolation, create negative emotions, promote pessimism, among many others; Levin, & Chatters, 1998).

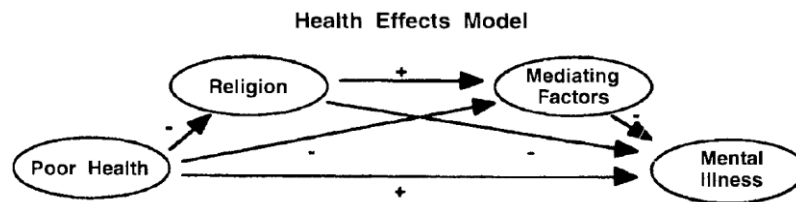


Figure 5. The health effects model. Adapted from Research on religion and mental health: An overview of empirical findings and theoretical issues (p. 43), by J. S. Levin, and L. M. Chatters, 1998. In H. G. Koenig (Ed), Handbook of Religion and Mental Health. Burlington: Academic Press.

The present research employs existing literature on migration and shared experiences of immigrants in the context of mental health and professional help-seeking, and the importance of religion and spirituality to develop a more comprehensive understanding of achieving favourable therapeutic outcomes. The study draws on theoretical models of religion and spirituality to explore practical ways of incorporating clients' religious and spiritual beliefs and practices in their therapeutic process. The present research further addresses the rarity of research on the practical multi-dimensional understanding of the interplay between religion, spirituality, and mental health at the intersection of immigration and cultural diversity.

Summary of the Chapter

The literature review chapter examines the role of religion and spirituality in the life of immigrants. The chapter further discusses the importance of religion and spirituality in developing a holistic view of clients who seek therapy to address their mental health issues. The chapter first places client experiences in the context of migration and highlights religion and spirituality's role in their pre-migration, in-transit, and post-migration phases. As this study is focused on Muslim immigrants, the discussion of themes is grounded within the Islamic faith tradition in the context of Western societies.

A subsequent theme of addressing religion and spirituality in therapy is explored through discussions on theoretical approaches to integrating religion and spirituality into the therapeutic process, challenges in fostering an integrative approach and research on immigrant mental health. Several key themes emerge from the reviewed literature.

Firstly, the literature reveals that the migration process significantly impacts the mental health of immigrants and their help-seeking behaviour. While immigrants may experience mental health-related issues and psychological disorders in their pre-migration phase, migrating from their habitual place of living to their host environment exposes them to higher degrees of traumatic experiences. Immigrants face challenges in post-migration as they go through the resettlement journey. Post-migration challenges, like discrimination, lack of community support and exposure to a new, culturally different environment, add to the stressful resettlement process. The mental health of Muslim immigrants, generally, and Afghan immigrants specifically, is negatively impacted by their post-migration experiences.

Secondly, the literature emphasizes the role of religion and spirituality in the life of immigrants and newcomers. Studies indicate that religion can have a multidirectional impact on the lives of immigrants. For many immigrants, religion and spirituality can be a source of support and a reliable coping mechanism in the wake of resettlement challenges in the post-migration phase. However, it can also negatively impact immigrant mental health by contributing to their stressors or, at times, being at the core of their distress. Nonetheless, studies indicate that integrating client religion and spirituality into their therapeutic process is essential to receiving clients holistically and inviting them as a whole rather than acceptable parts (i.e., emotional) and unacceptable parts (i.e., spiritual or religious) of themselves. Growing research in recent decades has shed light on many aspects of the interplay between religion and mental health. However, there remains a significant gap in research on immigrants and culturally diverse clients in the western context.

Thirdly, the literature highlights clinician hesitancy and ambivalence towards integrating religion and spirituality into the therapeutic process due to inadequate skills development and lack of education and training on integrative approaches to religion and spirituality. Furthermore, the reviewed literature underscores the need for future research to address the gaps in understanding the complex relationship of culture, religion, spirituality, and psychotherapy in the context of immigrants living in the West who are often seeking therapeutic support from practitioners predominantly trained in Western models of psychological care. This review emphasizes that religion and spirituality play an essential role in the therapeutic process of immigrants, and there is thus a need to identify the place of religion in their therapeutic process.

Chapter Three:

3. Research Design and Methodology

Individuals do not follow their religious and spiritual paths in isolation; instead, they undertake their journeys within more extensive fields of social and cultural forces, including religious group, age, ethnicity, family, community, and culture (Bartoli, 2007; Gallup, 1999; Pargament et al., 2014). Several studies, including content analyses and meta-analyses, indicate that there is relatively little material in the academic literature that could assist psychotherapists and counsellors in educating themselves and engaging in culturally responsive and proficient practices with Muslim populations (Captari et al., 2018; Graham et al., 2019, 2020; Abu-Raiya & Pargament, 2010; Hodge et al., 2006). Similarly, Canadian research on the mental health of Afghan immigrants and, to a lesser extent, first-generation Afghan immigrants is scarce (Alemi et al., 2015; Bronstein et al., 2012; Lindencrona et al., 2008; Mehrabi, 2002; Omeri et al., 2006; Sheikh & Gatrad, 2000; Wilson et al., 2010).

In light of these gaps in the extant scholarship, understanding the place of religion and spirituality in the psychotherapeutic process of first-generation Muslim Afghans in Canada is the primary objective of the present research. The following two central questions guide the present research:

1. What role does religion play in the lives of Canadian Muslim Afghan immigrants?
2. What place does religion hold in the psychotherapy of Muslim Afghan immigrants?

Research methodologies are situated within paradigms of epistemology, ontology, and the philosophy of science that are particular to the researcher, their institutional requirements, their cultural context, and other factors (Haverkamp & Young, 2007). The choice of methodology for

a research project should reflect its purpose, the contextual reality of the phenomenon being investigated, the positionality of the researcher, and the best approach to answering the research questions.

The present study seeks to document and comprehend the role of religion in the lives of Afghan immigrants and its therapeutic significance in the counselling and psychotherapy of first-generation Muslim Afghans to achieve the primary objective and address the central questions. The proposed study investigates the current gap between Islam as a religion, client expectations from the psychotherapeutic process, and mental health practitioners' perspectives on the significance of religion in therapeutic work with Muslim Afghan immigrants in Canada.

3.1. Qualitative Research in Psychology

Qualitative research methods, such as interviews, are well-suited for the study of spiritual and religious phenomena concerning psychological and mental health processes because they can capture the complexity and fluidity of people's experiences, which are often difficult to encapsulate in appropriately contextualized ways using quantitative approaches (Coyle, 2008). Quantitative research methods advocated in early epistemological debates within the field of psychology have been instrumental in aligning the field with the rest of scientific community (Henwood & Pidgeon, 1994), which resulted in reduced utilization of qualitative research in psychology throughout late 20th century (Coyle, 2016). Given the content and context of the field of psychology, with many aspects of it focusing on the study of the inner world of the human being, qualitative methods have become more accepted in psychology research due to their compatibility with the types of data that must be gathered or interpreted (Coyle, 2016).

All qualitative research methods share the fundamental premise that psychological and social 'realities' are multiple and context-dependent (Camic, 2021). Humans are complex, and

various internal psychological and unique external factors influence their experiences. In addition to humans being the primary focus of qualitative research, the researchers are always human, generating even more variations of relative experience within a given research setting. Thus, qualitative methods recognize that people, social structures, social allegiances, ideologies, and context contribute to the realities of the studied subjects (Camic, 2021). Instead of attempting to comprehend a particular experience from an exclusively external perspective, qualitative methods seek to answer queries such as ‘What is it like?’ and ‘How is this phenomenon understood and represented in society?’ (Coyle, 2008).

According to Corbin and Strauss (2015), a qualitative research design is well-suited for investigating insufficiently researched areas and identifying pertinent variables that can be tested through quantitative research (Corbin & Strauss, 2015). Qualitative research is preferred when a holistic and exhaustive approach to studying phenomena is employed. The principal advantage of qualitative research design is the ability to probe responses and observations as necessary to obtain detailed explanations, descriptions, and characterizations of behaviours, beliefs, and experiences (Guest, Namey & Mitchell, 2013). Considering the objectives of the present study, a qualitative research design is the most appropriate method.

There are a variety of approaches to qualitative research, each of which is grounded in a unique theory about how to generate psychological information and the best way to put that theory into practice (Denzin & Lincoln, 2011; 1994; Camic, 2021). This diversity of qualitative research methods results from differences in epistemological commitments or specific assumptions regarding how knowledge is generated (Coyle, 2016). Quantitative methods were historically supported by the epistemology of positivism, which assumes that researchers can take an impartial stance and thus determine objective conclusions about subjects; empiricism,

which favours categorizing observations; and hypothetico-deductivism, which develops, and tests hypotheses based on theories (Coyle, 2016). In contrast, qualitative methods are frequently supported by epistemologies that presume a more subjective reality in knowledge production.

One of the most defining characteristics of a qualitative approach is that it considers and incorporates the impact that a particular setting has on a study's topic or topic area. How various qualitative methods deal with or understand the role of context in the production of psychological knowledge can be observed in their epistemological approach to research, and such methods can be selected for specific studies based on their fit. Multiple authors have previously classified qualitative research methods based on their respective fields of study (Jacob, 1987; Lancy, 1993; Tesch, 1990; Wolcott, 1992; Denzin & Lincoln, 2011). Creswell and Poth (2018) identify five qualitative research methods based on their prevalence in the social, behavioural, and health sciences literature. In addition, the authors based their grouping on the presence of systemic research methods (i.e., narrative research, phenomenology, ethnography, case study, and grounded theory).

Narrative research focuses on the individual stories told by participants, whereas phenomenological research focuses on the shared experiences of research participants (Creswell & Poth, 2018). Alternately, an ethnography concentrates on an entire culture-sharing group, with the ethnographic researcher describing and interpreting patterns of values, behaviours, beliefs, and language of the culture-sharing group (Creswell & Poth, 2018). Furthermore, the purpose of ethnography is to determine how a culture functions. In contrast, the case study approach focuses on developing a detailed comprehension of a particular case or using a specific case to illustrate a problem or issue (Creswell & Poth, 2018).

An interpretative phenomenological analysis is an example of a phenomenological method that focuses on “obtaining detailed descriptions of an experience as understood by those who have that experience to discern its essence” (Coyle, 2016, p. 15). Discourse analysis is an example of social constructionism, founded on the epistemological assumption that human experiences are products of particular cultural and historical contexts and is concerned with how social realities are constructed within these contexts (Coyle, 2016). This study employs grounded theory, a particular type of qualitative research that considers the context in a certain way since it is the best methodological match for the study’s purposes. However, even within the subcategory of qualitative research known as grounded theory, there are a variety of approaches.

3.2. Choice of Grounded Theory Research

Developed by American sociologists Barney Glaser and Anselm Strauss in the 1960s, grounded theory is a qualitative research method (Kenny & Fourie, 2014). The two researchers were dissatisfied with the overemphasis in their field at the time on researchers verifying theories instead of the actual process of theory generation (Kenny & Fourie, 2014). This dissatisfaction was the impetus for the creation of the approach. Glaser and Strauss (1967) noted in their seminal work on the development of the approach, *The Discovery of Grounded Theory*, that “since verification has primacy in contemporary sociology, the desire to generate theory often becomes secondary, if not completely lost, in specific research” (p. 2). They also criticize the lack of empirical research in developing social theories, noting that a gap between theory and empirical research prompted them to develop a novel approach to bridge this gap.

Glaser and Strauss (1967) advocate “developing theories from data-grounded research rather than deducing testable hypotheses from existing theories” (p. 4). The theory is emergent in that it is developed as a result of the findings from collected data and not as a result of a

synthesis of previous research findings. It is especially useful for developing new theories concerning a phenomenon or question for which “existing theory is incomplete, inappropriate, or absent” (Henwood & Pidgeon, 1992, p. 102). In grounded theory, theory development is the explicit, primary focus of the research endeavour from the inception, as opposed to the result of existing resources.

Although much has been written about integrating religion and spirituality into the psychotherapeutic process, research on practical models of integrating religion and spirituality for Muslim immigrant clients is particularly scarce (Bemak, 2003; Capatari et al., 2018; Mehraby, 2002; Slewa-Younan et al., 2017). Due to their position at the intersection of multiple factors, Muslim immigrants’ experiences in the Western context are distinct from those of other religious communities. These unique intersecting factors include their experiences of discrimination due to religious identity, also known as Islamophobia (Emel, 2022; Williams et al., 2022), their discriminatory treatment for being immigrants and refugees (Qasqas, 2014), being racialized/persons of colour (Smith & Silva, 2011; Williams et al., 2022), belonging to communities with strong stigma toward mental health help-seeking (Hassan et al., 2021), and a lack of awareness about counselling and psychotherapeutic processes.

Given that purely secular conceptualizations of psychology and psychotherapy do not align effectively with the mental health needs and help-seeking patterns of Muslim immigrants in the Western context, as argued in the previous chapter, the primary objective of this thesis is the development of theory to encapsulate an integrative model. Therefore, grounded theory is selected as the appropriate methodological approach. No other qualitative methodology explicitly focuses on the generation of theory; the method’s overall epistemology is explored below before concentrating on the version of grounded theory that is utilized in this research.

A grounded theory poses the question of, ‘What is occurring here?’ by collecting data that targets the clarification of what and from whose perspective of a given experience, process, or relative reality is significant, how understanding emerges, under what conditions and by whom control of the processes is exerted, how meaning is attributed, and how it changes. For instance, Magaldi-Dopman et al. (2011) conducted a grounded theory study on the effect of psychotherapists’ spiritual identity on their psychotherapy practice. How psychotherapists’ identities may have influenced how they interacted with religious/spiritual material during sessions formed the basis of their research. The engagement with data generation in the cited study consisted of elucidating the experiences of psychotherapists by attempting to comprehend their experiences, with the analysis and resulting theory being grounded in the psychotherapists’ own words. In this instance, the resulting theory was derived directly from the participants’ expressed experiences. As the purpose of this study is to determine the place and role of religion and spirituality in the psychotherapeutic process of Afghan immigrants, the grounded theory approach enables the researcher to comprehend the experiences of Afghan immigrants regarding their therapeutic journeys, expectations, and religious and spiritual selves in their own words. The study investigates these themes in greater depth with clinicians and mental health practitioners who have worked with Afghan clients in their professional capacities and can cast light on the practical aspects of client religiosity and spirituality in relation to their therapeutic processes. Thus, the analysis and emergent model are based on the experiences of clients and the realities of the therapeutic process.

3.2.1. Constructivist Grounded Theory

What has been described thus far are the general principles of grounded theory, which comprise the overarching framework of methods that fall under the broader methodological

domain. There are three primary grounded theory variants within this domain: realist-positivist (Glaser, 1992), post-positivist (Strauss & Corbin, 1990), and constructivist-interpretivist (Charmaz, 2014).

Realist-positivist grounded theory assumes that a single truth can be discerned from data and that knowledge thus emerges from that data (Glaser, 1992; Madill, Jordan, & Shirley, 2000; Rennie, 1996; Thomas & James, 2006). This may be due to the fact that realist-positivist grounded theory is the original form of grounded theory and therefore emerged during a time when positivist-empirical epistemological orientations were favoured.

As its name suggests, the post-positivist grounded theory attempts to move away from the notion that everything can be directly measured and instead embraces incorporating interpretations of the experiences of the people being studied (Strauss & Corbin, 1994). However, the post-positivist approach concerns objectivity and eliminating bias (Annells, 1996; Charmaz, 2014).

The constructivist-interpretivist approach “rejects the notion of objectivity and focuses on the meanings that can be constructed from interpretations of the data” (Weed, 2017, p. 5). Due to the highly subjective and interpretive nature of religious and spiritual experience and the psychotherapeutic process, the constructivist approach to grounded theory was chosen as the most appropriate methodology for this study.

Creswell and Poth (2018) observe that key concepts of Straus and Corbin’s methodology include categories, initial codes, theoretical codes, and systematic procedures guided by constant comparison of field-collected data with emerging categories. Comparatively, Charmaz’s constructivist approach advocates for “an emphasis on diverse local worlds, multiple realities, and the complexities of particular worlds, views, and actions” (Creswell & Poth, 2018, p. 86).

Constructivist grounded theory embraces the method's adaptability while opposing its mechanical application. Clarke (2012) emphasizes that research must incorporate what the researcher and participants contribute. Charmaz (2014) highlights the significance of the researcher's values and preconceptions in constructivist grounded theory research, noting that these values and preconceptions influence the facts the researcher identifies. Recognizing that the researcher actively participates in the theory generation process, grounded theory research adopts a more interpretive stance. Charmaz (2006) and Hutchison, Johnston, and Breckon (2011) assert that the researcher is a part of the world being studied and the data being gathered, and they propose that grounded theories are constructed through the researcher's past and present involvement with people, perspectives, and research practices. From a constructivist standpoint, the logic of interpretive practice requires the researcher to be constantly conscious that knowing entails seeing or hearing from within the individual, institutional, or other socio-culturally embedded perspectives and locations (Henwood & Pidgeon, 2003).

3.2.2. Data Generation in Grounded Theory Research

The questions posed in grounded theory research are process-oriented to facilitate the emergence of answers that are authentic to the investigated process. This strategy is also reflected in the data generation strategy. Data collection is not like picking fruit from a tree; rather, it is an active process in which the researcher and the participants are intimately involved in generating the data through dialogue. In Magaldi Dopman et al.'s (2011) grounded theory study, the researchers considered their own orientation to spirituality and how it may have influenced and interacted with the participants' responses during the interviewing process. They stated that "the researchers relied on the participants' perspectives of the topic being studied

while acknowledging the impact of their own backgrounds on the research they were conducting” (Magaldi Dopman et al., 2011, p.289).

Data in grounded theory research can consist of interviews, qualitative surveys, participant observation, documents, diagrams, maps, and photographs (Charmaz, 2014), but semi-structured interviews or observations are the most common sources of information (Payne, 2016). In this study, qualitative data originates from the responses of knowledgeable participants to individual interview questions through a process known as “key informant interviewing” (Gilchrist, 1992). Gilchrist (1992) defines key informants based on their position within a culture, which in the context of this study is understood as a group and/or context characterized by specific experiences, perspectives, and/or values. Key informants have “special knowledge, status, or communication skills” and are willing to share their insights based on their experience with the researcher (Gilchrist 1992, p. 75). They serve as expert intermediaries and communicators of the experiences of members of their culture, although the researcher must be aware that key informants will also have personal stakes in the research topic. In the past, key informant interviews have proven useful in the field of mental health. For instance, Potter and Coyle (2017) utilized this data generation method to obtain expert insights regarding the efficacy of mindfulness in treating obsessive-compulsive disorder. Given that immigrant mental health, religion, and spirituality of Muslim immigrants is a highly specialized field with limited academic research and writing, the majority of sources of knowledge in this area are experiential and consist of the personal and professional experiences of clients and individual practitioners. Although there is a formal or operationalized approach to integrating religion and spirituality into psychotherapeutic processes, there is a significant absence of understanding regarding the place of religion in the psychotherapeutic process for Muslim Afghan immigrants. As alluded to

in the previous section, some mental health practitioners currently implement interventions designed for clients of other faiths and spiritual traditions in their work with Muslim clients. In contrast, others entirely disregard the role of religion and spirituality in the therapeutic process of Afghan immigrants. Consequently, generating data in the form of insights and first-hand accounts from such informants is perhaps the best, if not the only way, to produce the data necessary for developing a model of integrating religion and spirituality in the psychotherapeutic process of Muslim Afghan immigrants.

Charmaz (2014) states that intensive qualitative interviewing and grounded theory methods are “open-ended yet directed, shaped yet emergent, and paced yet unrestricted” in reference to the type of interviewing that solicits the type of data that is pertinent to the emergence of theory (p. 28). This study’s interview protocols followed a format designed to elicit rich data in the form of personal experience and reports from participants through the use of open-ended questions. The interview begins with descriptive questions that invite the informant to describe their experience, followed by structural questions that focus the responses on the research objectives and concludes with contrast questions that further clarify the responses (Gilchrist, 1992). Field notes, initial interviews, follow-up interviews following the classification process, and information from the records and reports can all contribute to the analysis and development of a grounded theory (Charmaz, 2014). With this in mind, it is essential to ensure the credibility and quality of the proposed study through extensive data. The data collection procedure adhered to the following guiding principles:

- Collection of enough background data about persons and processes to understand and portray the full range of context of the study during the data collection stage.

- Gain a detailed description of a range of participants' views and actions during the data collection stage.
- Ensure that the data reveals what is beneath the surface during the data collection stage by asking probing questions. Gain multiple views of the participants' range of actions.
- Ensure the collection of data that enables the research to develop analytic categories.
- Understand the impact of data comparison on forming ideas with the researcher.

In order to develop a nuanced understanding of the process, the researcher conducted a second round of interviews with selected participants as preliminary themes emerged and new questions arose.

The researcher also gained a deeper understanding of the process during the initial coding phase. According to Charmaz (2001), multiple interviews allow the researcher to follow up on earlier leads and bring the researcher closer to the process by strengthening the emergent processual analysis. While information-gathering methods impact the utility of the collected data, the researcher is also a crucial component of the process. In grounded theory research, Charmaz (2014) emphasizes the researcher's capacity to "see" what is present in the data (p. 26). The author opposes the notion that the researchers are solely scientific observers or neutrality claimants. The researcher therefore remained an active part of the data-gathering process through effective engagement with participants and exploration of emerging themes.

3.3. The Sample and Method of Data Collection

In contrast to quantitative studies, which frequently employ random sampling, qualitative research tends to use 'purposeful' non-probability sampling, in which the researcher actively selects the most efficient sample to answer the research question (Marshall, 1996), or "criterion-based" sampling, in which participants are selected based on defined characteristics pertinent to

the research question. Non-probability sampling refers to a method of sampling that is not systematic and does not ensure that each subject in the target population has an equal chance of being selected (Guest et al., 2013). Small sample sizes and non-probability sampling are the norms in qualitative studies since qualitative inquiry is not meant for statistical generalizability (Guest et al., 2013). According to Guest et al. (2013), the primary purpose of qualitative studies is to comprehend or identify shared cultural knowledge and norms. The authors argue that qualitative studies are not concerned with generating population-based estimates and that the effort required to acquire a proper sampling frame, which is required for most probability samples, is unjustified (Guest et al., 2013).

This study recruited participants using the judgmental sampling technique of the purposeful sampling approach (Guest et al., 2013; Lindop & Taylor, 2002). In this form of non-probability sampling, the researcher relies on their own discretion when selecting participants from the population (Guest et al., 2013). Schwandt (1997) explains the rationale behind the use of judgmental sampling as follows: “Sites and cases are selected because there may be a good reason to believe that what occurs there is essential to understanding some process or concept, or to testing and elaborating an existing theory” (p. 122). The logic of judgmental sampling, according to Patton (2002), “lies in selecting information-rich cases for in-depth study... those [cases] from which one can learn a great deal about issues of central importance to the purpose of the investigation” (p. 230). The initial selection of participants for a qualitative study is based on the diversity of perspectives and experiences within the pool of potential participants. Marshall (1996) states that “an appropriate sample size for a qualitative study is one that adequately answers the research question” (p. 523).

This study recruited a total of eleven participants through two sampling endeavours: initial sampling and theoretical sampling. A sample of six participants in the first round of data collection was recruited from Ottawa and Toronto, where the largest concentration of Afghans reside (Statistics Canada, 2016). Sampling at this stage was conducted in two categories based on the following criteria:

- Group A: four first-generation Muslim Afghan immigrants who had undergone some form of psychotherapy/counselling (i.e., counselling, psychotherapy with registered psychotherapists, psychotherapy with registered social workers, or psychotherapy with a psychologist or a psychiatrist) while living in Canada.
- Group B: two first-generation Muslim Afghan immigrants who had not undergone any form of psychotherapy/counselling (i.e., counselling, psychotherapy with registered psychotherapists, psychotherapy with registered social workers, or psychotherapy with psychologist or a psychiatrist) while living in Canada.

The goal was to collect a representative sample that could shed light on the research problem, with the understanding that answering the question thoroughly typically requires multiple phases of research, each of which uses complementary samples that progressively extend the emerging research picture (Marshall, 1996).

In accordance with article 2.1 of the Tri-Council Policy Statement on ethical conduct for research involving humans (Canadian Institutes of Health Research, Natural Sciences and Engineering Research Council of Canada, and Social Sciences and Humanities Research Council of Canada, 2018, p. 13), the researcher began fieldwork after receiving approval from the Research Ethics Board of Saint Paul University, Ottawa. As highlighted by Maxwell (2013), to ensure that the interview protocol questions were developed in accordance with the study's

purpose and research questions, the researcher piloted the interview protocol with individuals whose characteristics mirrored those of the study's participants.

The pilot consisted of two interviews with individuals who shared characteristics with the study group (i.e., first-generation Afghan immigrants with some exposure to psychotherapeutic processes) and who provided feedback on the questions and interview procedure, resulting in a few minor modifications to the interview protocol. These two interviews were not recorded and were not analyzed. Castillo-Montoya (2016) explains that these stages are necessary to refine an interview protocol for grounded theory research.

The researcher initiated the recruitment process by distributing written announcements to community organizations as well as immigration and mental health service-providing agencies (e.g., *Ottawa*: Islamic Association of Afghans in Ottawa, Afghan Student Association, Islamic Society of Gloucester, Ottawa Muslim Association, Islam Care Centre; *Toronto*: Afghan Canadian Islamic Community, Afghan Professionals of Ontario, Afghan Association of Ontario, Afghan Association of Support for Culture).

The study sample was representative of the diverse cultural and ethnic backgrounds of the Afghan diaspora community in Canada. Participants practised various sects of Islam (i.e., Sunni, Shia) and had varying levels of expertise in their English language skills. Participants also differed in their immigration status (i.e., protected persons, permanent residents, and Canadian citizens) and time spent in Canada as immigrants, and all factors significantly contributed to the perspectives of participants. Participants who practiced the Shia sect of Islam shared their unique experiences as a minority subgroup within the larger group of Muslims. Participants with varying language skills and time spent in Canada shared their unique experiences and perspectives during their resettlement journey in Canada.

Table 1 and 2 illustrates the main characteristics of Group A and Group B participants in the study.

Table 1. *Demographic table of participants in Group A*

| Demographic Information of Participants in Group A | | | | |
|--|----------------------|--------------------|-----------------------|---------------------|
| | Participant 1 | Participant 2 | Participant 3 | Participant 4 |
| Gender | Male | Male | Female | Female |
| Education | Graduate | Undergraduate | Graduate | No formal education |
| Occupation | Addiction Counsellor | IT Technician | Social Service Worker | Unemployed |
| Marital Status | Married | Single | Separated | Divorced |
| Legal Status | Citizen | Permanent Resident | Citizen | Permanent Resident |
| Place of Birth | Afghanistan | Afghanistan | Afghanistan | Afghanistan |
| Migration category | Refugee | Refugee | Refugee | Refugee |
| Time Spent in Canada | Over ten years | Over four years | Over eight years | Over five years |

Table 2. *Demographic table of participants in Group B*

| Demographic Information of Participants in Group B | | |
|--|------------------|--------------------|
| | Participant 1 | Participant 2 |
| Gender | Female | Female |
| Education | Post-Secondary | Undergraduate |
| Occupation | Unemployed | Non-Profit Sector |
| Marital Status | Single | Single |
| Legal Status | Protected Person | Permanent Resident |
| Place of Birth | Afghanistan | Afghanistan |
| Migration category | Refugee | Refugee |
| Time Spent in Canada | Over two years | Over six years |

Sampling in grounded theory typically relies on data saturation. While acknowledging that the scope of some research questions and resource constraints may limit the likelihood of

achieving saturation in any given study (Marshall et al., 2013), Payne (2016) defines saturation in the context of grounded theory as the accumulation of “further examples of meaningful units as one proceeds through the transcripts until no new instances of a particular category emerge” (p.78). In grounded theory research, fieldwork and analysis occur simultaneously following the collection of initial data. The analysis of collected data is used to formulate an emerging theory, guiding subsequent sampling and fieldwork. Thus, sampling evolves as the emergent theory evolves, and additional input is required to reach saturation from additional sources. This method is known as “theoretical sampling” and is the characteristic sampling technique for grounded theory (Glaser & Strauss, 1967). In this approach, the sample is emergent in the sense that as data are generated from interviews, the researcher reflects on the resulting analysis in light of the emergent theory, which then guides the following stages of data generation. During this step, the researcher endeavoured to identify perspectives that had not yet been incorporated into the data set but may enrich, extend, or challenge the emerging theory. The researcher then attempted to enlist participants who were likely to hold and share these perspectives. As Weed (2017) asserts, research designs that complete data collection before proceeding to analysis violate one of the fundamental principles of grounded theory methodology. In contrast to the initial sample, which is based on practical considerations by selecting immediately apparent candidates, subsequent selection criteria were data-driven in that additional participants were deemed necessary based on data collected from previous interviews (Johnson, 1990).

This study’s theoretical sampling continued with another group of five mental health practitioners from the primary urban centres of Ottawa and Toronto who had worked with Muslim Afghan clients. The researcher made written announcements to mental health professionals via professional organizations (i.e., the College of Registered Psychotherapists of

Ontario, the Ontario College of Social Workers and Social Service Workers, the College of Nurses of Ontario, the College of Occupational Therapists of Ontario, the College of Physicians and Surgeons of Ontario, and the College of Psychologists of Ontario) in order to recruit mental health professionals.

The theoretical sample of clinicians also represented those who dealt with Afghan immigrants and reflected a cross-section of multiple levels of clinical practice in mental health services. Professionals who were actively engaged in delivering psychotherapy services, professionals who were associated with case management and counselling, and professionals who also performed at supervisory levels to other mental health professionals were included in the sample. In addition, the theoretical sample brought diverse individual experiences. The sample included professionals who publicly identify as Muslims and professionals who were not immediately identifiable as Muslims but were racialized individuals. Such representation played a crucial role in shedding light on clients' experiences interacting with Canada's mental health support systems. It also allowed the study to benefit from differing perspectives of practitioners who possessed relevant knowledge about culture and religion yet had contrasting professional experiences.

The researcher collected data remotely using Zoom, an online meeting platform that adheres to PHIPA⁴ and PIPEDA⁵ online security regulations (Gary et al., 2020). After each interview, the researcher conducted an online debriefing session. On request, participants were also offered access to online short-term counselling sessions. Arrangements for provision of short-term counselling sessions were made with Muslim Family Services of Ottawa to ensure that participants had the opportunity to process any traumatic memories or reactions that

⁴ Personal Health Information Protection Act

⁵ The Personal Information Protection and Electronic Documents Act

occurred during or immediately after the interview. None of the participants, however, requested a short-term counselling session.

Creswell and Poth (2018) position ethical considerations at the heart of the data collection procedure, highlighting the need to adhere to ethical implications throughout all phases. In accordance with the principles of ethical research, the researcher sought the participants' consent. Before beginning the interview, participants received written consent information. The information clarified the study's purpose, risks and benefits, voluntary participation, confidentiality, and the participant's right to withdraw at any time. The interviews were conducted predominantly in English, and the process was audio recorded. At the request of the participants, the researcher also conducted two interviews with participants of Group A and B in one of the national languages of Afghanistan (Dari), in which he had fluency, when the participants were hesitant to share their thoughts in English due to a potential lack of proficiency in the language and a desire to express their thoughts and feelings in their native language with greater clarity.

The interviews were audio recorded using the built-in functionality of the Zoom online meeting platform. All the data gathered through interviews conducted in Dari was translated from the original language into English. All Dari interviews were back-translated to avoid discrepancies and compare the quality and accuracy of the translated transcripts with the original content. Back-translation is valuable for avoiding translation-related discrepancies in cross-cultural contexts (Brislin, 2000). Back-translation, also known as back-to-back translation, was completed in three stages: translation of the original transcript by an independent translator who holds a Master's degree in psychology and works as a mental health counsellor in Afghanistan and has fluency in both Dari and English language, followed by back-translation of the translated

text to the original language by a second independent translator, who has a Bachelor's degree in psychology and fluency in Dari and English languages, and confirmation of the two versions' reliability by a third person with a Master's degree in psychology and language proficiency in both English and Dari as well as cultural exposure and expertise in mental health (Brislin, 1980).

The original transcripts and field notes were stored in a password-protected file and a locked container to which only the researcher had access. All digital study data were saved on the researcher's encrypted hard drive. In case the original study files were lost, corrupted, or infected with malware, a copy was made to protect the data and allow for its recovery.

3.4. Constructivist Interviewing Perspective

Qualitative research employs in-depth phenomenological interviews as the primary data collection method due to their efficacy in gathering rich information about people's beliefs, perspectives, and meaning-making (Roulston & Choi, 2018). Qualitative interviewing is reported as a method of choice by researchers who work with the Afghan population for its emphasis on taking the time to engage with participants in an unhurried fashion and keeping a constant and continuous check on sociocultural paradigms of the participants (Arnold et al., 2014; Islam et al., 2010; Russo et al., 2015; Sulaiman-Hill & Thompson, 2011).

According to Patton (2002), in-depth phenomenological interviews concentrate on “describing how people experience some phenomenon—how they perceive it, describe it, feel about it, judge it, remember it, make sense of it, and talk about it with others” (p. 104). Charmaz (2014) characterizes the similarities between grounded theory and in-depth interviews as open-ended and directed, structured and emergent, and positioned and unrestricted. The open-ended, conversational style of in-depth interviews, which is more familiar, and the fact that respondents do not need to be literate to respond to the questions, made in-depth interviews appropriate for

the current study (Guest et al., 2013). In addition, it allowed the researcher to rephrase the questions and allow participants to respond if they did not comprehend the terminology or wording of a question. A significant enabling effect of the in-depth interview is its suitability for questions concerning polarizing, sensitive, confidential, or highly personal topics that may expose the respondent to social embarrassment, financial loss, or physical injury (Guest et al., 2013).

From the initial stages of grounded theory research, the emphasis is on discovering what is occurring. The flexibility of in-depth or intensive interviews enables the researcher to uncover discourses and pursue ideas and issues that emerge during the interviewing process (Charmaz, 2014). In contrast to the constructivist method, Charmaz (2014) claims that objectivist interviewing places too much emphasis on the emergent categories and not enough on the effect of the questions on the respondents. While emphasizing the importance of a balance between hearing participants' stories and searching for analytic properties and implications, Charmaz further emphasizes the collaborative aspect of constructivist grounded theory, which fosters an egalitarian exchange compared to research interviews. Charmaz emphasizes the primacy of theoretical concerns over story collection in light of the logical extension of grounded theory strategies, noting that a constructive perspective differs from the conception of the interviews as either a mirror of reality or a mere account presented to answer a question and that the interview is an action of exploration, emergent understanding, legitimation of identity, and validation of experience.

3.4.1. Significance of Language

In an interview for grounded theory research, the first question with a few clarifying comments and receptive responses might be enough for a story to emerge naturally (Charmaz,

2014). The constructivist approach opposes the objectivist approach of focusing on the essentials instead of becoming lost in details in favour of noticing relevant details and going into emergent phenomena. Charmaz (2014) argues that the researcher can build explicit ‘what and how’ questions into the data collection process by taking apart an emergent phenomenon. Attention to language and discourse by a constructivist grounded theory researcher encourages participants to reflect upon their experiences in ways that advance theory construction. The constructivist researcher emphasizes eliciting the participant’s definitions of terms, situations, and events to understand the participant’s perspective (Charmaz, 2014).

An essential step in in-depth interviews for grounded theory studies is the establishment of rapport with the participants so that they will disclose detailed perspectives about responding to an action or process (Creswell & Poth, 2018). Considerable time and attention were paid to constructing an interview protocol that allowed for rich data to come out of the interaction with the participant and that followed a progressive development of the interview itself. The first part of the schedule posed general questions about participants’ relevant experiences. This was designed to ease the participants into the interview and develop rapport with the researcher to create a comfortable, conversational interaction from the onset to set the tone for the participant’s willing engagement (Charmaz, 2014).

Once a comfortable conversation had been established, the topics of religion, spirituality, and mental health were introduced, and the participants’ personal stances and ideas were explored without specific direction from the researcher: for example, ‘*Tell me about the role of religion in your life,*’ or, ‘*What were the struggles you went through due to your religious views?*’ This part of the interview process was designed to elicit the participant’s own views on the

subject without much leading or direction from the researcher and to allow them to offer insights that may not have been expected or anticipated.

The next part of the interview protocol then focused on the particular principles that the participants identified as central, such as, “*How has your religion and religious views affected your mental health in the past?*” or, “*How do you think religion can be used in the process of psychotherapy/counselling?*” At this point in the interview, once the participant had the chance to give input without much influence from the researcher, the questions then became more interactive and reflective of both the ideas brought up by the participant earlier in the interview and/or similar ideas and concepts that came up in previous interviews with other participants (Charmaz, 2014). For example, the researcher may have asked, “*What do you expect from a mental health professional when it comes to your religious views and practice?*”

The idea of the arc of the interview protocol was to create an atmosphere that enabled rich conversations, allowed participants to bring their own views to the table, and then interact with those views in the context of the research aims and the nascent grounded theory (Charmaz, 2014).

3.4.2. Memo-Writing

Throughout data collection, transcription, initial coding, and focused coding, the researcher wrote memos to permit himself to analyze data and codes early in the research process. Charmaz (2014) identifies memo writing as a crucial phase in grounded theory analysis because it prompts the researcher to analyze the data and code early in the research process. Memos were records of the researcher’s evolving ideas, thought processes, codes, and relationships (Montgomery & Bailey, 2007).

Memos represented the researcher's thought process instead of describing the social context. Given the significance of memo writing in the process between data collection and writing the result, Charmaz (2014) argues that memo writing enables the researcher to actively engage with the material, develop ideas, fine-tune data gathering, and engage in critical reflexivity.

3.4.3. Transcription

Transcribing data for grounded theory analysis involves converting audio or video recordings into written text. Grounded theory transcription aims to capture the richness and nuances of the data to facilitate the subsequent coding and analysis processes (Charmaz, 2014). The researcher initially familiarized himself with the data by listening to the recordings and understanding the content. Non-verbal cues such as laughter, pauses, sighs, or other contextual information that may be relevant for the analysis and conveyed meaning are included in the transcript. The researcher also took notes of significant points, key themes, and recurring patterns that emerged during the data review. An intelligent verbatim method of transcription was adopted for this study. Intelligent verbatim allowed the researcher to use his knowledge and familiarity with the data and omit certain elements that were not helpful to the analysis process. The researcher used Nvivo⁶ software to transcribe the recorded data.

3.5. Analytic Procedure

Charmaz's (2014) constructivist grounded theory was applied to the analysis of the transcripts, as described in the preceding section on methodology. The approach enables the development of new theoretical insights directly from a systematic examination of data and is

⁶ NVivo is a computer software program that allows researchers to manage, analyze, and visualize qualitative data and documents systematically and individually (Dhakal, 2022).

particularly useful in areas where existing theory is incomplete, inappropriate, or nonexistent (Charmaz 2014; Payne 2016). The constructivist approach to grounded theory methodology acknowledges the constructed nature of human experience and the multiplicity of possible participant and researcher perspectives. It considers their contributions and the resulting analysis to be an integral part of a collaborative effort to construct and develop theoretical insights.

3.5.1. Initial Coding

Following grounded theory methodology, data generation and data analysis in the present study occurred concurrently. Initial coding, also known as open coding, which entailed identifying and designating units of transcript text, such as a word, phrase, sentence, or larger section of the text, was used to analyze the data (Payne, 2016). Coding grounded theory necessitates that the researcher poses analytic queries regarding the collected data (Charmaz, 2014).

The data was coded to capture the qualitative material's specifics, variations, and complexities (Henwood & Pidgeon, 2003). During the initial categorization of data fragments, words, lines, segments, and incidents were examined analytically, and participants' analytically significant phrases were occasionally employed as codes. Initial codes define what is occurring in the data and provide the researcher with insight into its significance (Charmaz, 2014). During the initial categorization, the researcher remained attentive to what the data imply, declare, and leave unsaid.

Furthermore, the analysis involved asking what theoretical category is indicated by a particular data set. The researcher employed line-by-line coding to break down participant responses into analytical codes. Subsequently, a paragraph-by-paragraph coding strategy was used to discern nuanced meanings of the data gathered from participants. Charmaz (2014)

contends that coding for actions, as opposed to coding for topics, enables the researcher to delve deeply into the studied phenomenon and explain it. Careful initial categorization also assisted the researcher in avoiding attributing personal motives, concerns, or unresolved issues to the respondents' data. As these codes were being created, they were compared to other codes, and any potential relationships were documented in process notes or memoranda. Analytic observations and conceptual connections led to the development of theoretical categories, which represent thematic concepts that organize data in relation to a developing theory or model (Charmaz, 2014).

3.5.2. Focused Coding

The technique of theoretical sampling (Glaser & Strauss, 1967) extended sampling by recruiting new participants who could elucidate emergent theoretical categories further. As theory is developed from data, the question of where and with whom to sample next is answered by contemplating which aspects of the emerging theory or model could benefit from additional clarification or elaboration.

The initial set of potential theoretical categories was then refined and developed through a process known as focused coding or axial coding (Charmaz 2014; Payne 2016). During focused coding, possible relationships between categories were identified, hypothesized, and tested against data obtained through ongoing theoretical sampling until saturation.

Focused coding was also conducted through Nvivo software. The process centred around establishing connections between categories, subcategories, and codes. The relationships and linkages between the initial categories identified were also analyzed during the focused coding process. Relationships such as causality, context, conditions, consequences, actions, and interactions among the categories were highlighted. The preliminary categories and

subcategories were then reviewed to ensure an accurate data representation and alignment with the emerging theoretical categories. The review process further helped remove redundancies and overlaps and merge similar subcategories.

3.5.3. Theoretical Sampling

According to Payne (2016), saturation is reached when no further examples of a given category can be gathered from the transcripts. In this phase of the study, saturation was attained just before the analysis of the transcript of the eleventh participant. Data acquired from interviews at this point produced only repeating codes and categories.

The emergent model of the place of religion in the psychotherapy of Muslim immigrants was subsequently re-grounded by returning to the data and validating it against the actual text (Payne, 2016).

In this phase, participants who worked with Afghan immigrants as mental health service providers and could serve as key informants were sought (Gilchrist, 1992). Qualitative interviews with various mental health professionals from diverse backgrounds provided the necessary data for developing a theoretical framework of the position of religion in the therapeutic process of Afghan immigrants. The models developed during this phase are presented in the following chapter and represent the place of religion in the psychotherapeutic process for Muslim immigrants.

Five mental health professionals who had dealt with multiple Muslim Afghan clients in their professional capacity as mental health service providers were identified. The researcher was aware of most respondents' self-identification as 'Muslim,' while others were identified through personal recommendations and snowballing. According to Biernacki and Waldorf (1981),

snowball sampling yields a study sample through referrals made among individuals who share or know of others who possess research-relevant characteristics.

All of the therapists had been trained in at least one Western therapy method, and some had substantial experience working with clients who were either immigrants or Muslims. The therapist had some form of professional affiliation with community-serving organizations that support diverse clients, which ensured their exposure to multiple first-generation Afghan clients.

Individual semi-structured interviews conducted by the researcher generated the data. The interview protocol included open-ended inquiries designed to elicit participants' accounts of how they incorporate client religion and spirituality into their own psychotherapy practices. The researcher asked participants to clarify their approach, and their experience and ideas were investigated without specific direction from the researcher. The interview protocol then focused on particular themes from the emergent model that resulted from the initial analysis of study one, such as, "*How do you believe religion can be utilized in the psychotherapy/counselling process?*"

Table 3 shows the main characteristics of Group C participants for theoretical sampling, including personal characteristics, professional affiliations, organizational affiliations, theoretical orientation, years in practice, and clientele.

3.5.4. Saturation of Initial Themes Through Participant Checking

Initial themes, subthemes, and major code categories were saturated through participant checking. Ely and colleagues (1991) describe participant checking as a process of seeking feedback from the study participants to check the accuracy of the researcher's interpretations of the participant's experience and is identified as an integral part of establishing credibility. Participant checking was also deemed essential due to political and socio-economic changes in

Afghanistan resulting from the collapse of the Afghan Republic governance structure in August 2021 and the takeover of the country by the Taliban, which resulted in a fourth wave of immigrants to the Western countries including Canada (for details refer to Afghanistan: A Brief Historical Background section, in Chapter 2 above).

Table 3: *Demographic table for participants in Group C*

| Demographic Information of Participants in Group C | | | | | |
|--|--|--|--|--|--|
| | Participant 1 | Participant 2 | Participant 3 | Participant 4 | Participant 5 |
| Gender | Female | Female | Female | Female | Female |
| Credentials | Counsellor and Case Manager | RP ⁷ (Qualifying) | RP | RP | RSW ⁸ |
| Professional Affiliation | Independent | CRPO ⁹ | CRPO | CRPO | OCSWSSO ¹⁰ |
| Clientele | Immigrants, persons of colour and minorities | Diverse, including visible minorities | Immigrants, persons of colour and minorities | Immigrants, persons of colour and minorities | Immigrants, persons of colour and minorities |
| Number of Afghan clients | Multiple Afghan families | Three Afghan Clients | Multiple Afghan Clients | Multiple Afghan Clients | Six Afghan Clients |
| Organizational affiliations | REPFO ¹¹ | JFS ¹² , MFSO ¹³ | JFS , MFSO | OMCS ¹⁴ | OCISO ¹⁵ |

Discussion on the leading factors and implications of the Taliban takeover of Afghanistan, although valuable, falls outside the scope of this research. However, the Taliban’s extremist interpretation of Islam and religion and the impact of their takeover as an Islamist group justifies the need to include perspectives of newly arrived immigrants to Canada in the present study. As the present study was at the final stages of analysis when the arrival of Afghan immigrants in the fourth wave occurred, participant checking became essential and a useful tool

⁷ Registered Psychotherapist (College of Registered Psychotherapists of Ontario [CRPO], n.d.)

⁸ Registered Social Worker (Ontario College of Social Workers and Social Service Workers [OCSWSSW], n.d.)

⁹ College of Registered Psychotherapists of Ontario (CRPO, n.d.)

¹⁰ Ontario College of Social Workers and Social Service Workers (OCSWSSW, n.d.)

¹¹ Regroupement ethnoculturel des parents francophones de l'Ontario [REPFO] (REPFO, n.d.)

¹² Jewish Family Services of Ottawa [JFS] (JFS, n.d.)

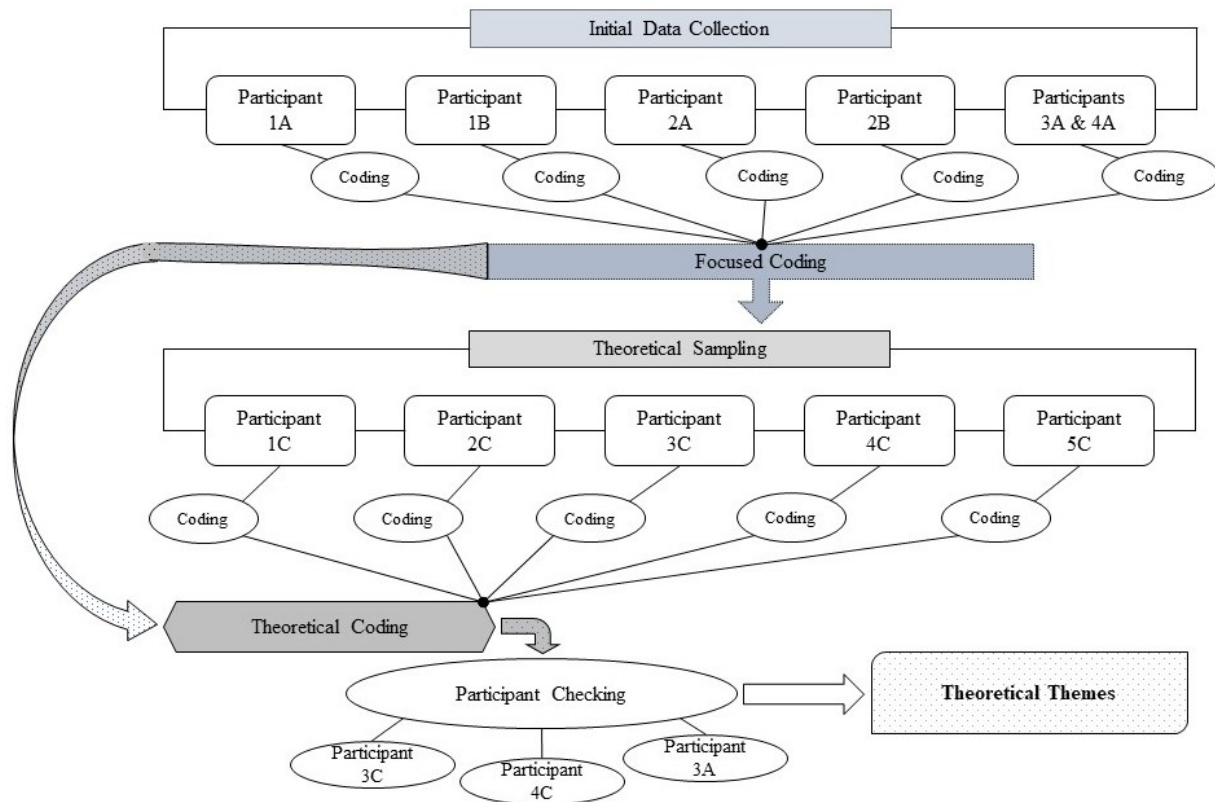
¹³ Muslim Family Services of Ottawa (MFSO, n.d.)

¹⁴ Ottawa Muslim Community Services (OMCS, n.d.)

¹⁵ Ottawa Community Immigrant Services Organization (OCISO, n.d.)

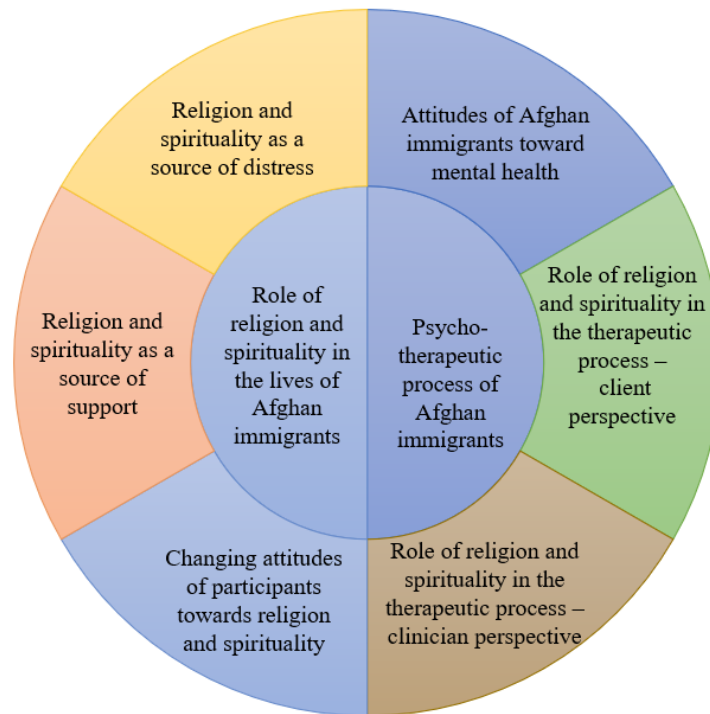
to gather feedback from key informants who were professionally engaged with newly arrived Afghan immigrants. Emergent themes of the study were shared with two participants initially interviewed as part of theoretical sampling and one participant who was interviewed as part of the initial sampling endeavour. They were encouraged to provide their perspectives, interpretations, and insights regarding the emergent themes and validate, challenge, or expand upon the categories. While their input shed some light on the experiences of newly arrived immigrants, they noted that most of their clients dealt with material challenges deemed more important and consequential than mental health. Participants agreed with two subthemes of the first emergent theme (1.1. religion and spirituality as a source of distress and subtheme 1.2 religion and spirituality as a source of support) and one subtheme of the third emergent theme (2.1 attitudes of Afghan immigrants toward mental health) but noted that reflecting on other subthemes was premature as newly arrived immigrants were mostly consumed by economic challenges. All themes and subthemes are discussed in Chapter Four: Analysis of Results and Discussion.

Charmaz (2014) highlights that categories are saturated when neither new theoretical insights nor new properties of the categories are sparked by data gathering. Conforming to the operational definition of saturation offered by Charmaz, when participants accepted initial themes, subthemes, and major code categories as reflective of their perspective and realities of Afghan immigrants as experienced by them as first-generation Afghan immigrants and clinicians who work closely with Afghan immigrants, initial themes were considered as saturated, leading to the emergence of themes and subthemes responsive to the two core research questions.

Figure 6 Process of data collection and analysis

3.6. Emergent Themes and Sub-themes

Since the goal of this stage was to expand on the theory and model established in the previous stage, the categories here reflected comparable themes to those developed in the first analysis. Consequently, the purpose of this phase with the additional participant sample was to further elucidate the emergent theory and investigate other domains in which the theory holds up or changes in response to new contexts in the psychotherapeutic application. Themes, sub-themes, and related categories to each subtheme are explored in further detail in Chapter Four through analysis of outcomes and discussion of results. Figure 7 illustrates themes and sub-themes that emerged as a result of the data collected.

Figure 7. *Emergent themes and sub-themes*

3.7. Quality Control in Grounded Theory Research

In grounded theory research, quality control is based on four factors: fit, work, relevance, and modifiability (Glaser & Strauss, 1967). Weed (2017) explains these four factors. ‘Fit’ refers to the degree to which the theory generated closely matches the phenomena it intends to represent and is ensured through constant comparison and theoretical saturation. ‘Work’ refers to a theory’s capacity to provide analytic explanations for processes within its context. ‘Relevance’ is the expectation that a theory will address the real-world concerns of those involved in the processes it endeavours to explain. Lastly, the generated theory should be ‘modifiable’ and open to development or expansion due to new insights provided by future empirical research.

Theoretical integration was devised to implement these four factors to ensure methodological integrity and high-quality results relevant to the model's applicability to psychotherapeutic interventions. In addition, as this research is primarily concerned with the domain of psychology as opposed to theology, and more specifically with the fit for psychotherapy, the analysis focuses on the breadth and depth of relevant themes that emerged from the study in terms of applying theory to practice. Constant comparison ensured that grounded theory remained grounded, and the argument for extending the analysis of a grounded theory study is inherent to the methodology itself. Data is contrasted with other data, and theoretical categories and concepts are continuously cross-referenced with one another to ensure that such concepts are still relevant in light of insights gained from subsequent data collection.

Summary of Chapter

The research design and procedures were employed to address the two core research questions regarding the role of religion in the life of Afghan immigrants and the place of religion in their psychotherapeutic process. The study used a qualitative research design as a preferred method to explore complex phenomena, understand subjective experiences, and gain in-depth insights into human behaviour, thoughts, and emotions. The grounded theory approach was employed for data collection and analysis to allow the emergence of theory from data in an organic fashion. Data was collected through semi-structured interviews and an iterative process allowing for constant comparison and exploration of emerging themes.

After completing a simultaneous process of initial data collection and open coding, relationships between initial codes and categories were established through focused coding. Focused coding further allowed the researcher to explore defining properties and dimensions of categories. Additional participants were recruited for theoretical sampling to ensure that data was

saturated. The researcher recruited participants with key information relevant to the study and sought insight from participants to evolve emergent theory. Once theoretical saturation was reached simultaneously with constant comparison of emerging categories with data, preliminary themes were shared with selected participants to perform participant checking and validate the researcher's interpretations. The following two major theoretical themes emerged from the data, each with subsequent sub-themes and major code categories:

1- The first theme defined the role of religion and spirituality in the lives of Afghan immigrants in the post-migration phase. Three major subthemes were directly related to this theme. Religion either appeared as a source of distress for Afghan immigrants or as a source of support. However, Afghan immigrants experienced a change of attitude towards religion and spirituality post-migration.

2- The second theme sheds light on the attitudes of Afghan immigrants to mental health and help-seeking. It further details the perspectives of clients and clinicians on the role of religion in the therapeutic process.

Each of the themes, its associated subthemes and major categories are analyzed, and the emergent model of the place of religion in the psychotherapy of immigrants is discussed in the following chapter.

Chapter Four:

4. Analysis of Results and Discussion

This research set out to explore and investigate the role of religion and spirituality with Afghan Muslim clients to determine the place of religion and spirituality in their psychotherapeutic process. The goal is pursued by finding answers to two research questions:

1. The role of religion and spirituality in the lives of Afghan immigrants in Canada.
2. The place of religion and spirituality in their psychotherapeutic processes.

The research mainly focused on exploring practical approaches for clinicians and mental health practitioners to address the needs of their Afghan clients effectively and holistically serve their clients. As analysis and discussion are often conducted simultaneously in grounded theory research to facilitate the iterative and emergent nature of the research process (Charmaz, 2014), the present study also presents analysis and discussion of themes relevant to data simultaneously. Furthermore, as the selected methodology of the present research focuses on developing theories directly from the data, and the emphasis is on capturing the underlying concepts, categories, and relationships, direct quotations are added when they contribute to the clarity of constructs and effectively illustrate and support the concepts, categories, or relationships identified in the analysis (Charmaz, 2014).

Results and data analysis through grounded theory show two emergent themes central to the discussion of findings and are at the core of the model for the place of religion in the psychotherapeutic process of Afghan immigrants. Emergent themes include:

1. *The role of religion and spirituality in the lives of Afghan immigrants*, with sub-themes of:
 - i) Religion and spirituality as a source of distress.

- ii) Religion and spirituality as a source of support.
- iii) Changing attitudes of participants towards religion and spirituality.

2. *Psychotherapeutic process of Afghan immigrants* with subthemes including:

- i) Attitudes of Afghan Immigrants towards mental health.
- ii) The role of religion and spirituality in the therapeutic process from a client's perspective.
- iii) The role of religion and spirituality in the therapeutic process from a clinician's perspective.

Each subtheme is further delineated into major code categories. In addition to the noted themes and subthemes, major code categories emerged that defined subthemes and, ultimately, themes in further detail. Significant code categories were directly related to each theme. Themes are discussed in detail in the following chapter; however, all subcategories are mentioned here for ease of understanding. For the sake of clarity, participants from group A (i.e., first-generation Afghan immigrants who have undergone some form of therapy) and group B (i.e., first-generation Afghan immigrants who have not undergone any form of therapy) are referred to as Afghan immigrant participants. Participants of group C (i.e., clinicians and mental health professional who have worked with Afghan immigrant clients) are referred to as Clinicians in the following sections. Analysis of the data shows that religion and spirituality have a multidirectional effect on the lives of Afghan immigrants. For some, religion is a source of distress; for others, it is a source of support. A third subgroup expressed a change in attitude towards religion and spirituality during their post-migration phase. For those who identify religion and spirituality as a source of distress, religion and spirituality's complex relationship with culture play a central role. Convergent and divergent aspects of culture and religion,

intolerance within religion, the association of religion with traumatic experiences, misuse of religion as justification for oppressive practices, and the challenges immigrants face as part of their acculturation process are significant signifiers of the distressing role of religion. On the other hand, religion is also a source of support as it provides adherents with coping mechanisms and is a reliable source of community support. Furthermore, religion is a meaning-making mechanism and a contributor to resiliency as individuals deal with resettlement challenges. Participants of the study also showed changing attitudes towards religion and spirituality, where some experienced an increase in their religiosity post-migration, while others experienced a decrease in their religious practices post-migration. A third subgroup took a different path and changed their belief system to atheism or a self-directed spiritual belief system.

The second theme offered insight into Afghan immigrants' post-migration psychotherapeutic process. Significant insight is gained into the overall attitude of Afghan immigrants towards mental health and help-seeking and the perspectives of clients and clinicians on the role of religion in the psychotherapeutic process. While clients consider integrating religion in their therapeutic process essential regardless of its role, clinicians express hesitance and ambivalence in proactively engaging with religion and spirituality as part of their professional practice. The following section of the thesis will provide details on each theme, subtheme, and major code category to highlight its significance in the clients' lives and allude to its implications in the therapeutic process. The chapter will further discuss an overarching model of the place of religion and spirituality in the psychotherapeutic process of Afghan immigrants and its multiple elements.

4.1. Analysis and Discussion of Themes

This section analyzes the emergent themes, subthemes associated with each theme, and different code categories that arise from analyzing major code categories in the data interpretation process. To ensure each theme, subtheme, and code category is discussed in detail, this section will first discuss each central theme from a macro lens and locate subthemes within each theme. As noted in the methodology section and in line with the constructive approach to grounded theory research, the researcher's perspective, positionality within the Afghan diaspora community, and expertise as a mental health professional play a significant role in the analysis and discussion of findings. Nonetheless, excerpts from participants are added to further clarify the analytical propositions. Analytical findings are further strengthened through discussion in light of literature.

4.2. Role of Religion and Spirituality in the Lives of Afghan Immigrants

Findings of the study show that religion plays an integral role in the lives of Afghan immigrants regardless of the degree of conservatism or how it is practiced. Six Afghan immigrant participants noted that religion gives meaning and purpose to their lives. Similarly, three mental health professionals noted that their clients found meaning in religion. Religion and spirituality also helped five Afghan immigrant participants overcome difficult situations as they resettle in Canada. Religion was also reported as a factor that reinforces social unity and contributes to the stability of Afghan immigrants in Canada. Analysis of the data shows that religion is a continuing thread for Afghan immigrants who participated in the study that links their present to their past as they deal with challenging identity issues and their role as immigrants in Canada. The collaborative practice of religion and spirituality, as in houses of worship or other places of religious gathering, is reported to bring Afghan immigrant participants

together physically, facilitate their communication and other social interaction, and thus strengthen their social bonds. For three of the Afghan immigrant participants, religious and spiritual practices enhanced their psychological well-being by being a source of comfort in times of distress and enhancing social interaction with others in places of worship. Analysis of the data shows that religion and spirituality are also used to cope with challenging situations. Three Afghan immigrant participants reported using religious coping as a reliable form of coping at times of crisis. Additionally, all five mental health professionals who participated in the study noted that Afghan immigrants use their religiosity to cope with stressors by putting their fate into the hands of God and accepting their experiences as God's will, which gives them a sense of safety, support, and tenacity to push through such challenging situations.

Similar findings are reported by Hasan and colleagues in their study of role of faith among Muslim Syrian refugees. The authors note that identifying as Muslim was an essential part of identity for Muslim Syrian immigrants and served as a source of comfort, strength, pride, and humility. Additionally, Gokani and colleagues (2023) report that Afghan immigrants used Islamic concepts, beliefs, and rituals as a coping mechanism as they went through resettlement journeys in Canada.

While religion and spirituality benefit many Afghan immigrants, the present study suggests that they can also be a source of distress and social conflict. In fact, three Afghan immigrant participants noted that they have experienced religion as a form of oppression and stated that they faced inequalities and discriminatory treatments rooted in religious perspectives. In the case of these participants this treatment resulted from convergent and divergent aspects of religion and culture that feed each other. Data analysis reveals that negative experiences related to religion may also be rooted in religious intolerance and misuse of religion as justification for

promoting inequality and sustaining patriarchal systems. Both Afghan immigrant participants and mental health professional who participated in the present study shed light on the following aspects of religion and spirituality in the lives of Afghan immigrants.

4.2.1. Religion and Spirituality as a Source of Distress

This subtheme emerged from group A and B participants responding to the questions about the role of religion and spirituality in their lives. Participants of group C further supported the subtheme by shedding light on lived experiences of their clients in therapeutic context. Analysis of data revealed that convergent and divergent aspects of religion and culture could be a source of distress for Afghan immigrants as they make sense of the differences and similarities between their religious beliefs and cultural practices. Religion was also at the centre of distress stemming from discrimination and religious intolerance that led to oppressive practices, especially for Afghan women who participated in the study. Religion was associated with traumatic experiences and misuse of religious doctrine as justification for maladaptive behaviours, contributing to the sustenance or increase of distress. Furthermore, the religious identities of children growing up in Canada and their acculturation process also emerged as a source of distress for Afghan immigrants who participated in the study. To better understand the negative impact of religion on immigrants' lives, each category of the subtheme is analyzed and discussed in detail.

A. Convergent and Divergent Aspects of Religion and Culture. Religion and culture, for all participants of the study, had a multidimensional relationship that defined their impact on the mental health of participants. According to their responses, the relationship between religion and culture is defined in two main ways: a) religious practices shaped by culture and cultural practices influenced by religion, and b) religion as culture. It is, however, essential to discuss

how religion and culture were defined by participants in the context of this research and how the two concepts were perceived as different.

Participants described religion as conditions and terms of approval, disapproval, acceptance, and rejection by religious and faith institutions. Religion for Afghan immigrant participants was also meant to protect and transmit meaning-making mechanisms and goals of life as designated by the faith system. On the other hand, culture for participants was described as a causal agent that is the outcome of the evolutionary process and continues to affect the people by human means rather than faith-driven systems, which are largely beyond human means. In other words, culture was defined as an indispensable device for increasing control of the environment, whereas religion was described as the system for defining the purpose of life that is largely beyond control and depends on the process of revelation.

All Afghan immigrant participants noted that the direction of effect and understanding or lack thereof regarding convergent and divergent aspects of culture and religion was at the core of experiencing distress stemming from the interplay between religion, spirituality, and culture. To discuss it in more detail, the following section breaks this category into two sections of a) Religious practices shaped by culture and cultural practices influenced by religion, and b) Religion as culture.

A. 1 Religious Practices Shaped by Culture and Cultural Practices Influenced by Religion. Religious beliefs for Afghans are shaped and affected by culture in many ways, including political climate, religiously oppressive practices that find their justification in cultural practices rather than religious revelation, and stigma towards mental health shaped by culture yet justified by religion (Sadat, 2008; Rostami-Povey, 2007). All Afghan immigrant participants noted that the political climate has had a significant impact on their mental health by presenting

politically motivated directives as religious requirements where the choice of not following is taken from people who adhere to such belief systems. In such situations, religion is largely reported as a contributor to distress and, at times, as a main source of distress. One participant noted that she was experiencing distress because the idea of birth control or using male protection during intercourse was portrayed as religiously forbidden. Mental health professionals who participated in the study and were familiar with Islam as a religion noted that such perspectives and practices are mainly rooted in the culture and aimed at maintaining male dominance over women by disallowing them to have a choice over their reproductive systems, yet such perspectives and practices are justified by religious means.

...because they were saying family planning or birth spacing is controlling the births, so it is not allowed in Islam. So, you are against Islam. ... Islam say these [children] are Muslim [and] if the number of Muslim [is] more, we should [be] proud as a Muslim.... [I] just want to [be] informed and want them to make informed choice [and] decision ...But that was something completely hard.

Othman (2006) notes that the use of Islam as a political ideology and the use of Islam as a source of law and public policy within the context of societies where Islam is interpreted from an extremist lens have had a particularly discriminatory and oppressive impact on women. Chang and colleagues (2022) further argue that religious conservatives in Afghanistan have instilled the supremacy of religious power and used spiritual privileges to maintain the interests of the culturally driven societies resulting in limiting the social rights of women and other disadvantaged groups through extremist interpretations of religious teachings.

Participants in all three groups found it challenging to distinguish between culturally driven practices and religiously rooted directives. Afghan immigrant participants noted that as

they immigrated to Canada and experienced greater freedom in relation to the imposition of religious beliefs and cultural practices, they can identify the oppressive nature of religious interpretations, but they continue to lack the ability to distinguish culturally oppressive practices from religious directives. Such challenges were also present for clinicians who participated in the study and noted that they often find themselves in a position to help clients make sense of discrepancies and help their clients make distinctions between culturally driven practices and religious directives.

Oppressive religious practices were reported as another by-product of the interplay between religion and culture in the form of religious practices shaped by culture by participants of the study from both groups of Afghan immigrant participants and clinicians who participated in the study. It could be argued that religious beliefs in Islam are not inherently oppressive (Al-Hibri, 2000; Barlas, 2019). However, extremist and intolerant interpretations of religious revelations and interpretations and classification of oppressive practices as religious beliefs can present an oppressive form of Islam as a belief system that may have adverse negative effects on adherents of Islam (Adams & Joshi, 2007; Al-Hibri, 2000; Barlas, 2019). For all Afghan immigrant participants, interpretations and justifications of oppressive cultural practices as religious beliefs, especially as religious directives falsely justified as religious revelations, were at the centre of their distress stemming from religion and spirituality. Participants associated such interpretations with religion and accepted the justifications. A good example of such misrepresentation was reported as the culturally driven and religiously justified gender roles in the Afghan community, including the Afghan Diaspora communities. Participants in the study noted that the belief that women have a limited way of life from an Islamic perspective was commonly shared by the Afghan immigrants they had come in contact with, whereas such

perspectives are disowned by other groups of the same religious belief system in many parts of the world (Muhibbu-Din, 2019). A Clinician interviewed for the study noted the following:

...I've had clients like who live here [in Canada] and the girls are not allowed to use buses, and they don't have cars. Their transportation is severely limited.

Almost all participants in all three groups referenced the stigma associated with mental health and help-seeking when dealing with psychological issues and vulnerabilities. One of the major factors in perpetuating such stigma was reported as the belief that a psychological issue or a psychologically vulnerable position is indicative of weak faith and lower religiosity. Stigma towards mental health, in this case, is being sustained by inappropriate justifications derived from religion.

...the environment that, let's say Afghanistan, we grow up in, people really do not believe in psychotherapy. They do not believe in mental health issues. In our culture, there is a stigma associated to that [mental health issues]. You do not bring out those issues. There are a lot of stereotypes. ... reason for it is both religious leaders and then Muslims understanding from mental health challenges.

However, from a religious point of view, there are no justifications for such assertions (Alemi & Montgomery, 2016; Alemi, et al., 2014; Alemi et al., 2015; Alemi et al., 2018). On the other hand, participants reported that people who struggle with mental health issues are culturally seen as weak and incapable of independent living. Such cultural practices are justified as religious beliefs to retain value in changing cultural dynamics as Afghan immigrants are exposed to different cultures and start to evaluate their maladaptive cultural practices. Not being able to discern cultural practices from religious directives was reported as a factor that plays a negative role in the utilization of mental health services by participants. In such instances, the negative

direction of effect is a significant contributor to distress and a deterrent from seeking help. Studies with Afghan immigrants in United States also report that Afghan immigrants are more likely to endorse traditional treatments such as going to herbal specialist and receiving counsel from an Imam, reading the Quran and prayer sessions as a valid form of treatment (Alemi & Montgomery, 2016; Alemi, et al., 2014; Alemi et al., 2015; Alemi et al., 2018; Byrow et al., 2020). Analysis of data further shows that similar to religious practices shaped by culture, there are also cultural practices influenced by religion that yield negative impacts on individuals. Although this direction of effect was not very prominent among participants in this study, it is nonetheless an aspect of experiences shared by two participants. In some cases, participants found it difficult to deal with cultural practices influenced by religion before their immigration journey began. As they go through their post-migration phases, they are exposed to other cultures, and experience more religious freedom and choice in the Canadian environment, they find it hard to treat cultural practices as cultural and disconnect them from the religious value that was once assigned to them. One participant alluded to the female clothing rooted in culture but influenced by religious principles as an example of this phenomenon. Two participants noted that as they go through resettlement in Canadian society, they realize that their attire sets them apart from being discriminated against; however, they report that they find it hard to rethink those cultural perspectives and detach the religious values associated with such cultural attire. Saidi's 2019 study of the shift in religious understandings of Afghan women in Germany highlights that migration experience and exposure to German society can impact conceptualization of culture and identity for Afghan women and result in change through one of three ways: enhancing Islamic values where relationship and involvement with religion

intensifies, becoming secular and trying to fully indulge into the new society, and adopting an elastic religious identity where they may blend Islamic values with Western-inspired lifestyles.

A.2. Religion as Culture. Some participants found religion and culture indistinguishable. For these participants, religious values persist through migration and take the form of identity. However, they note that this identity piece associated with their religion is also at the core of their understanding of the root causes of discrimination as they resettle in the host environment. Participants with such attitudes towards religion perceive their Islamic religious beliefs as the most dominant part of their identity and note that being religious becomes a source of distress as it puts them on the path of being discriminated against. While it could be argued that discrimination may be the source of distress, participants in the study often associate their experiences with their religiosity and reported feeling the need to hide parts of their identities that may reflect their religious beliefs (i.e., popular Muslim names like Muhammad and other Arabic sounding names) and present an unreal self when interacting with the dominant culture. An example of such a presentation was the following quotation when a participant noted they usually hide their full name and religious self to avoid being discriminated against, although for them, being a Muslim is at the core of who they are and that they see themselves as.

I remember when my [organization's] operation director asked me, 'How do you want your [name] need to appear on your email?[Sic]' I said I wanted to see only my middle name. And I totally wanted to avoid [first name that is a common Islamic name]. I don't have any problem with that [first name], but I prefer [middle name] because I don't want to be judged.

Although the impact of discrimination based on visible cultural markers and identities particular to Afghan immigrants in Canada is hardly studied, there is limited literature on Arabic

sounding names and Muslim names and their impact on discrimination in the United States and European context (Arai et al., 2016; Carpusor & Loges, 2006; Widner & Chicoine, 2011). Studies carried out in the United States and countries within the European Union report that immigrants whose names carried strong ethnic and religious connotations and revealed affiliation to a specific group often opted for covering their Muslim identity with neutral European names to avoid discrimination in the host society (Ahmad, 2020; Arai et al., 2016; Khosravi, 2012; Widner & Chicoine, 2011).

B. Intolerance Within Religion as Source of Distress. Intolerance within religion is a second category of religion as a source of distress subtheme where participants find religion as a source of distress in their lives and therapeutic processes. Afghan immigrant participants associated religion and its contribution to their experiences of distress due to intolerant perspectives towards differing religious interpretive frameworks within religion, including sectarian groups like the Sunni, Shite, Wahhabi, Ahmadiyya, and Sufi as well as other groups within Islam such as different schools of Islamic law (i.e., Shafite School, Hanafite School, Malikite School, and Hanbalite School; Braswell, 2000). One participant who followed the Shia sect of Islam noted the following:

...The struggles I had was with the differences between Shia sect and Sunni sect... I was Shia, in a Sunni majority place... I couldn't pray with them I was having trouble with that, and people were making fun of me I was being bullied because of that [being Shia]..

In this context, some participants defined intolerance as discriminatory attitudes of followers of Islam towards different sects present within the broader umbrella of Islam. Others noted that intolerance was extremist interpretations of religious revelation and guidance. Participants also noted that intolerance is when target subgroups within the Muslim community

use their patriarchal interpretations of religious revelations and guidance to subjugate, alienate, and oppress marginalized populations.

Participants noted experiencing a significant degree of intolerance in belonging to one or the other of the two major sectarian groups in Islam (i.e., Sunni and Shia). Participants also noted that holding liberal views of the religion set them apart in many situations and made them a target of extremist groups within the Muslim community. A female participant noted the following:

I was beaten by Taliban for the no reason, they beat me because I could not hold onto my burqa. I was wearing a burqa while I had my daughter in my arm and also holding a breadbasket over my head. I wanted to put the breadbasket on the ground that's when the front of my burqa went up. Just when I was putting the basket down to pull the burqa back into place, I was hit from behind with a whip, I was beaten so hard that I thought I could die right then and there. I decided to move to Iran.... After some time my husband decided to return to Afghanistan. I said, I don't want to return to Afghanistan. Then my husband said, if you don't want to go back, I will divorce you.

Women and other marginalized populations like people who identify as members of the LGBTQ+¹⁶ community are usually at the centre of these interactions and feel powerless due to the oppressive interpretations of religious revelations and guidance (Afrouz et al., 2021; Redcay et al., 2019; Sachdej, 2021).

C. Association of Traumatic Experiences and Discrimination with Religion. While much of the research on the role of religion and spirituality of Afghans in general and Afghan immigrants in particular focuses on the positive role of religion in coping and meaning-making,

¹⁶ Lesbian, gay, bisexual, transgender, queer/questioning, plus (others; Merriam-Webster, n.d.).

for five Afghan immigrant participants of this study, religion played a negative role as they associated religion with their traumatic experiences in their pre-migration, in-transit or migration, and post-migration phases. One clinician who participated in the study also spoke about working with Afghan clients for whom religion played a negative role in their life. Although many participants referred to the positive aspects noted above, and those themes will be analyzed later in this chapter, the focus here remains on the impact of religion and religious beliefs on trauma and the aftermath of trauma.

Religion was directly associated with childhood and adulthood traumatic experiences by five participants. Participants noted that they developed a fearful image of religion as a child due to experiences of corporal punishments at places of worship and religious education. They further noted that a lack of compassion from parents, caregivers, and elders regarding adherence to religious beliefs and practices was remembered as a traumatic experience that continues to affect their lives in the present. One participant noted that although their parents initially did not resort to corporal punishment in enforcing religious practices, the encouragement of community members and other elders pushed them to opt for harsh means of enforcement of religious practices on them and their siblings.

At first, my mother was not saying anything, but after she told her uncle's wife about it, she told her to beat me and break me into pieces so I would pray. As soon as she [participant's mother] heard it, because her uncle's wife was like a mother to her [participant's mother], she started forcing me to prayer. I prayed, but in a lot of tears ... and once I turned 13-14 years of age, I didn't pray anymore... Look, religion and faith is the reason families, and their children grow bad.

Similarly, experiences of physical and sexual abuse by religious educators and clergy were highlighted as a major traumatic incident that left a lasting impact on the well-being of participants. Such experiences were reported to result in a severely negative image of religion and other symbols associated with religion. Clinicians who participated in the study noted that they were rejected as matched counsellors by Muslim Afghan clients who appeared to have had significant traumatic experiences with religion and religious figures. The clinicians further highlighted that their physical appearance (i.e., Islamic attire like wearing Hijab) was reported as a triggering factor for clients seeking therapeutic services. One clinician noted the following:

...And she [the client] said, 'I don't want to see anyone who is Muslim or looks like her,' pointing at me [participant], 'because I'm from Afghanistan and my dad abused me and he was Muslim and now I go to this other centre and ... I'm a Christian now and I don't want to have anything to do with this [referring to hijab], and I don't want to see her'.

Furthermore, Afghan immigrant participants noted that they associated their experiences of domestic abuse with religion and religious beliefs, which had a negative impact on their well-being and image of religion. They noted that since their abusers used religion and religious beliefs as justification for abusive behaviours and marginalization, it was hard not to associate religion with their experiences of abuse by intimate partners, parents and caregivers and other close relatives.

... a reality we face is forced marriages. Which happens here [in Canada] too, like parents think young girl isn't doing what she's supposed to be doing within the cultural sort of understanding what a young girl should be doing, so the solution is to let's pack her bags, get her passport, and take her to Afghanistan. She gets married off and she'll be alright. That has happened.

Traumatic experiences associated with religion were also reported during the resettlement journey of many participants in the post-migration phase. Participants reported being discriminated against for being Muslim, identifying as Muslim or even being perceived as a Muslim in the Canadian context. They were targets of discrimination by members of the dominant culture in Canada, including experiencing discriminatory treatment from clinicians whom they trusted to share their vulnerabilities with expectations of gaining support. Discrimination was also experienced by many from within the Afghan diaspora community, where other Afghan immigrants often expressed discriminatory attitudes towards other Afghans for holding different religious views or differing religious preferences of their family members. An example of this was reported by a participant who experienced discriminatory and disrespectful treatment from other Afghan immigrants because of their daughter's conversion to Christianity.

... when I came to live between my own people, my own relatives, my children, and me were insulted and humiliated... All Afghans said [the participant] is Christian. I tell them no ... I am Muslim, I have not converted to Christianity, my daughter converted. Then one of them said: "just because you are like this [does not impose belief on others], your daughter converted to Christianity".

While much of literature on association of religion with traumatic experiences is focused on various denominations of the Christian faith tradition, there is significant rarity in research on fearful images of Islam with victims of physical and sexual abuse, corporal punishment, and domestic abuse and the traumatic impact of physical and sexual abuse as experienced by adherents of Islam. Although a limited number of studies have explored the negative impact of religiously justified corporal punishment and abusive acts (Alsehaimi & Alanazi, 2015; Durrant,

2005), there is need to research on mental health related outcomes of trauma inducing acts justified as religious directive in the immigrant communities, in particular Muslim immigrant communities.

D. Misuse of Religion as a Justification for Maladaptive Psychological Mechanisms.

Religion can play a negative role in addressing mental health issues and psychological problems when used as a deflection or defence mechanism (Durrant & Poppelwell, 2017). Religious fatalism and spiritual bypass are two examples of such practices frequently appearing in participant responses in the present study. In the context of this study, religious fatalism refers to the idea that health and mental health outcomes of individuals are either predetermined or purposeful by a higher power and that the individual has no control over the outcomes of their psychological and mental health issues (Nageeb, 2018). People who perceived mental health issues as a punishment for their deeds by a higher power often found addressing mental health issues through counselling and psychotherapy means as futile and inconsequential (Nageeb, 2018). Furthermore, many used these perspectives as avoidance mechanisms that influenced their lower levels of seeking mental health support and overall help-seeking behaviour (Franklin et al., 2008). Two participants of the present study reflected on their mental health struggles stemming from pre-migration struggles in Afghanistan and issues they reportedly went through during their in-transit journey. They defined their mental health challenges (i.e., feeling anxious, feeling depressed, avoidance of emotion when they are reminded of their traumatic experiences) as the will of God and noted that counselling would not be a good fit for them, as they could address these issues through prayers and recitation of the Quran.

On the other hand, analysis of responses provided by clinicians who participated in the study showed that for some of their clients, reliance on religion alone appeared as a maladaptive

way to address their mental health issues by only addressing them through religious and spiritual means. Clinicians who participated in the study alluded to the prevalence of superstitions, magical thinking, and evil eye as root causes of mental health issues by their clients, which in turn has the potential to lead individuals to help-seeking from people who are not professionals in health and mental health. Although superstitions are mainly influenced by culture, they find their justifications in religion and religious interpretations (Oriya & Alekozai, 2022).

Spiritual bypass is another use of religion as a maladaptive form of coping mechanism with excessive reliance on religious practices that was found prevalent with Afghan immigrant clients, as clinicians in the study reported. Clinicians who participated in the study alluded to tendencies to assign religiously driven explanations of mental health issues where clients expect solutions to be driven purely by religious interventions.

Some people who have some kind of special faith in Mullahs [religious figures] and believe they can only find their cure of any kind of pain, physical illness, or mental illness from a Mulla in shape of what they call, Tawiz.¹⁷

While these maladaptive coping mechanisms like spiritual bypass and superstitions may act as a defence mechanism in many situations and, at times, protect individuals from exposure to further harm, it does not resolve the underlying issue but rather glosses over a problem, leaving it without a solution (Jastrzbski, 2022). Multiple studies with Muslim immigrants, including Afghan immigrants, have found similar results about excessive reliance on superstitious beliefs and other maladaptive religious coping mechanisms (Ahmad et al., 2022;

¹⁷ Tawiz, commonly translated as amulet, is a healing tradition to seek protection and cure against the evil eye. An amulet writer writes Quranic prayers on a piece of paper or a tablet to invoke divine powers. Tawiz or amulets is a pouch normally made of leather, cloth, or metal hanged using a black string. The affected person wears it around the neck or ties it on the arm. It is believed that tawiz has powers to protect and cure against diseases, sufferings, and misfortunes (Qamar, 2013).

Amiri et al., 2019; Teunissen et al., 2014). However, there is still a significant rarity of research on understanding the root causes of the phenomenon and its long-term effects on mental health and help-seeking for mental health related issues.

E. Acculturation and Religious Identities of Children Growing in Canada. A major challenge associated with religion and religious beliefs that ultimately resulted in distress for many participants was their cultural identities as first-generation immigrants in Canada. As first-generation immigrants in Canada, Muslim immigrants, including Afghans, reported being conscious of and concerned about passing on their religious and cultural identities to their children, who are now raised in the Canadian environment (Ochocka & Janzen, 2008). A major factor in the acculturation process is the influence of the dominant culture of Canada, which is predominantly influenced by the Christian faith tradition and Western values but is increasingly integrative of values from multiple immigrant cultures thus exposing children to multiple perspectives, including other religious and non-religious perspectives. For three Afghan immigrant participants, the environment they are raising their children in is vastly different from the environment they were raised in, which brings the challenge of identifying appropriate ways of communicating religious beliefs and practices. Participants further noted experiencing challenges in navigating how to define the role of religion in their children's lives and addressing issues that stem from differing perspectives of religion between them and their children. Furthermore, participants who were parents and caregivers also found it hard to find religious resources that would assist them in educating their children on their religious beliefs and value systems. Another challenging aspect of religion concerning acculturation was the expectation and, to a large extent, the need to fit in and adapt to the dominant culture during the resettlement process. Additionally, the religious identities of children were also reported as a concern by

parents involved with Children Aid Societies (CAS),¹⁸ where children and families involved with CAS experience discriminatory treatment from case workers and other staff members.

Furthermore, children involved with CAS also find it distressing that they aren't able to follow religious practices when placed in foster homes, which contributes to high levels of distress associated with religion. Participants, particularly women, reported feeling the pressure of balancing their religious views and meeting the dominant culture's expectations in their attire and clothing style. Female participants noted that they preferred wearing clothes that were according to their religious beliefs (i.e., covering their hair or wearing a Hijab). However, they also noted that such clothes styles often brought with them the stereotypical perspectives of oppression by members of the dominant culture. In other words, if they were to wear clothes that reflected their religious preferences, they were also subject to being perceived as oppressed. Dealing with such inquiries and reactions was associated with religion. Once again, there is little to no research available on how the host culture in Canada can impact worldview and interpretation of religion for Afghan immigrants, in particular women and how it may change their view of their attire. However, there is some literature available on experiences of Muslim immigrant Arab women, which shows similar results. El-Geledi and Bourhis (2012) reported that youth in universities had a more favourable view of Arab women dressed in Western clothing than those dressed in the Islamic veil. However, the authors also highlight that similar attitudes were not shown for women dressed as Catholic nuns, signifying that the women's religion played a significant role in how they were being treated by those around them. Phillimore (2011) also refers to the struggles Afghan women experience due to their clothing choices that are influenced

¹⁸ Children's Aid Societies provide child protection services and are governed by the Child, Youth and Family Services Act, 2017 (Government of Ontario, 2023).

by religion and culture; however, the author falls short of discussing the root causes and the impact it may have on the attitude of Afghan immigrant women on their view of religion.

4.2.2. Religion and Spirituality as a Source of Support

Religion and spirituality are both entrenched in an attempt to comprehend the meaning of life and, in some cases, how a relationship with a higher power can impact that meaning.

Religion and spirituality share a similar foundation but vastly distinct practices. Spirituality resides within the individual and what they personally believe, whereas religion is an organized, community-based system of beliefs. Religion gives people something to believe in, a sense of structure, and typically a community of people with similar beliefs. As discussed in the chapter on literature, these characteristics can have a substantial positive effect on mental health. More than half of Afghan immigrant participants recognized religion, religiosity, and spirituality as vital resources for dealing with mental health problems and maintaining health. Religious coping, specifically turning to God as a method of seeking solace, support, and guidance from a divine being, either within the domain of Islam as a religion or on a more informal path through one's own spirituality, was reported as a key contributor to participants' well-being.

People's religious views and involvement in religious activities were additionally highlighted as sources of the social support they experienced by clinicians interviewed for the study. Clinicians further noted that religion provided essential organizational structures through which people interacted and strengthened their communities, in addition to inspiring them to serve others. One clinician noted the following:

... I find that ...there's a lot of social support in it [religion], especially for larger groups, newcomers, and it's just a sense of safety for them [religious communities] as

well, knowing that there are people [who] understand them [newcomers], and that community is built around their religion.

Furthermore, habitual reappraisal and high levels of perceived coping abilities, fostered by religious coping, led to more adaptive behaviours that promoted increased resilience, reduced distress symptoms, and maintained emotional well-being. The following section discusses each category of the subtheme in detail.

A. Religion and Spirituality as a Coping Mechanism. Participants viewed spiritual practices as beneficial for coping with stress due to their sense of meaning and the higher power that these practices provide. Some respondents viewed the focus placed on religious and spiritual concepts like forgiveness, compassion, and humility as attractive and beneficial to their mental and emotional well-being. Traditional religious settings, such as mosques, provided four Afghan immigrant participants with a sense of community and the opportunity to meet others seeking connection to a higher power. Others deemed open forms of spiritual practices in less traditional contexts favourable.

...So is that idea that Allah sees me like I pray to Allah and like at night in the middle of the night like I talked to him, he sees what I suffer. So, Allah is like a witness of suffering. So, and he will help me. He will guide me.

Most Afghan immigrant participants referred to “Reliance on Allah,” known as *tawakkul* in Dari and Pashto (Afghan immigrant languages). Originally from Arabic, the term translates as entrusting one’s affairs to a superior power. As one of Allah’s Names, *Al-Wakeel*—the Disposer of Affairs—is synonymous with ‘trust,’ the concept is also ingrained in religious belief systems. The Quran refers to Allah as *Al-Wakeel* fourteen times, making it a religiously grounded approach that will surrender and reliance on Allah as a superior power and Creator. Participants

regarded reliance on God as one of the essential Islamic virtues. Participants also identify this as one of the spiritual development stages for those who preferred a less structured approach and found themselves spiritual believers in Allah as the Creator. Participants engaged Tawakkul as a coping mechanism. Reliance on God has cognitive, emotional, behavioural, and relational components for Afghan immigrant participants. In a cognitive conception, individuals viewed God as the primary cause of daily events, believing that nothing could occur without Allah's permission. At the emotional level, individuals develop the readiness and inclination to trust Allah and consider Him sufficient to provide for their needs. When considering how to carry out the plan in a way that was right and permitted, Afghan immigrants put their trust in Allah as the behavioural component of the idea. On a relational level, pursuing God's proximity and having faith in His availability and support was essential. In addition, participants identified spiritual grounding as a significant contributor to their mental health and emphasized the need to genuinely show up for oneself and others and to feel spiritually grounded. Similar themes were also reflected by clinicians interviewed for the study.

...when it came to [mental health] a lot of what grounded them, in particular Afghan clients, was their connection to their faith. And how they made sense of what had happened in their life.

All Afghan immigrant participants found stability in their spiritual beliefs within or beyond the confines of Islam. Participants who found their own spiritual paths to be more dominant in their lives found it beneficial to connect with their inner powers of thinking, experiencing, deciding, and willing. They also relied extensively on their spirituality or religion as a source of resilience within and as a trustworthy guide to discovering the purpose of their lives. Similar results are found by other scholars, where religion is used as a coping mechanism

by many Afghan immigrants, particularly women. The extent of studies on the effectiveness of such coping mechanisms are relatively rare, yet the results show that religion is often used to deal with psychological issues and stressors. Copolov and Knowles (2023) reported that Afghan immigrant women felt at peace when they prayed; it gave them a sense of hope that they could deal with personal difficulties. Additionally, Gokani et al. (2023) found that Afghan immigrants found the concept of migration rewarding from a religious perspective, which positively impacted their ability to cope with resettlement stressors. Similar results are also reported in other Muslim immigrant communities (Litalien et al., 2021).

B. Religious and Spiritual Community as a Source of Support. In the context of this study, the term *religious and spiritual support* refers to the social support that individuals receive as a direct result of their religious beliefs and their involvement in religious activities within religious communities. In this context, social support results from a larger social network and a sense of belonging to one or more groups. All Afghan immigrant participants expressed gratitude for the emotional support they received and, at times, anticipated from their social network based on shared religious beliefs. The emotional and physical well-being of many participants was improved by the emotional and spiritual support they got from their respective religious and spiritual groups, and this support also gave them a sense of belonging in their communities. It was also revealed that non-religiously driven social support (i.e., general social support) is a beneficial element and contributor to mental health that often stems from belonging to religious and spiritual communities. Involvement in religious and spiritual communities allowed individuals to expand their social networks and access otherwise unavailable resources. However, participants who regularly attend religious activities tend to have larger social networks and engage in more activities than those who do not routinely attend religious activities

and pursue their own spiritual path. When confronted with mental health issues or traumatic events, faith and community leaders additionally emerged as the initial point of contact. In times of crisis, participants indicated that they turn to respected religious leaders in their communities before turning to mental health professionals. Although participants report pursuing social and mental health-related assistance from religious and spiritual communities, little can be said about whether or not their needs are adequately addressed.

Traditional religious leaders, also known as Imams, are responsible for leading prayers, delivering sermons, conducting religious ceremonies, and advising individuals and families on religious matters. However, for many in the Muslim immigrant communities and, in particular, Afghan diaspora, Imams provide mental health services through their religious interventions (Ibrahim & Mojab, 2023; Islam et al., 2023; Zia et al., 2022). Because many Muslims turn to Imams for mental health-related issues, Imams are transformed into unintentional counsellors or spiritual healers, even though they might not have professional counselling or medical training (Islam et al., 2023). Although they may not be able to effectively address the psychological issues of their congregation, their religious knowledge bestows them an authority that other community leaders do not have. Muslims believe the Imam will provide sound advice and viable solutions based on their knowledge of Islamic scripture.

C. Religion and Spirituality as a Meaning-Making Mechanism. Meaning-making is conceptualized and operationalized as a positive re-evaluation of stressful events, searching for, and finding meaning in the root cause of the stressful event, comprehending how one's life has changed due to the stressful event, and posttraumatic growth. Three Afghan immigrant participants of the study reported that meaning-making was more helpful than problem-focused or emotion-focused coping strategies when dealing with events they could not alter or control.

Clinicians who participated in the study also noted the importance of reframing life events in a positive way. Meaning-making approaches to evaluate and addressing challenges, including the search for meaning and the presence of meaning, was pointed out as a significant factor in psychological adjustment to immigration stressors by clinicians interviewed. Participants also identified meaning construction as a potential source of the capacity to experience negative and positive affect following an unsatisfactory outcome or problematic event. In other words, they discovered that the addition of positive affect to a situation that might inherently evoke negative affect was an effective method for coping with stressors and that the ability to surpass previous levels of well-being or psychological functioning after a stressful life event could be facilitated by conceptualizing events in a religious context to find meaning. In addition, participants reported experiencing personal development due to regaining religious beliefs that they had abandoned before immigration. These include increased personal and social freedom, power and autonomy, a greater multidimensional understanding of the world, empathy, motivation for personal accomplishments, and self-respect. Participants further reported experiencing a sense of order, purpose, and fulfillment in their lives. Personal, communal, environmental, and transcendental dimensions are central to religious and spiritual meaning-making and well-being. Participants' sense of meaning, purpose, and values comprised the personal aspect of religious and spiritual meaning-making. On the other hand, the communal aspect defined the nature of their relationships. The environmental aspect was primarily concerned with physical world considerations, whereas the transcendental aspect focused on attitudes toward a higher being. Another positive aspect of religion when considering Islam as a way of life is that it provides Muslim immigrants with specific guidelines to adhere to as they adjust to a culturally different environment (Moghissi et al., 2009). All Afghan immigrant participants with the exception of

three viewed Islam as both a religion and a comprehensive way of life. Islam offered them comprehensive guidance on their life's social, economic, political, moral, and spiritual dimensions. Although prayer, fasting, almsgiving, and pilgrimage are the essential modes of worship in Islam, the religion's guidance on how to live encompasses all facets of life, including mundane or vital daily activities, whether personal, social, educational, economic, or political. This consequently makes it simpler for immigrants to adhere to a prescribed lifestyle. The relationship between meaning-making, religion and spirituality, and development in relation to immigration has been a prominent theme in this study; however, there is limited research on the concept in relation to the larger landscape of recent migrations of communities from non-Western societies to Western societies. The concept is even more rarely studied among Afghan immigrants, who are the focus of the present study. Nonetheless, Spännäri and Laceulle (2021) in their study with migrants in Finland note that religion and spirituality are present in the lives of their participants in a variety of ways and play a significant role in their meaning making. Similar to what participants of the present study noted, Spännäri and Laceulle (2021) report that some migrants in Finland found meaning through traditional religious institutions, while others chose paths of spiritual seeking that led them away from traditional religious practices toward new expressions of spiritual meaning making.

D. Religion and Spirituality as a Key Contributor to Resiliency. Clinicians interviewed for this study underlined the significance of religion and spirituality in the resilience of Afghan immigrants in the aftermath of traumatic experiences. Clinicians interviewed for this study defined resilience in this context as the capacity to overcome obstacles and regain a satisfactory quality of life and endure adversity, recover, and flourish despite life's setbacks. Habitual reappraisal and high levels of perceived coping abilities fostered by religious and

spiritual belief systems and coping mechanisms were identified as resulting in more adaptive behaviours that promoted increased resilience, decreased distress symptoms, and improved emotional well-being. Welsh and Brodsky (2010) have studied the role of religion and spirituality in the resiliency of Afghan women in the context of migration and note that women who engaged in religiously driven resiliency were experiencing relatively low levels of mental health difficulties, suggesting that the coping mechanisms the women engaged in were effective. The moderating effect of religion in resiliency was also found higher in females than males by Stemple and colleagues (2017) in their study of distress and resilience among Afghan refugees in Northern California.

In summary, the first emergent theme shows that religion and spirituality can have a bi-directional influence on the lives of Afghan immigrants. They can foster resilience and function as a meaning-making and coping mechanism as immigrants deal with challenges in their resettlement journey in the post-migration phase. It can also play a negative role in the form of a contributor or source factor of distress when interpreted in an intolerant and extremist form and in relation to the growing unfavourable view of Islam as a religion reported by many in the Western societies, including Canada (Korzinski, 2023). It may also be closely associated with traumatic experiences, gender-related disparities, and maladaptive mechanisms of spiritual utilization for coping. Study participants further pointed to two other themes of changing attitudes towards religion and spirituality and the psychotherapeutic process of Afghan immigrants. Each theme and its subthemes and contributing categories are discussed in subsequent sections.

4.3. Changing Attitudes Towards Religion and Spirituality

The data uncovered a second recurring theme that contained some unexpected subthemes, which we discuss and analyze in this section.

Although some subthemes of change in attitude toward religion and spirituality were anticipated in light of available literature on the role of religion in the lives of immigrants, as discussed in the first theme, including an increase in religious and spiritual practices as a mechanism to deal with the stressors of resettlement during the post-migration phase, other subthemes of change in attitude toward religion and spirituality were unforeseen. The researcher did not anticipate the decrease in religiosity, the shift from religious beliefs rooted in Islam as a religion with formal structures to spirituality where individuals chose their own paths of connecting with a higher being outside of the boundaries of formal religion, and the conversion from Islam to other faith traditions. Mentioned themes were unanticipated by the researcher because they were not referenced or referred to in the literature available on Afghan immigrants and their utilization of mental health services as well as the interconnection between religion and mental health of Afghan immigrants. As noted in the literature review section of this thesis, studies with Afghan immigrants predominantly find religion and spirituality as a positive contributor to mental health of Afghan immigrants. There are also studies where negative effects of religion on sub-sections of Afghan immigrants (i.e. women, people who identify as LGBTQ+) are highlighted, however, available literature on Afghan immigrants reviewed by the author of this thesis does not address the themes of shift from religious beliefs rooted in Islam as a faith system to self-directed spiritual path. The present study sheds light on the emergent theme, however, there is need for more in depth analysis of root causes, predicting factors, and

effectiveness of a self-directed spiritual path with Afghan immigrants in the context of their mental health and help-seeking attitudes.

Changes in attitudes of two Afghan immigrant participants toward religion, spirituality, and their respective religiosity were primarily the result of their immigration journey and their exposure to both positive and negative aspects of life in Canada. In other words, participant attitudes toward religion and spirituality depended on their pre-migration trauma experiences, the availability of resources associated with religion and spirituality in the host environment, their experiences of religious freedom and expression of thought in the Canadian context, and their exposure to a variety of ways of connecting with a higher power. In order to successfully adjust to their new surroundings and integrate into host communities during the post-migration stage, immigrants must find ways to bridge considerable religious and cultural differences. Differences in immigrants' attitudes and host community members' attitudes catalyze immigrant attitude change. Studies show that individuals who are relatively secular at the time of their integration into the host society and express only nominal adherence to the religious traditions they were previously exposed to during their pre-migration phase or the faith of their ancestors may be close to the dominant culture of the host society in terms of values, beliefs, and behaviours, thereby decreasing the pressure that may have been present in the past due to the strict imposition of religious practices (Soltan, 2023; Stack & Iwasaki, 2009). In contrast, those who are devout believers and faithful practitioners of religious rituals may be quite distant from the dominant culture and other immigrants in terms of values and behaviours, resulting in an increased reliance on religion and spirituality (Khanlou et al., 2008; Soltan, 2023; Stack & Iwasaki, 2009). However, data from the present study show that freedom of expression and religious belief in Canada may also act as a buffer for immigrants to explore new ways of

engaging with their inner spiritual self and find new ways of engaging with a higher power, thereby facilitating a shift from adherence to a structured religious belief system to an open, self-directed spiritual practice. However, there is a need for further study of the phenomenon on a larger scale and through quantitative measures.

Following analysis of the collected data in the present study, the following three major subthemes emerge under the overarching theme of changing attitudes toward religion and spirituality: a) an increase in religious and spiritual practice in the post-migration phase, b) a decrease in religious and spiritual practices in the post-migration phase, and c) a change in belief system in the post-migration phase. Each subtheme is broken down into its component parts to explain how it plays a part in the participants' lives, which, in turn, helps to shed light on the role that religion plays in the participants' psychotherapy journeys.

4.3.1. Increase in Religious and Spiritual Practices in the Post-Migration Phase

The vast majority of Afghans have some religious upbringing, with beliefs passed down from generation to generation (Emadi, 2005). Religion is also likely to influence many Afghans' life experiences and choices (Emadi, 2005). Religious institutions are regarded as important sources of social capital, as they provide members with access to various social connections and foster the formation of social networks with other religious group members (Emadi, 2005). Yet, as discussed in previous sections, religion can also be a source of distress for many Afghans, resulting in lower levels of adherence during their pre-migration period. Despite this, emerging subthemes from the data suggest that perspectives of four Afghan immigrant participants on religion and spirituality changed during their post-migration phase from being less religious to becoming more religious and showing increased religious involvement as part of their resettlement and social integration process in the host society. When considering the connection

between religion and social integration, it is essential to remember that religiosity is not a fixed or trait-like quality, however, it may be modified by a person's level of social integration into networks within the host society (Dürlinger & Pietschnig, 2022). Afghan immigrant participants who placed less emphasis on religion prior to migration and for whom religion did not play a positive role in developing social connections before migration reported a change in their attitude toward religion and spirituality post-migration. They made these adjustments by capitalizing on the previously less prominent elements of religious identities to access community resources and employment possibilities in the host environments during their post-migration phase. Participants also described their altered perspective due to the role religion and religious identities played in forming social bonds in their host societies. Supposedly, religious, and spiritual entities in host societies facilitate the development of community ties among newcomers and immigrants. However, these organizations and their members often are more comfortable with individuals who share their beliefs and worldviews. Participants who were less religious before migration could establish more co-ethnic contacts immediately after moving to Canada, which strengthened their religious practice. In addition, the study's female participants reported feeling a deeper sense of religious devotion and connection to their faith due to their experiences in Canada and the greater religious tolerance prevalent among the Afghan diaspora and a greater degree of acceptance in the host society. Although the focus of religion in the pre-migration phase for female participants was on gender constructs within extremist interpretations of religious revelations and guidance, they reported an increase in the role of religion in their lives and an interest in the intersections between religion and gender when more accepting and feminist interpretations of religion were adopted. Religion was discovered to be a source of empowerment for women when it assumed less patriarchal forms in the Canadian context than in

their home countries. Freedom of religion and belief empowered women to determine for themselves what they believed and how they desired to live.

The feminist reinterpretation of religion as a source of women's empowerment has become more visible, primarily due to debates on multiculturalism and the recognition of women's complex multiple identities (Golnaraghi & Dye, 2016; Golnaraghi & Mills, 2013; Zine, 2012). These identities, including religious affiliation and traditions, have led to a growing challenge to the alleged irreconcilable divide between religion and women's rights within the context of Islam. Additionally, clinicians interviewed for the study noted that clients might also find their way back to religion after going through the therapeutic process. This was particularly reported as true for younger first-generation immigrants who initially find the differences between the religious teachings of their parents and their own worldview as irreconcilable. Clinicians noted that their clients often can gain a deeper understanding of religion's role in their life when they engage with the topic as part of the therapeutic relationship. Studies on how young first-generation immigrants process their religious identities are rare in the Canadian context, however, research carried out with Afghan immigrants and youth in the United Kingdom, Australia, India, and Turkey show that the attitude of Afghan immigrants towards religion plays an integral role in their acculturation journeys and highlight that increase in religiosity can help youth in their resettlement and integration to the host societies (Akcapar, 2019; Fiddian-Qasmiyeh & Qasmiyeh, 2010; Gladwell & Elwyn, 2012; Radford & Hetz, 2021). Furthermore, literature on feminist views of Islam as it relates to women also sheds light on the empowering aspects of religion for women regardless of the dominant patriarchal interpretations pushed forward by fringe elements within the larger discourse of Islam as a way of life for Muslims. Jacinto (2006) invites women to take proactive action to re-interpretations of Islam

from a feminist perspective and Zain (2012) further argues that inscribing Islam in a singular conception of being irreconcilable with feminist goals reduces the broad epistemological expressions of Islam de-legitimizing the discursive challenges made by Muslim women. Such theoretical presuppositions are then reaffirmed by the way women utilize religion in dealing with challenges posed to them during their resettlement journey in post-migration (Beg, 2005; Bhanji, 2011; Dossa, 2008; Shakya, 2010). Nonetheless, there is need for research with Afghan women to develop an in-depth understanding of the way Afghan women approach the reconciliation process of re-interpretation of religion from a feminist perspective and interpretations of Islam as predominantly practiced by a majority of Afghan immigrants in Canadian diaspora.

4.3.2. Decrease in Religious and Spiritual Practices in the Post-Migration Phase

Analysis of data show that attitude towards religion and spirituality is multidirectional and dependent on multiple factors, including exposure to the trauma associated with religion and spirituality, preferred coping mechanisms, degree of connection with the ethnic community in the post-migration phase, and shifts in ideological perspectives towards religion and spirituality. In contrast to the preceding subtheme, three Afghan immigrant participants reported a decline in the perceived significance of religion and spirituality in their lives. One of the primary elements discussed in a nuanced manner by the participants was trauma. Some individuals tried to comprehend the meaning of their traumatic experiences by making appraisals of the significance of such events. Others adopted an avoidant stance and sought to distance themselves from factors associated with their traumatic experiences. Studies with immigrants and refugee populations show that both approaches may be prevalent and may impact the individual's attitude towards help-seeking for mental health related issues and acculturation (Cepeda-Benito & Short, 1998; Rousseau et al., 2002; Hameed, 2018; Wylie et al., 2018). In the present study, Afghan immigrant

participants who reported being religious prior to immigration interpreted traumatic events as having religious significance, thereby increasing the likelihood that their religious beliefs would change. In this context, belief change was defined as modifying, elaborating, or rejecting existing beliefs to reduce inconsistencies or maintain disengagement. Participant responses were indicative that the magnitude of the change is influenced by the ability to find satisfactory explanations for traumatic events, the perceived freedom to disengage from religion, and the assurance that there will be no life-threatening consequences. Participants with experiences of marginalization and gender-based oppression in their host society found religiously intolerant interpretations and extremist ideologies within Islam as the main reason for their decreased involvement with religion in the post-migration phase. Two Afghan immigrant participants as well as one clinician noted that the understanding of religion as practiced by members of Afghans as an ethnic group in Canada continues to hold intolerant and extremist views, thus making it hard for the Afghan immigrants who reject such views to engage with religion on a communal basis. They added that Islam, as practiced by community members, was largely influenced by oppressive and gender-exclusionary cultural practices and carried a political undertone. These factors further impacted their assessment of the viability of religion and its role in their lives negatively. Discrepancies in interpreting religious revelations and guidance between what Afghan immigrant participants referred to as the Afghan way of practicing Islam and other Muslim communities also influenced their disengagement. After being exposed to multiple cultures and faith traditions in Canada, their appraisal of Islam as practiced within their respective communities was unacceptable for them. In particular, the idea of Islam being the superior religion was a significant deterrent. While studies on conceptualizing Islam as a superior religion and the impact it may have on Muslim populations in general, and Afghan immigrants in

particular, are rare in the Canadian context, a study with Pakistani youth in United States show that disagreement with conceptualizing Islam as a superior religion leads to Pakistani immigrant youth believing that they can either be Muslim or American from a cultural point of view, which often translates into placing themselves outside the realm of American cultural citizenship (Ghaffar-Kucher, 2015). In contrast to an appraisal-based approach, other participants found disengagement with religious communities as a useful coping mechanism to deal with traumas associated with religion. Such disengagement helped individuals prevent re-traumatization by reliving painful memories of the past. Freedom of belief in Canada was reported as a significant aid factor, as they could decide to be whom they wanted to be without fear of harmful repercussions as opposed to following a specific set of beliefs enforced by religious authorities in their home society before migration. One participant noted that their reduced engagement with religion was due to lack of access to community resources during their resettlement journey in the post-migration phase. Although lower degrees of community engagement were attributed to discriminatory attitudes of the larger Sunni sectarian group towards other smaller Shia and Sufi sectarian groups, it had a negative effect on engagement with religious beliefs on a personal level too. Changes in ideological perspectives also contributed to lower and, at times, total disengagement with religion in the form of religious skepticism and atheism. One participant who developed skeptical viewpoints of religion after exposure to differing cultural, religious, ideological, and philosophical standpoints that were largely inaccessible to the participant in the pre-migration period led to disengagement with religion.

4.3.3. Change of Belief System in the Post-Migration Phase

Reappraisal of religious belief systems, their role in one's life, and alignment with one's worldview and values further resulted in a belief system change for some participants. This

change was mainly in two forms: a) conversion to other faith traditions aligned with one's value system and worldview, and b) moving away from a formally structured religious system to a self-driven spiritual practice, at times utilizing Islamic scripture (i.e., Quranic verses).

Conversion was either to other faith traditions like Christianity or to spiritual belief systems based on the assumption that the spirit is present in everyone and in everything that Jastrzębski (2023) refers to as new age spirituality. It was the ideal approach for those who found their value systems and worldviews aligned with either a different faith tradition or in spiritual traditions where healing means connecting with universal spiritual energies (i.e., chi in Chinese spiritual traditions, or prana in Sanskrit; Jastrzębski, 2023). However, the conversion also brought with it negative consequences for the individual and their kin and families. Conversion to other faith traditions or leaving Islam, also known as apostasy, is condemned in Islam, and negatively viewed by many Muslims (Saeed, 2017). Alternatively, one Afghan immigrant participant noted that despite disengagement with formal religious practices, she retains the core values of Islam and understanding of the sacred, continuing to believe in Allah as the Creator and relying on him for support at times of distress. The participant who had experienced significant trauma associated with Islam as a religion in childhood and as an adult noted the importance of reciting verses of Quran at times of distress and its calming effects on them, despite her disengagement from Islam as a formal religion. She further noted that she adheres to a self-driven spiritual form of Islam and cherishes her relationship with Allah as the sacred and Creator.

Previous studies with those who identified as Muslim either discuss religiosity and religious practices of Muslims who continue to identify with Islam as their faith tradition or elaborate on the experiences of those who formerly identified as Muslim and went through conversion from being religious to non-religious or converted to a different religion (Aune, 2011;

Maliepaard & Schacht, 2020). Furthermore, previous studies also discuss the levels of religiosity and engagement of different groups (i.e., first- and second-generation immigrants) with religious activities (Brubaker, 2013; Maliepaard et al., 2014). However, there is scarcity of literature on those who find themselves disengaged with religious doctrine yet stay rooted in its conception of the sacred, as seen in the present study. Here again, there is need for further research.

In summary, the emergent theme reflected the potential for change in the attitude of Afghan immigrants towards religion, spirituality, and their understanding of their role in their life. The change of attitude was multidirectional and resulted in a new conceptual understanding of the place of religion and spirituality in the psychotherapeutic process of Afghan immigrants. Through the emergent conceptual understanding, Afghan immigrants may utilize religion and spirituality in three major ways, two of which are studied to some extent with other Muslim populations (i.e., conversion to other religions or adopting a new age spiritual perspective). However, the third conceptual understanding highlights that Afghan immigrants may continue to accept Allah as the sacred but disengage from religious directives and doctrine. Although this aspect of the emergent theme is neither studied in the Afghan immigrant populations, nor in other Muslim immigrant populations, it is relevant for the therapeutic process of Afghan immigrants who may present with such conception of religion or spirituality. Additionally, despite some attempts to investigate the phenomenon of change in religious practice and religiosity of Muslim immigrants in the wake of migration to Western societies carried out in Europe (Aune, 2011; Brubaker, 2013; Maliepaard et al., 2014; Maliepaard & Schacht, 2020), there is a significant rarity of research on the phenomena in North American and more specifically in the Canadian context. Albeit consequential, further investigation to understand the causes, mediating factors, and dimensions of the impact of the change in attitude towards religion and spirituality falls

beyond the scope of the present study. Nonetheless, the need for further exploration of these aspects remains pressing and must be addressed in future studies. In light of its guiding questions, the present study further explored the psychotherapeutic process for Afghan immigrants to better conceptualize the place of religion in that process. The third emergent theme presented in the following section discusses the analysis of the emergent theme and its subthemes.

4.4. Psychotherapeutic Process of Afghan Immigrants

Forced immigrants frequently suffer from anxiety, post-traumatic stress disorder, depression, and other mental health issues (Bambra et al., 2010; Braverman & Gottlieb, 2014; World Health Organization, 2014). After a person has moved to a new country, they may still be affected by the traumatic experiences that led them to make the move or those that occurred while they were migrating to their destination (Chiu, Ganesan, Clark, & Morrow, 2005; O'Mahony, Donnelly, Bouchal, & Este, 2013). In addition to the trauma experienced during the pre-migration and in-transit phases, many people struggle greatly with survivor's guilt once they arrive at host locations (Elshahat & Moffat, 2022; Jahed, 2023). Mental health problems can also be exacerbated by various causes, including exposure to trauma while navigating the asylum system and the legal uncertainty, language and cultural challenges, isolation, and a loss of identity (Allen et al., 2014; Bogic et al., 2015; Bogic et al., 2012; Chen et al., 2017).

The present study participants referenced the features mentioned earlier and other newly emerging categories. While the present research focuses on understanding the role of religion and spirituality in the psychotherapeutic process, it is important to discuss elements associated with the overall mindset of Afghan immigrants toward mental health and the utilization of mental health-related services. This understanding is detrimental to comprehending the position of

religion inside their therapeutic procedures. Previous research has indicated that the Afghan population, including the Afghan diaspora around the world, has a largely unfavourable view of mental health because of a lack of education about the topic (Alemi et al., 2016; Miller et al., 2008; Saxena et al., 2007). Some people have only recently become familiar with the concept of mental health, while others are unfamiliar with the terms describing feelings of despair, anxiety, or isolation in their native languages (Alemi et al., 2014). Some view mental health conditions from a religious standpoint, believing that they are God's punishment (Lavdas et al., 2023). Consequently, people could resort to their religion for the answers they need instead of turning to their family, friends, or even professionals for help when they are going through difficult circumstances (Alemi et al., 2016; Mehrabi, 2002; Wilson et al., 2010).

The present study uncovers similar themes regarding Afghan immigrants' mental health and service utilization attitudes in Canada. The stigma associated with mental health and its adverse impact on the utilization of mental health services is one of the most important aspects highlighted by the participants in the present study. Afghan immigrant participants with mental health problems are less likely to seek help from mental health professionals at the initial stages as a result of stigma, instead turning to their friends, family, doctors, clergy, and other influential people. Additionally, when Afghan immigrant participants seek mental health support from professionals, a lack of awareness, lower levels of familiarity, and a lack of cultural awareness among clinicians and other mental health professionals greatly impede the course of therapy. These factors constituted the third and last emerging theme from the data analysis, in addition to the role of religion in the therapeutic process. Two subthemes of Afghan clients' mental health attitudes and help-seeking patterns describe the role of stigma, lack of awareness, and rarity of culturally competent services. The third and fourth subthemes and their respective categories cast

light on the client and clinician perspectives on the role of religion and spirituality in the therapeutic process of Afghan immigrants. The following section will elaborate on each of these themes and subthemes.

4.4.1. The Attitude of Afghan Immigrants Towards Mental Health

The attitude of Afghan immigrant participants towards mental health is influenced by several factors that can be grouped into deterrents from seeking professional mental health support and factors that hinder the therapeutic process. Deterrents in the present study are mainly linked to the stigma associated with mental health and psychological disorders. Although the stigma is culturally rooted where individuals who express mental health distress are considered weak and lacking in self-esteem, it gains legitimacy from culturally influenced religious interpretation (the concept is discussed as part of the religion as a source of distress subtheme in the previous section). One-way stigmas impact the mental health of Afghan immigrant participants is by lowering their tendency to seek professional help from mental health professionals. Six Afghan immigrant participants reported that their initial reaction to experiencing distress is to keep their experiences and struggles to themselves and find ways to help themselves. Similar attitudes were reportedly observed by clinicians who participated in the study. Self-help strategies vary based on individual preferences and awareness. They may include using religiously rooted practices in isolation to deal with issues, using physical and social means to address distress such as sports or getting married, maintaining close relations with friends and family to deal with the sense of loneliness, and volunteerism to deal with a lack of sense of belonging and survivor's guilt. While these approaches can positively impact their mental health, they do not appear to foster a long-lasting positive impact when mental health distress becomes chronic (Purgato et al., 2021).

Clinicians interviewed for the study noted that many Afghan clients represent their psychologically rooted distress in a somatic form, whereby stress may be presented as headaches or depression may be presented as digestive issues or sleep issues. An explanation for this form of presentation may be rooted in the lack of more befitting words for emotional distress in their native languages and refraining from verbalizing their issues as psychological to avoid perceived judgment from others as being weak (Midgette & González, 2023). Afghan immigrant participants also reported to resort to mental health help-seeking after they exhaust other sources of support like family and close connections, medical professionals, and religious authorities. They reported to seek support from mental health professionals due to referrals from medical professionals, religious authorities, and other influential individuals. In most situations, family members, friends, and close connections were the first source of support, followed by physicians and medical professionals. Clinicians reported that Afghan clients also sought support from religious authorities simultaneously to undergo psychotherapeutic processes. However, the stigma associated with mental health is commonly held in the initial stages of resettlement in the host society; participants of the study noted that many individuals change their perspective towards therapeutic processes after exposure to the dominant Western culture and alternative interpretations of Islam as a religion that is often contrary to culturally influenced interpretations they may have held before migrating to Canada.

Where stigma impacts help-seeking behaviour prior to the arrival of clients to the therapeutic process, lack of awareness and education about Western models of talk-therapy impact the effectiveness of the process for Afghans after they arrive at the clinician's office (Kohlenberger et al., 2019). Afghan immigrant participants reported often being unaware of the nature of the psychotherapeutic relationship and the processes associated with mental health

support from a Western point of view (i.e., counselling or psychotherapy predominantly in talk-therapy form). Clinicians note that the deterring impact of such lack of awareness is exacerbated by significantly lower degrees of cultural responsiveness in clinicians trained predominantly in a Western model of care that emphasizes individuation and the self-directed nature of healing processes. Clinicians further stated that the interplay between lack of awareness and lack of cultural responsiveness often results in clients using therapeutic relationships to merely verbalize their struggles and expect clinicians to direct the process, show them the ‘right way,’ and help them make decisions. Alternatively, many individuals opt for a solution-oriented approach directed at exploring immediate solutions rather than figuring out the root causes of their distress. For many Afghans, culture remains integral to their identity as they undergo resettlement in the post-migration phase (Alemi et al., 2023). Clinicians reported that their Afghan immigrant clients often associated fear of being coerced to assimilate into the dominant culture during the therapeutic process as a significant reason for their hesitance to seek mental health support. For others, hesitance was associated with fear of losing their religious identity and belief system. Contrary to previous representations of attitudes towards help-seeking and mental health, individuals who are marginalized in some form (i.e., gender oppression or religious discrimination) found mental health support and therapeutic relationships as empowering after they overcame the initial challenges of developing a rapport with their clinicians and overcoming the cultural gap between the client and clinician. Regardless of initial attitude towards psychotherapy, individuals who engaged in the process as clients, individuals who reflected on potentially seeking mental health support, and clinicians who worked with Afghan clients noted the importance of religion and spirituality in the lives of Afghan

immigrants. Afghan immigrant participants and clinicians shared insights on religion's role in the therapeutic process. Each perspective is detailed in the following subthemes.

4.4.2. Role of Religion and Spirituality in Therapeutic Process – Client Perspective

As stated previously, participants noted a desire to discuss religious or spiritual issues in their therapy, and some also indicated that religion and spirituality are of essential importance to their healing and growth. In this study, Afghan immigrant participants classified religion as an institution or group with laws, traditions, and leaders, whereas spirituality was a personal connection with a power beyond the self, a Sacred, a God or divine, creativity, or good in the world. Participants who discussed their perspectives on the significance of religion and spirituality in treatment either participated in religious or spiritual activities on a regular basis or occasionally practised their faith. The majority of Afghan immigrant participants in this study fell into the first category. A subset of participants reported being at odds with their religious communities but noted that they practice a self-directed version of their religiously ingrained spiritual views, whereas others reported having abandoned religion. Although non-religious participants did not engage in religious practices on a daily basis, religion played a significant role in their lives through interactions with family and community members, and for some, it was also associated with their distress. Afghan immigrant participants also emphasized turning to their religion and spirituality when they experience mental health issues and utilizing their faith or spiritual practice to contend with life's stresses. They viewed religion and spirituality as essential components in secular or religious contexts and desired to discuss religious and spiritual issues as part of the therapeutic relationship. Clinicians reported that their Afghan clients who self-identified as very religious discovered that therapies incorporating spirituality and religion were particularly significant to their growth in the therapeutic process. This was

reportedly owing to the fear of discrimination by others in the dominant culture for their religious beliefs, whereas a therapeutic relationship was reported as a safe, non-judgmental place for such discussions. In addition, clinicians noted that their client's perceptions of the appropriateness of religious and spiritual interventions were associated with the quality of the therapeutic relationship established with their mental health practitioner and the practitioner's willingness to integrate religion and spirituality into the therapeutic process.

Analysis of the data shows that client perspectives on the role of religion and spirituality in the therapeutic process is bi-directional in this study, where clients initially focus on the importance of religion and spirituality in their therapeutic process and their expectations of their practitioners. On the other hand, openness of practitioners to discussions on religion and spirituality and the way clients may assess and engage with their practitioners regarding religion and spirituality is also integral to effectiveness of the process. The following section details different aspects of the two subthemes.

A. Inclusion of Religion and Spirituality in Therapeutic Process. Afghan immigrant participants and clinicians, regardless of their personal preference for religion, spirituality, or neither, deemed it necessary to integrate religion, spirituality, and culture into the therapeutic process. Clinicians reported that many individuals identified religion and spirituality as potent sources of meaning and purpose. This is despite the fact that for some participants, religion did not play a significant role in their lives. At the time of data collection, all Afghan immigrant participants stated having engaged with religion in the past. In the aftermath of post-migration religious disengagement, spiritual values assist many Afghan immigrant participants in making meaning of their life's purpose (role of religion in meaning making is discussed in detail in previous section). Religion and spirituality were therefore found to be essential to their

therapeutic processes, either as sources of strength, as the foundation for finding meaning in life, as instrumental in promoting healing and well-being, or as factors central to their struggles and distress that require unpacking within the context of therapy, where clinicians can help patients gain insight into the ways their core beliefs and values are influenced by their belief systems.

Afghan immigrant participants also found religion and spirituality to be a valuable aid to the therapeutic process with the potential to influence the process from start to finish. Four Afghan immigrant participants who had received psychotherapy noted that working with a practitioner who shares religious, spiritual, and cultural similarities helps them greatly in establishing a trusting relationship with their practitioners. This element becomes even more important when the stigma towards mental health held by many members of the Afghan community is considered (for more details, refer to the subtheme on stigma towards mental health; Alemi et al., 2023). Additionally, Afghan immigrant participants with exposure to psychotherapeutic processes also found shared experiences of religion and spirituality helpful in fostering meaningful progress, as cultural awareness of the practitioner eliminates the need or, at times, the expectation of educating the practitioner on the client's cultural or religious values and they can focus on more nuanced aspects of religion and spirituality's impact on them.

Clinicians interviewed in the study found religion as a grounding element that is more accessible to their clients at times of distress and significantly impacts self-regulation. While therapeutic insights gained in the therapy process were reported as useful, clinicians noted that religion and spirituality usually stayed with their clients beyond the therapy room and therapeutic relationship; thus, combining the two positively influenced the healing process. Gathering information about the client's religion, spirituality, and culture in a non-judgemental, accepting, and respectful manner is essential to gaining a holistic understanding of the client and a more

nuanced conceptualization of the client's presenting issues on the part of the clinician, but also for clients as they experience a welcoming environment and feel empowered to bring all aspects of their self to therapy, as opposed to leaving their religious and spiritual side behind (Hodge, 2013).

Clinicians further reflected on the potential of secular therapeutic approaches and interventions in dealing with religiously rooted issues in the context of secular therapy. For example, this could include the use of narrative therapy interventions when the client presents issues with God that may be rooted in their understanding of the divine and their worldviews, or the use of attachment therapy interventions when clients present with attachment issues with God. Similarly, religiously driven processes or techniques may be useful in secular therapeutic modalities to help the client achieve better results. For example, Religion-Adapted Cognitive Behavioral Therapy (de Abreu Costa & Moreira-Almeida, 2021) uses the client's religious beliefs, values, teachings, and practices to resolve mental health issues.

Clinicians noted that including religion and spirituality in the therapeutic process also plays an important and empowering role with clients who may have gone through oppressive experiences associated with religion and its misinterpretations to subjugate women and other marginalized populations. For example, clinicians noted that they were consulted when distinguishing healthy religiosity from unhealthy religiosity, identifying oppressive practices that may be influenced by culture and justified by misinterpretation of religion. Additionally, clinicians noted that being able to openly discuss abusive experiences in the context of their religion in a non-judgmental and accepting environment can be empowering in its own right. Nonetheless, Afghan immigrant participants noted hesitance in discussing issues related to religion and spirituality without having a fairly good sense of their clinician's attitude towards

religion and spirituality and their openness to including religion and spirituality in the therapeutic context. They noted the importance of testing clinicians' openness and awareness of their religious, spiritual, and cultural views, and these two aspects are discussed next.

B. Clinician Openness to Inclusion of Religion and Spirituality in Therapy. Afghan immigrant participants noted the feeling of needing to know if their therapist is open and sensitive to the inclusion of religion and spirituality in the therapeutic process. Discussion of religious and spiritual issues can be immensely helpful to the healing process, yet perceived negative responses of practitioners can potentially put the therapy relationship at risk (Pargament, 2013). Therefore, the effectiveness of a clinician's attempt at integrating spirituality into therapy has significant implications for client engagement and may be affected by a range of factors that we are only beginning to identify (Pargament, 2007).

Afghan immigrant participants reported that their therapists were either not open to or unappreciative of the place of religion and spirituality in their clients' lives and therapy, which negatively impacted their therapeutic relationship, as even amidst what seems to be a secular therapeutic conversation, religious and spiritual content may emerge for discussion. They noted testing practitioners if they would impose their own values and perspectives on the client on minor issues before opening up about their more serious religiously rooted issues. They further noted that they assessed if their therapist would accept the client's feelings regarding their religion and spirituality and be open to working with that instead of redirecting their religious experiences to other psychological processes. Afghan immigrant participants also stated that therapists attempting to reduce the hierarchy in the therapy relationship by being more open with clients and sharing their perspective on religion was a positive indicator of clinician openness and aided in the empowerment of clients to discuss their religious issues. They further noted that

they usually ensure that the clinician remains open and non-judgmental and recognizes that there are multiple ways of addressing religious and spiritual needs other than purely secular therapeutic approaches.

4.4.3. Role of Religion and Spirituality in Therapeutic Process – Clinician Perspective

The second subtheme relating to the role of religion and spirituality in the psychotherapeutic process of Afghan immigrants is focused on clinician perspectives. While Afghan immigrant participants found integrating religion into their therapeutic process essential, clinicians interviewed for the study had different responses. All five clinicians interviewed for the study found it beneficial to integrate the religion and spirituality of Afghan clients into the therapeutic process, and many noted that client-presenting issues could, in many instances, be linked to their religious belief systems or their cultural dynamics, which are often mixed with their religious beliefs and practices. However, when elaborating on their clinical practice, there appeared to be a dominant subtheme of hesitancy. Clinicians' hesitancy in engaging with religion and spirituality can be explained by major code categories highlighting their limited capacity to deal with religious issues, unconscious diversion from religion to other psychological constructs, and limited engagement with their religious and spiritual perspectives. Each of these major code categories will be discussed in the subsequent section. Regardless of the apparent ambivalence, when asked about their perspective on the effective integration of religion and spirituality into the therapeutic process, clinicians highlighted the need for cultural humility, safe and effective use of self, and engaging through a number of inclusive approaches like religiously integrative secular approaches, approached with mixed methods of secular therapy and conventional religiously driven counselling methods and Islamic psychotherapy.

A. Clinician Ambivalence Towards Religion and Spirituality. Clinician ambivalence towards the integration of religion and spirituality in the therapeutic process is rooted in multiple factors explored in the literature review section (Adams et al., 2015; Cashwell & Young, 2004; Chiang et al., 2020; Dobmeier & Reiner, 2012; Hage et al., 2006; Moffatt & Oxhandler, 2018; Plum, 2011; Post & Wade, 2009; Walker et al., 2004; Whitley, 2012; Young et al., 2002; Young et al., 2007). Mental health professionals have tended to ignore or pathologize the religious and spiritual dimensions of life, partly as a consequence of their own personal belief systems or the predominantly monocultural orientation of educational institutions (Hodge, 2013). Psychology professionals also tend to embrace scientism as a principle ideological position, considering religion and spirituality inconsistent with the study of mind and mental health (Hodge, 2013; Worthington et al., 1996; Worthington et al., 2013). However, clinicians interviewed for this study did not subscribe to these ideological or intellectual perspectives. Nonetheless, a majority of them showed hesitance in the robust integration of religion and spirituality into the therapeutic process and their therapeutic interventions. While all clinicians interviewed for the present study identified themselves as culturally responsive, most of them expressed an apparent ambivalent response to their clients' active integration of religion and spirituality into the process. In the context of this study, participants defined culturally responsive as the ability to understand cultural differences, recognize potential biases, and look beyond differences to work productively with clients whose cultural contexts are different from that of the clinician.

Considering the above definition, responsiveness to religious and spiritual beliefs falls under the umbrella of cultural responsiveness, as an individual's beliefs, values, attitudes, and conventions are largely infused by their religious and spiritual belief systems and practices. These subsequently determine the client's psychological and existential frameworks and play a

key role in determining behavioural variables with a direct bearing on mental health. Analysis of participants' approach towards integrating religion and spirituality in their professional practice sheds light on some key factors that impact the above-mentioned disconnect between the perceived cultural responsiveness of clinicians and the experienced lack of responsiveness to their client's religious and spiritual needs.

Clinicians noted not engaging with religion and spirituality in therapeutic relationships for a myriad of reasons that can be grouped into two main professional self-assessments by professionals: a) Not having adequate expertise in the religious and spiritual domains of their clients to assist clients with their religious and spiritual concerns, and b) Favouring purely secular approaches as opposed to a mixed method approach that integrates religion and spirituality. Although two clinicians noted that the reason for not integrating religion and spirituality for them was unconscious, they noted that what is labelled as unconscious may also stem from not having expertise and favouring purely secular approaches. Consequently, the lack of interest shown by clinicians often results in disengagement or reduced interest of their clients to explore their religious or spiritual selves in the therapeutic context. Many clients conclude that their practitioner is not open to accepting their religious or spiritual selves in therapy (Hodge, 2013; Pargament, 2007). Additionally, a lack of attention to the client's religion and spirituality may result in limited and non-culturally responsive case conceptualization (Hodge, 2013). Such case conceptualization may not only hinder the therapeutic process but also lead to misdiagnoses and, at times, reinforces negative impacts of negative elements of religion and spirituality.

Alternatively, three clinicians reported some engagement with the client's religion and spirituality; however, they also refrained from actively integrating it into the process, which arguably did not allow clients to feel empowered enough to bring their whole selves into the

therapeutic relationship. Clinicians who sought some information at the intake stage or initial information-gathering sessions noted that religiously or spiritually oriented information shared by clients was usually understood through a psychological perspective, equating it to psychological phenomena. By comparison, two clinicians who did not gather information found it challenging to work with clients' religion or spirituality and associated issues, which usually led to either disengagement with related concerns in the therapeutic process or deliberately shifting focus from religion or spirituality issues to other issues. Clinicians also reported experiencing a sense of incompetence and a lack of preparedness from an educational point of view to engage with religion and spirituality in the therapeutic context.

Ambivalent attitudes in these situations, although comparatively more inclusive, do not address the core issue of active integration, resulting in inadvertently pushing clients to let go of their religious or spiritual selves (Adams, 2012, 2015; Worthington et al., 2013). Some clients may also be pushed to accept the abusive environment around them, and this may strengthen the stigma present for many around psychotherapy and help-seeking for their mental health.

B. Cultural Humility. Clinicians identified multicultural competencies as an important aspect of working with culturally diverse clientele, especially when considering the client's religion and spirituality in the therapeutic process. In the context of this study, participants defined multicultural competencies as a combination of knowledge, skills, and awareness therapists need to navigate cultural, religious, and spiritual interactions, topics, and issues in therapeutic relationships. Although clinicians highlighted the importance of multicultural competencies, they identified limitations for clinicians to get educated on these competencies and put them into practice using practical therapeutic strategies and interventions. Clinicians further emphasized a cultural way of being with a client that values diversity, recognizes the

clinician's own cultural and religious or spiritual perspective, and acknowledges that multiple valid cultural, religious, and spiritual lenses exist through which to view the world. Clinicians referenced the concept of 'Cultural humility' as part of a therapist's multicultural competency and noted that being culturally humble can help facilitate a strong working alliance with clients across diverse cultural and religious backgrounds. Clinicians also noted the importance of self-reflection when working with clients' religious and spiritual issues in the clinical setting. Self-reflection was defined as the examination of and attention to the clinician's own ideas, thoughts, and feelings.

Clinicians noted that like the clients, their upbringing and personal experiences also inform their actions, values, beliefs, and assumptions and shape their perceptions and expectations of others, including their clients. Clinicians emphasized the examination of ideas, thoughts, and feelings they may have internalized and how they may relate to engaging with diverse populations, both in and outside the therapy room or therapeutic relationship. Taking time to self-reflect can help clinicians identify the way they perceive differences, understand how their worldview may shape their perspective about other people's worldviews, make sense of their own belief systems or lack thereof, and consequently understand themselves better (Davis et al., 2010; Hook et al., 2013). When clinicians judge situations, make decisions, and solve problems, they routinely use cognitive shortcuts and internalized knowledge based on their experiences, exchanges with colleagues, reading information, and hearing from opinion leaders, patients, scholars, and so on (Owen et al., 2016, 2017; Wampold & Imel, 2015). Studies with clinicians note that these mental shortcuts could assist them in processing large amounts of information in a short time and are an important tool for experienced clinicians in their case conceptualization. However, they also noted that these shortcuts may also appear as biases in the

therapeutic process (Breuninger et al., 2014). Clinicians interviewed for the study referred to this phenomenon as ‘therapist bias,’ ‘counsellor bias,’ or clinician’s bias.’ They highlighted multiple forms of biases related to practitioners, each identified as an important aspect to account for by clinicians. Some clinicians noted that, at times, they might judge therapeutically intervening in religious and spiritual issues in a therapeutic context as harmful and decide not to intervene under the principle of ‘do no harm.’ Others noted a somewhat closely related bias where clinicians maintain the stable status quo before presenting religious and spiritual issues due to assumptions regarding potential ruptures in therapeutic alliance and discomfort.

All clinicians interviewed for the study emphasized awareness of self in order to prevent such biases from occurring in the therapeutic relationship, but also highlighted the need for continuously engaging with clients in a curious manner to learn more about their religious and spiritual perspectives. Cultural curiosity, as a desire to learn and understand more about people whose cultural backgrounds, experiences, and perspectives are different from one’s own, was noted as the main source of learning by clinicians. Clinicians noted that this process might involve learning facts about the client’s cultural heritage or understanding how the client thinks, feels, or behaves in light of their cultural and religious background. Cultural curiosity aims to develop an appreciation for different cultures and people from those cultures (Adams et al., 2015; Post & Wade, 2009). Clinicians noted that understanding the client’s culture and religion can help them better empathize with them, which might create a more comfortable working relationship.

C. Safe and Effective Use of Self. Therapies share ‘common factors,’ which include the degree to which the therapist is supportive, empathetic, and validating (Cuijpers et al., 2019). Some approaches are more directive, while maintaining a strong emphasis on the therapeutic

interaction, while others are more exploratory, focusing on gaining insight, recognizing how developmental patterns repeat, and employing this awareness to alter contemporary patterns (Nahum et al., 2019). Clinicians pointed out that the quality of the interaction between client and practitioner is linked to therapeutic efficacy regardless of therapy style. Understanding how practitioners utilize ‘the self’ requires delving into the specifics of individual experiences, identifying reoccurring themes, and classifying these themes into organizing categories that can assist clinicians in forming a more meaningful therapeutic alliance.

D. Inclusive Therapeutic Approaches. Culturally and religiously responsive care was identified as the intentional and consistent decisions mental health care providers make to see, respect, and celebrate the aspects that make each person unique. It was recognized as the acknowledgment of an intersectional existence of clients in the world and how these intersections shape their experiences. Intersectionality in this context considers the simultaneous and mutually constitutive effects of the multiple social categories of identity, difference, and disadvantage that individuals inhabit (Viruell-Fuentes et al., 2012). Clinicians emphasized the use of culturally and religiously adapted therapeutic modalities whenever possible. Although not very common and less researched, these modalities were reported as highly effective. An example of these modalities include adapted therapy for Muslim clients that are based on behavioural activation, and an existing evidence-based psychosocial treatment for depression. Another example is religiously adapted cognitive behaviour therapy to work with clients from collectivistic cultures (Heim, 2019; Naeem, 2019; Rathod, 2019).

Some clinicians also denoted the effectiveness of collaborative work with like-minded religious scholars and spiritual leaders when working on a mix of clients’ psychological and religious or spiritual issues. However, clinicians emphasized the nature of the collaborative

practice, where clinicians were encouraged to establish value-laden professional relationships with religious scholars and spiritual leaders when working with clients from a collaborative perspective. A prominent model of such approach is proposed by Breuninger and colleagues (2014), which allows the client's religion and spirituality to be utilized for positively influencing therapy (see literature review section for more details). Clinicians also pointed out the effectiveness of Islamic Psychotherapy with highly religious clients who may find a therapeutic modality rooted in the Islamic belief system more effective in their healing process. Islamic Psychotherapy was defined as a therapeutic modality that is deeply rooted in the idea that belief in the Islamic context has a profound impact on the psychological and emotional well-being of individuals and that this well-being lies in the interplay between nafs (ego), qalb (heart), and aqal (mind; Rothman & Coyle, 2021). Table four illustrates themes, sub-themes, and major code categories in a summarized format.

Table 4. *Summary of themes, sub-themes, and code categories.*

| Theme 1 | Role of religion and spirituality in the lives of Afghan immigrants |
|------------------|---|
| Subtheme 1.1 | Religion and spirituality as a source of distress: |
| Major categories | <ul style="list-style-type: none"> • Convergent and divergent aspects of religion and culture • Intolerance within religion as a source of distress • Association of traumatic experiences and discrimination with religion • Misuse of religion as a justification for maladaptive psychological mechanisms • Acculturation and religious identities of children growing up in Canada |
| Subtheme 1.2 | Religion and spirituality as a source of support: |
| Major categories | <ul style="list-style-type: none"> • Religion and spirituality as a coping mechanism • Religious and spiritual community as a source of support • Religion and spirituality as a meaning-making mechanism • Religion and spirituality as a key contributor to resiliency |

| | |
|------------------|---|
| Subtheme 1.3 | Changing attitudes of participants towards religion and spirituality |
| Major categories | <ul style="list-style-type: none"> • Increase in religious and spiritual practices in the post-migration phase • Decrease in religious and spiritual practices in post-migration phase • Change of belief system in the post-migration phase |
| Theme 2 | Psychotherapeutic process of Afghan immigrants |
| Subtheme 2.1 | Attitudes of Afghan immigrants toward mental health |
| Subtheme 2.2 | Role of religion and spirituality in the therapeutic process – client perspective |
| Major categories | <ul style="list-style-type: none"> • Inclusion of religion and spirituality in the therapeutic process • Clinician openness to inclusion of religion and spirituality in therapy |
| Subtheme 2.3 | Role of religion and spirituality in the therapeutic process – clinician perspective |
| Major categories | <ul style="list-style-type: none"> • Clinician ambivalence towards religion and spirituality • Cultural humility • Safe and effective use of self • Inclusive therapeutic approaches |

4.5. Discussion of Analytical Outcomes

Thus far, analysis of the emerging themes, subthemes, and major code categories show that integrating religion and spirituality is an important element of the psychotherapeutic process of Afghan Immigrants. The data leads to two major analytical positions: a) religion and spirituality play a central, multidimensional, and multidirectional role in the lives of Afghan immigrants; and b) Afghan immigrants seeking therapy and clinicians who work with Afghan immigrants identify integration of religion and spirituality in the therapeutic process of Afghan immigrants as essential yet a challenging task. Their relationship is described in the following paragraphs for clarity of discussion and understanding of the interplay between analytical outcomes.

The previously discussed theme of the role of religion and spirituality in the life of Afghan immigrants highlights that religion is always present in their lives and can impact them in three different ways. Religion and spirituality can either be a source of support for Afghan immigrants or a source of distress. Each direction of effect is discussed in section 4.2 on the role of religion and spirituality in the lives of Afghan immigrants. A change of attitude is the third way lives of Afghan immigrants can be affected by religion and spirituality. Such change and its impacts are discussed in section 4.3 on changing attitudes towards religion and spirituality. How clients' lives are impacted by religion and spirituality can be related to their therapeutic processes directly or indirectly. Consequently, it becomes essential for mental health practitioners who work with Afghan clients to fully understand the multidimensional and multidirectional nature of religion and be able to work with clients' religiosity and spirituality in the clinical setting (i.e., therapy rooms or social work settings).

Analysis of data gathered through the present research as noted in section 4.2 shows that religion and spirituality showing up as a source of distress is often intertwined with the client's culture and intolerant interpretations of Islam. Participants noted that they often find it hard to discern the extent to which their distress may be related to their religiosity or spirituality, their culture, or the intolerant interpretations of religion. Analysis further noted that clinicians are often considered the experts and expected to help clients ascertain the direction of effect. Clients with oppressive experiences also expect clinicians to empower them and assist them in turning their lives around. Additionally, the interplay of religion and culture as discussed in section 4.2.1 may also show in relational dynamics in the therapeutic context, where parents express concerns about their children and challenges they may experience as parents in passing on their religious and cultural values systems to their children who, on their part, are exposed to a myriad of

ideological and religious perspectives in the Canadian society. A clinician's openness to the integration of the client's religious and spiritual belief systems may strengthen the alliance and increase the impact of common therapeutic factors on the healing process (Alemi et al., 2016; Khan et al., 2018; Koenig et al., 2012; Rosenberg et al., 2022). Alternatively, clinicians' ambivalence towards religion and spirituality, or their disapproval of them, may negatively impact the alliance and have an adverse effect on the therapeutic process (Chiang et al., 2020; Moffatt & Oxhandler, 2018). Such adverse effects may also inadvertently contribute to the stigma associated with mental health and help-seeking to address mental health-related issues within marginalized communities.

Religion and spirituality are often seen as a source of support by clients (Pargament et al., 2013). Clients may use religion as a coping mechanism to deal with the challenges of resettlement and post-migration stressors (Allen et al., 2014; Bogic et al., 2015; Bogic et al., 2012). They may also use religion and spirituality to deal with traumas and psychological issues rooted in their pre-migration and in-transit experiences (O'Mahony, et al., 2013). Utilization of such a vital resource that clients are familiar with is arguably the most important tool for clinicians and mental health practitioners to rely upon as they work with clients in an unfamiliar and new environment. On the flip side, underutilization of this resource may not only result in a less effective therapeutic process but may also make the integration process of newcomers and immigrants significantly challenging, pushing them to make new meaning structures and adopt unfamiliar value systems that may be at odds with their existing value systems. Religion and spirituality may also have a supportive role in the client's life as a meaning-making mechanism and contributor to the client's resilience. Sections 2.7, 2.8 and 2.9 of the literature review chapter discuss the effectiveness of a religiously integrative therapeutic approach in detail.

Additionally, as outlined by analysis of data through the present research in sections 4.2 and 4.4, clients may be able to access community support because of their religious identities and beliefs. Although noted aspects mainly take effect outside the therapeutic relationship, they may still positively impact the healing process. More importantly, understanding how religion and spirituality play a central role in clients' meaning-making mechanisms and their interaction with the environment must be an essential part of the clinician's conceptual framework when working with immigrants (Alemi et al., 2014; Pargament et al., 2013).

Attitudes of clients towards religion and spirituality are not limited to positive direction of effect (i.e., a source of support) and negative direction of effect (i.e., a source of distress). For many clients, exposure to different ideological positions, conflicting worldviews, and freedom to practice religion and spirituality based on personal preferences poses challenging questions that may have been too threatening to entertain in their pre-migration phase. In other words, when immigrants experience the freedom of religion in the Canadian context while trying to make sense of their traumatic experiences under oppressive authoritarian regimes, there is often either a decrease in their religiosity or a shift from being bound to a formal religion to a self-directed spiritual value system. Section 4.3.3 discusses the way participants of the present study experienced a change in their belief system as they became free of reportedly threatening environments. In addition to the value such a change brings to therapeutic case conceptualization, the shift in religious and spiritual perspectives often brings challenges in the therapy room. In the absence of an integrative approach, clients may fall victim to maladaptive therapeutic interventions (Davis et al., 2010; Hook et al., 2013). An integrative approach is also important to ensure that clients can experience a sense of acceptance by their practitioner. As discussed in section 2.8 of the literature review, fostering this sense of safety and acceptance is

essential for clients as they often rely on their assessment of how open their practitioners are towards religious and spiritual issues before fully opening up in therapeutic relationships.

While the essential role of religion and spirituality in therapeutic relationships is understood by clients as well as mental health practitioners, there remains the challenge of competency and ambivalence on the part of clinicians and the lack of an integrative model that considers the multidimensional and multidirectional elements of integrating religion and spirituality in therapeutic processes (Adams, 2012; Adams et al., 2015; Post & Wade, 2009). Clinicians also highlight the importance of cultural humility in their practice with immigrants and the need to continuously be open to learning, keep their biases in check, and adopt culturally responsive therapeutic interventions (Davis et al., 2010; Hook et al., 2013). They further emphasize the role of safe and effective use of self and self-evaluation in dealing with different cultures, religious and spiritual beliefs, and values systems (Owen et al., 2017). The interplay of the two value systems also leads to the emergence of an integrative model that can respond to the challenges highlighted above and guide practitioners on the path of integrating religion and spirituality throughout the therapeutic process from start to finish, inclusive of the preparation stage for clinicians that comes before the formal commencement of therapy with clients.

The emergent model discussed in the following section lays out a practical multidimensional approach to integrating religion and spirituality into the therapeutic process at different stages on different levels and intensities, guiding clinicians to overcome ambivalence towards religion and spirituality in a therapeutic context and engage with client religion and spirituality throughout the therapeutic process.

4.6. Emergent Model of the Place of Religion in Psychotherapeutic Process

Rooted in the humanistic paradigm of psychology, this emergent model seeks to place religion and spirituality across different stages of the psychotherapeutic process for Afghan immigrants. But given the commonalities of their experiences and worldviews with other Muslim immigrants on one hand (Moghissi & Goodman, 2009; Simich et al., 2003) and rootedness of the emergent model in Pargament's (1997) theory of religious coping on the other hand (discussed in section 2.13 of chapter two), the emergent model can be used with other Muslim immigrant communities as well. The emergent model in light of the humanist paradigm of psychology harmonizes the essential human values of self-discovery, self-actualization, and personal growth with religious and spiritual experiences that the client may bring to the therapeutic process (Gold, 2013).

The humanistic paradigm, with its emphasis on the innate goodness and potential for growth within individuals, aligns remarkably well with the core tenets of Islam. The emergent model, while building on the core tenets of humanistic paradigm like human capacity for self-actualization, self-direction, and choice (Hoffman et al., 2014; Miller et al., 2014; Tudor, 2015), takes a social constructivist perspective with the assumption that, although reality exists, truth or anyone's perception of the truth about reality is relative and rooted in the multilayered context of an individual (Jones-Smith, 2019). This context includes history, culture, religion, relationships, language, and the natural world (Fleuridas & Krafcik, 2019). As Muslim immigrants confront the challenges of acculturation, the interplay between their spirituality and psychological well-being becomes an intricate tapestry that must be woven into the therapeutic fabric (see sections 2.1, 2.2, 2.3 and 2.9 of chapter two). The emergent model enables the practitioner to acknowledge that spirituality is not only an intrinsic aspect of the human experience but also an influential

force in shaping identity, meaning-making, and coping strategies. This in turn helps the clinician to take practical steps in the integration of clients' religious and spiritual beliefs into their therapeutic process. This emergent model recognizes that the spiritual dimension cannot be isolated from other aspects of an individual's life. The humanistic perspective in conjunction with social constructivist perspective emphasizes the holistic nature of human beings and encourages therapists to understand and respect the various facets that contribute to an individual's sense of self (Fleuridas & Krafcik, 2019). By embracing this holistic view, the emergent model acknowledges that spiritual beliefs and practices of the client and the therapist are interwoven with their cultural identity, interpersonal dynamics, and personal aspirations.

By grounding the emergent model in the humanistic and social constructivist paradigms, the author aims to provide a nuanced framework for mental health professionals and therapists working with Muslim immigrants. As practitioners navigate the intricacies of spirituality within the context of psychotherapy, it is imperative to foster a therapeutic environment that not only acknowledges the uniqueness of each individual but also empowers them to integrate their spiritual beliefs into their psychological healing journey (Pargament, 2011). Ultimately, this emergent model stands as a testament to the enduring power of humanism and the capacity of the social constructivist approach to unite diverse elements of the human experience in a manner that promotes growth, resilience, and well-being.

Considering the challenges in fostering an integrative approach in psychotherapy discussed in section 2.9. of chapter two, the emergent model is positioned in three environments: a) the therapist outside the therapy room, b) the therapist and client inside the therapy room, and c) the client outside the therapy room. The therapist outside the therapy room delves into dimensions that can address the key challenge of competency and education that often occurs

outside the therapy room and are considered the responsibility of practitioners as part of their continuing education efforts (Cleary et al., 2011; Dezorzi et al., 2019; Oxhandler et al., 2019; Moffatt et al., 2021). The therapist and client inside the therapy room outlines steps to integrate religion and spirituality while working with the client. The client outside the therapy room takes into account the practitioner's role and ethical responsibilities to support clients in addressing their issues through referrals when the practitioners are unable to support them (Gladding et al., 2019; Moore et al., 2013). Although each of the three environments has its unique features, characteristics, and operating assumptions with a significant impact on the therapeutic process, they are all connected by the shared goal of providing therapy to the client to facilitate the healing process, enable the client to have a corrective emotional experience and undergo positive change, improve social functioning, and increase satisfaction with the overall quality of their life.

The relationship of mental health professionals with psychotherapy is not limited to therapy rooms, where they actively engage with their clients. Professional work on their therapeutic skills and professional development and professional relationship building outside the therapy room are both essential (Delphin et al., 2008; Mlambo et al., 2021). These activities directly impact the effectiveness of their work inside the therapy room. On the other hand, clients also have a life outside the therapy room and bring selected parts of their life to therapy. While it is essential for clients to feel their whole self is welcome in the therapeutic context, it is also true that they prioritize between issues that may occupy more space in their therapeutic journey. As a result, there may be instances where the therapist they are working with is a good fit (LeJeune & Luoma, 2019). There may also be instances where the therapist is not a good fit, and the client is faced with the decision of exploring other options. In some instances, the client and therapist can mutually decide if the therapist is a good fit or not. In such instances, clients may wish to explore

other options either independently or using therapist recommendations (Swift et al., 2022). However, the most significant work takes place between therapist and client inside the therapy room, where the alliance between the client, as the authority in their life experiences, and the therapist, as the expert on mental health and psychology, collaborate and establish a meaningful relationship. Such a therapeutic relationship is then used to overcome the client's presenting issues, enhance their ability to cope, improve sound decision-making, and help the client live a happier, healthier, and more productive life (LeJeune & Luoma, 2019).

As discussed extensively in previous sections (literature review, analysis, and discussion of findings), religion and spirituality play a central role in the life of Afghan immigrants and therefore are integral to their therapeutic processes. Accordingly, the emergent model places religion and spirituality across all three environments of the therapeutic process and proposes a practical path for the integration of religion and spirituality into the psychotherapeutic process of Afghan immigrants.

The following section discusses the positionality of religion and spirituality mentioned three environments: a) the therapist outside the therapy room, b) the therapist and client inside the therapy room, and c) the client outside the therapy room. This discussion is followed by a diagrammatic illustration of the emergent model for ease of understanding.

4.6.1. Therapist Outside Therapy Room

Therapists and mental health professionals must interact with religion and spirituality outside the therapy room on three major fronts: i) self-education, ii) expanding theoretical orientations, and iii) professional relationship building.

A. Self-Education. A growing body of research has highlighted mental health professionals' lack of familiarity, expertise, and confidence with the integration of religion and

spirituality in the therapeutic process (Adams et al., 2015; Cashwell & Young, 2004; Chiang et al., 2020; Dobmeier & Reiner, 2012; Hage et al., 2006; Moffatt & Oxhandler, 2018; Plum, 2011; Post & Wade, 2009; Walker et al., 2004; Walker et al., 2004; Young et al., 2007; Young et al., 2002). It is particularly challenging because unfamiliarity may impact non-Western clients more than Western ones (Flynn et al, 2020). As noted in section 2.9.1 of chapter two, training programs in clinical psychology, psychotherapy, counsellor education, social work, and psychiatry provide minimal education in working with clients' religions and spirituality in the therapeutic context. While an overall push for reform in training programs is unavoidable, self-education and professional development efforts can address the lack of formal education for therapists and mental health professionals in practice. By incorporating readings, lectures, and discussions on religion and spirituality into continuing education efforts, and professional development programs, practitioners can address the educational gap and develop professional skills, directly impacting the effectiveness of the therapeutic process (Adams, 2012, 2015; Baggs et al., 2011; Dobmeier & Reiner, 2012; Robertson, 2010; Souza, 2002). Clinical supervisors can also help practitioners and supervisees develop competencies to work more effectively with their clients' religious and spiritual issues (Tsui; 2014). Supervision can especially be effective by attending to observable religious and spiritual content in therapy sessions, how supervisees contextually view the religion and spirituality of their clients, and the way supervisees contextually view their own religion and spirituality (Captari et al., 2022; Polanski, 2003; Ross, 2014). Professional organizations can also increase awareness and education in this area by sponsoring pre-conference workshops and conference presentations on religion and spirituality (ASERVIC, n.d.). Authors and editors of religion and spirituality texts must broach this topic in addition to other multicultural issues. Another significant area of self-education is self-education

on culturally adapted treatment modalities. Culturally adapted treatments involve a systematic approach to modifying a treatment to align it with the client's cultural values (Griner & Smith, 2006). These treatment modalities maintain the core principles and techniques of the therapeutic orientation (e.g., conceptualizing the presenting problem from a cognitive-behavioural model) but focus on adapting the specific way in which the treatment is carried out (Breuninger et al., 2014; Harris, 2000; Mahrer, 1996; Propst, 1996; Shafranske, 2004; Steinfeld, 2000; Trautmann, 2003; Watts, 2000; West, 2004).

B. Expanding Theoretical Orientation. Mental health professionals must also expand their theoretical orientations and explore perspectives outside the dominant Western model of care. Professionals can use the faith traditions that they are most familiar with as their starting point and develop a universal framework of engaging with religion and spirituality in their theoretical orientations (Jastrzbski, 2023).

Although theoretical orientations to religion and spirituality are mostly based on an existential approach to counselling, they incorporate unique features of different faith traditions as well as spiritual but nonreligious traditions (Slater et al., 2001; Duggal & Sriram, 2022; Captari et al., 2022). As highlighted in literature review sections 2.8 and 2.9, professionals must attempt to understand the diversity and fragmentation of contemporary ways of understanding spirituality and religion from a theoretical perspective. Practitioners need to further expand their theoretical foundations to understand and conceptualize religion and spirituality and related topics. An essential aspect of expanding theoretical orientations is to explore different approaches to bridge knowledge that comes from spirituality, psychology, sociology, philosophy, and theology in light of historical and methodological backdrops (Pargament et al., 2013).

Recent developments in research on multicultural orientation towards mental health service provision are yielding promising results. Multicultural orientation is a method of practice that allows practitioners and mental health professionals to navigate clients' cultural values and incorporate them into their therapeutic approaches (Owen, 2013). Considering significant advancements in linking constructs based on multicultural competencies to therapy outcomes, especially those focused on the qualities of the therapist, mental health professionals may overcome clinicians' ambivalence by incorporating the main components of multicultural orientations (i.e., cultural humility and self-reflection, identification of cultural opportunities with clients, and increasing cultural comfort of practitioners) in their theoretical orientations (Owen, 2013).

C. Building Professional Relationships. Data collected through the present research suggests that Imams, religious and spiritual leaders, influential community members, and medical professionals often come in contact with Afghan clients before mental health professionals. In many instances, there are already established trusting relationships between clients, their Imams, and religious community members. Imams and religious institutions also offer their congregation members free or low-cost services (i.e., spiritual counselling, marital dispute resolution, and religious guidance). Furthermore, Imams and religious and spiritual leaders are also regarded as credible and reliable sources of support, capable of framing the problem in religious or spiritual terms that are more comfortable for the client (Humam et al., 2023; Leavey et al., 2007; Memaryan et al., 2016; Syed et al., 2020). While Imams and religious leaders are increasingly becoming aware of their limitations in helping clients with psychological issues and rely on mental health professionals to assist members of their congregation with such issues (Al-Krenawi, 2016; Shah & Culbertson, 2011), there are still many who do not use

knowledge derived from empirical research in dealing with psychologically rooted issues (Isgandarova, 2014). Collaborative professional relationships of Imams and religious leaders with mental health professionals can potentially address the core issue of providing effective care to clients through further understanding of limitations and access to accredited professionals for referrals (Ali & Milstein, 2012). On the other hand, mental health professionals can also benefit from developing collaborative relationships with Imams and religious and spiritual leaders to address their need for self-education and ongoing curiosity by utilizing the religious and spiritual knowledge of Imams and religious leaders. Collaborative work with Imams and religious leaders can assist mental health professionals in dealing with clients' complex religious and spiritual issues in the therapeutic context (Breuninger et al., 2014; Curtis et al., 2017; Saleem & Martin, 2018). After all, although appearing different on the surface, both professionals deal with individuals who need assistance in times of crisis (Humam et al., 2023). Development of such collaborative relationships outside therapy rooms allows practitioners to ensure the effectiveness of their relationship before hands and reduce the burden of work at the time of referral or collaborative work. As described by Curtis and colleagues (2017), a professional collaborative relationship in this context is dependent on four factors: mutual respect; pre-established professional relationships; sensitivity to religious, spiritual, and mental health issues; and training in spiritual and emotional care.

4.6.2. Therapist and Client in Therapy Room

As therapists and other mental health professionals prepare themselves to integrate clients' religion and spirituality into therapeutic processes, they must put that knowledge and skillset into practice from the initial stages of their therapeutic relationship. Therapists and mental health professionals predominantly use initial meetings to build a relationship and gather

information about clients (Gabbert et al., 2021). They gather information about issues that directly affect their client and may indirectly impact the client's presenting issues. Initial sessions are also an important part of the process for clients, as they read verbal and non-verbal messages of the professional and make inferences about their clinician and the therapeutic process (Gabbert et al., 2021). While clients may not disclose their religious and spiritual identities and issues that may have a direct or indirect effect on their presenting problem in the initial stage of the therapeutic relationship, their assessment of the degree to which their practitioners come across as open to the inclusion of religion and spirituality may set the stage for religious and spiritual disclosures in subsequent stages of the therapeutic relationship (Mandelkow et al., 2022). Therefore, it is essential for the clinician to attend to religion and spirituality as part of their intake process (Captari et al., 2022). Furthermore, information gathered during the initial stage of therapy can significantly contribute to the process of assessment during the in-depth exploration stage of the therapeutic relationship (Mandelkow et al., 2022). In this stage, the clinician is focused on collecting and classifying information about the client's life situations and reasons for seeking therapy. Clinicians and clients may use gathered information to set goals and determine the role of religion in the therapeutic process. The relevance of information gathering on religion and spirituality in each of the mentioned stages and practical approaches to integrating the client's religion and spirituality into the therapeutic process is discussed here in detail (Davis et al., 2018).

A. Religious and Spiritual Assessment as Part of Intake Process. Intake is a critical first step in developing a therapeutic alliance. It is crucial to take into consideration the client's religion and spirituality as part of the intake process. This is because the intake process serves as the basis upon which the structure of the therapeutic relationship is constructed (Pearce, 2013).

The client's history, experiences, viewpoints, and the clinician's observations of the client's nonverbal behaviour all contribute to the formation of the groundwork for the therapeutic relationship that both the therapist and the client engage in. The practitioner's theoretical framework usually dictates the particular type of intake, which in turn substantially predicts the type of therapy chosen for a client (Butts & Gutierrez, 2018; Hodge, 2015). Another element that makes the intake process more challenging is the fact that the majority of treatment selections lead to the suggestion of an appropriate treatment method or technique, whereas the success of therapy is almost equally determined by the personal and professional characteristics of the therapist as well as by the therapeutic relationship (Ackerman & Hilsenroth, 2003; Cuijpers, 2019; Ortega, 2023; Hodge, 2015). In light of this, the process of selecting a therapy includes careful consideration of how well the client and the therapist are a personal fit for one another.

In the context of the present model, the role of religion and spirituality during the intake process is discussed considering the four essential elements of intake proposed: 1) thoroughly examining the client's perspective, 2) informing the client, 3) conceiving the decision process as a collaboration between the client and the clinician, and 4) leaving the final choice between equivalent alternatives to the client (Butts & Gutierrez, 2018; Hodge, 2015; Van Audenhove, & Vertommen, 2000).

Examination of the client's perspective is at the starting point of clinical intake and consists of gathering information about the client's view on the presenting issue, their view on the healing process, and their overall view of health (Butts & Gutierrez, 2018; Hodge, 2015). As religion and spirituality play an integral role in all three aspects, it is essential to integrate questions related to clients' religious and spiritual perspectives on all three levels. The client's religious and spiritual perspectives on the presenting issue provide clinicians with an

understanding of the presenting issue from the worldview of their client, as opposed to a purely clinical perspective that the clinician may utilize as part of their clinical assessment (Hodge, 2015). The client's religious and spiritual perspectives on the healing process inform the therapeutic process of the complex patterns of ideas and expectations that clients may have concerned their healing process (Pargament et al., 2013). The client's perspective on healing may also include elements such as place of religion and spirituality in problem-solving methods and the setting, format, frequency, and duration of therapy, among other clinical aspects of the therapeutic process. Finally, the client's overall religious and spiritual perspective on the overall healing process consists of religion and spirituality's role in the goals and values they want to reach through psychotherapy (Hodge, 2015).

The second important element of religion and spirituality in the intake process is informing the client of the integrative therapeutic approaches available to them. Clients often have their own ideas and expectations about the role of religion and spirituality in their therapy process (Holmberg et al., 2017; Trusty et al., 2022). But those ideas may not be conveyed to the therapist by default (Owen et al., 2016). Thus, to ensure the effectiveness of integrative approaches, it is necessary to inform the client about the options that are sometimes unknown to them unless explained by therapists. Such information can be given in a direct way by means of open discussions on integrative approaches based on the clinician's therapeutic orientation or in an indirect way by having open discussions with clients on their therapeutic style (Owen et al., 2016). Nonetheless, sharing information with clients must address two goals. First, shared information must help the client make an informed decision about what is acceptable to them as an integrative method of change. Second, discrepancies between the client's expectations or preferences and the reality of the integrative approaches must be clarified. In other words,

expectations or preferences that are incompatible with any integrative form of treatment should be corrected, while requests that are incompatible only with a specific therapeutic approach or therapist should be discussed as part of the decision-making process (Holmberg et al., 2017; Owen et al., 2016). This process of informing the client, conceived as an integrative method of treatment, not only enhances the treatment outcome but also addresses elements of stigma towards mental health and facilitates the positive perception of the psychotherapeutic process (Nakash et al., 2019).

The decision-making process for the integration of religion and spirituality in the therapeutic relationship is conceived as a negotiation process in the present model. Negotiation in this context implies that the client's preferences for the various approaches of integrating religion and spirituality (i.e., spiritual process, episode, or intervention; Jastrzębski, 2023) and differing degrees of integration—such as through collaborative work with religious and spiritual experts (Breuninger et al., 2014) or through specialized religious therapeutic approaches (Captari et al., 2018)—are not only offered to the client but are also examined critically. Put differently, results of data analysis of the present study as discussed in section 4.2.2 and 4.2.3 of chapter four suggest that the client's preferences on different aspects and characteristics of integrative approaches should be elicited in terms of their preferences for approach (e.g., integration through the therapist's therapeutic approach or integration through collaboration with an Imam), preferences for characteristics of professionals to collaborate with on religious and spiritual issues (e.g., an Imam, community leader, spiritual leader, or religious scholars); and preferences for the role of religion and spirituality in their therapeutic journey (e.g., active role or passive role). When the client's preference is sought, the motives behind each are explored, and, if possible, their relation to the client's presenting issue is discussed (Harris et al., 2016). In

addition, the clinician presents alternative possibilities, and their pros and cons are discussed. Therapists also present their viewpoints based on their expertise and clinical knowledge.

Conflicts between the point of view of the client and therapist must also be discussed openly and congruently (Gunnerson, 2021). In the event of a conflict of opinion or worldview, the clinician must express their concern about the risks and consequences connected to the client's preferences and choices (Gunnerson, 2021). The considerations of the clinician must be communicated in such a way that the client is invited to reflect on them and to question the clinician's opinion critically. In this way, the clinician's expert perspective is introduced into the process but not on a take-it-or-leave-it basis. As a consequence, clients may choose to move forward with their therapeutic relationship or explore options outside the present therapeutic relationship. The latter option is discussed in detail as part of the client's outside therapy environment.

B. Religion and Spirituality as Part of Diagnostic and Case Conceptualization

Process. The multidimensional assessment of the client's belief system that was outlined earlier naturally leads to a multidimensional approach to case conceptualization and treatment planning, which includes a consideration of the religious and spiritual aspects of the client's life.

Understanding the significance of clients' faith and spirituality, particularly related to the problems they present in therapy and their goals for their lives, is an essential part of the diagnostic and case conceptualization process (Hodge, 2015). Data analyzed for the present study suggests that it is because religion and spirituality are major sources of meaning in the lives of many clients; for others, religion may also be a source of distress. When therapists conceptualize presenting issues of their clients, they try to comprehend and describe how their client's religious and spiritual orientations and issues may be connected with the symptoms they

experience (Gladding & Crockett, 2019). The therapist's goal in light of the present study is to address questions such as: Are the client's religious and spiritual issues a source of distress, perhaps causing or exacerbating their present problems? Is their religion and sense of spirituality a possible source of strength and a useful resource that might assist them in coping with and overcoming the challenges they face? As part of the planning process for treatment, therapists and their clients work together to establish objectives for therapy. These goals should be intended to assist clients in coping with and resolving the issues that brought them to therapy and foster clients' healing, growth, and long-term welfare. A client's treatment plan could contain therapeutic objectives and interventions in multiple facets of their lives, such as their biology, psychology, interpersonal relationships, professional activities, or academic pursuits (Gunnerson, 2021).

According to Richards and Bergin (2005), therapists need to incorporate one or more general spiritual goals into their clinical work. These goals may include assisting clients in affirming their spiritual identity, living in harmony with their religious and spiritual practices, resolving religious and spiritual issues that may be related to their presenting problems, and exploring the possibility that their faith and spirituality may be a resource that can assist them in treatment. If a client expresses interest, the therapist will work with them to develop a set of religious or spiritual objectives that are relevant to their needs and values (Jastrzebski, 2023). In light of the integrative paradigm of religion and spirituality proposed by Pargament and colleagues (2013), it is essential to ensure that the integration process considers multiple levels of religiousness and spirituality among clients as well as multiple dimensions and multiple valences of religion and spirituality. Each aspect is discussed in detail as part of chapter two, particularly in section 2.6.2. It is, however, essential to note here that the diagnostic and case

conceptualization process takes place once the role of religion in the following four areas is determined: 1) the significance of religion and spirituality for the client, 2) the context of religion and spirituality for the client, 3) religious and spiritual resources of the client, and 4) if religion and spirituality are part of the problem. Gathering such information can take place through a series of questions posed in a culturally appropriate manner.

Significance can be determined through gathering information on the importance or relevance of spirituality and religion in the client's life, whereas questions about the client's religious and spiritual practices may determine the larger religious or spiritual context of the client's belief system (Hodge, 2013; Hodge, 2015). Results of the present study indicate that it is also important to discern if clients have rejected a particular faith tradition or are experiencing spiritual struggles related to their faith community. Insight into the use of spirituality and religion as a means to cope with problems can help clinicians ascertain if clients' belief systems are a resource for them (Alemi et al., 2015). Clients may become overwhelmed by their present challenges and overlook available resources (Pargament, 2007). By determining if clients have used religious and spiritual assets before to help them deal with problems, practitioners may be able to help clients leverage strategies used in the past to address present problems (Pargament, 2007). Additionally, seeking information about the client's understanding of the relationship between their presenting problem and their expression of spirituality and religion is also important to determine if their belief system is related to the problem they are experiencing (Hodge, 2013; Hodge, 2015). Practitioners should be alert for signs of impaired religious functioning, spiritual and religious struggles, and other clinically relevant issues (Cashwell & Swindle, 2020).

An essential aspect of the integrative paradigm presented by Pargament and colleagues (2013) is careful analysis of preliminary information gathered about the client's religion and spirituality in light of the clinician's theoretical orientation. Clinicians' multiculturally oriented diagnostic and case conceptualization processes enable the clinician to identify the role of religion and spirituality either as limited and peripheral to the presenting issues or as a core issue that impairs the client's psychological functioning, ameliorates psychological problems, and constitutes constraints to treatment (Gladding & Crockett, 2019). A thorough conceptual understanding of the role religion and spirituality play in the lives of clients and in the therapeutic relationship consequently determines the appropriate course of action on the part of the therapist to integrate the client's belief system (Hodge, 2013).

C. Religion and Spirituality as Part of Therapeutic Process. The role of religion and spirituality in the psychotherapeutic process is discussed in detail throughout this thesis (see sections 2.3, 2.8, 2.9, 2.10, 2.11 of chapter two and sections 4.2, 4.3, and 4.4 of chapter four). However, it is important to identify where religion and spirituality can be positioned from a practical perspective. Clients' religious and spiritual beliefs and worldviews can be integrated into therapy through three distinct methods: 1) through secular techniques used to work with the client's religious or spiritual beliefs, 2) through secular techniques modified to include religious and spiritual content, and 3) through interventions that utilize actions and behaviours derived from religious and spiritual practices (Jastrzebski, 2023; Pargament et al., 2013). The emergent model presented here discusses the positionality of each method in relation to the presentation of religious and spiritual content in a therapeutic context and the intensity of such content relative to clinical diagnosis and case conceptualization. Preliminary assessment and the therapist's

clinical assessment of the presenting issue provide clarity on the nature of religious and spiritual issues (Hodge, 2013).

Analysis of data from the present study further suggests that religious and spiritual issues may also be ancillary to other psychological issues. In this case, the direction of effect may aid the therapeutic process, as consequential to the presenting issue or as neutral but present. Such presence discussed in detail in section 4.2 and 4.3 of chapter four is labelled as peripheral in the present model. The concept of religion as a peripheral aspect of a client's presenting issue was first used by Toledano (1996) to describe the role of religion in Jewish identity and its perceived function in intra-cultural family therapy, where being Jewish served the purpose of belonging in a non-Jewish society. Although research on such a role of religion is scarce, there are similarities between functions of religion for the Jewish community and those who follow Islam (Dupper et al., 2015; Husain & Howard, 2017; Schlosser et al., 2009). Each direction of effect can subsequently be integrated through secular techniques used to work with the client's religion and spirituality. Examples of such interventions and methods can be dependent on the intensity of the issues. As proposed by Jastrzębski (2023) and discussed in section 2.11.1 of chapter two, spiritual process can be used when an unexpected development in otherwise routine, problem-focused therapy is experienced. The spiritual process allows the therapist and client to recognize that a religious or spiritual issue has appeared and must be integrated into therapy and dealt with here and now. A spiritual episode alternatively takes time and may be an appropriate method of integrating an abrupt spiritual discovery. Conversely, a spiritual intervention may only be required when the process of regular therapeutic work is affected by religious or spiritual doubts or obstacles. The therapist may utilize a spiritual intervention to address the hurdle, though the goal of spiritual intervention may not be religious or spiritual. The therapist and practitioner must

also remain attentive to various indicators during the initial assessment that may suggest a connection between the client's presenting issue and their religious and spiritual beliefs. The presence of such patterns is often indicative of a more intense role played by the client's belief system (Hodge, 2013). The present model labels such presentations as core. The word core in the context of the present model signifies the importance of religion and spirituality in the client's therapeutic process and highlights the importance of addressing it to the clinicians. In such circumstances, a comprehensive assessment may be required to establish if the client's representation of beliefs (e.g., hearing the Creator's voice) indicates mental illness or are healthy manifestations of religion (Hodge, 2013). When these beliefs connect to the presenting issue that the client brings to therapy, it may be necessary to thoroughly evaluate their spiritual and religious practices.

A comprehensive investigation of a client's religious and spiritual beliefs, practices, and experiences, as well as the ways in which these factors are connected to the client's issues and potential solutions, are the primary objectives of such an assessment (Hodge, 2013; 2015). This includes finding out how normal clients' religious and spiritual lives are compared to their religious reference group, how much psychological problems affect clients' religious and spiritual functioning, and how clients' spiritual and religious beliefs and practices help solve problems or get in the way of treatment (Hodge, 2013; 2015). However, at least two factors of client openness and clinician's competency must be considered before moving to conduct a comprehensive assessment of the client's religious and spiritual beliefs (Hodge, 2013). It is essential to determine whether or not clients are open to the concept of progressing to a more detailed assessment. As stated in the literature review section (i.e., 2.3, 2.8, 2.10 and 2.11), most clients prefer to include their religious and spiritual values in the therapeutic process. However,

as one participant of the present study also noted, some clients may feel that discussing spirituality and religion in clinical settings is improper (Cashwell & Swindle, 2020).

Additionally, other clients may be apprehensive about trusting practitioners with such a sensitive aspect of their being due to the very personal character of spirituality and religion (Chouinard & Cram, 2019). It is also important to obtain informed consent from the client before conducting a comprehensive assessment (Hodge, 2013). Clients may be open to answering the relatively few questions in the preliminary assessment, but they may be apprehensive about discussing their beliefs comprehensively. In fact, it is probably best to think of informed consent as a continuous process in which practitioners constantly monitor their clients' responses to make sure they are fully on board (Hodge, 2013).

The clinician's competency to work with the client's religious background and values is an additional consideration (ASERVIC, n.d.). It is crucial to assess one's capacity to deal with a different cultural worldview in an ethical and professional manner. This is particularly pertinent given the difference in worldviews that exists between many practitioners and their religious clients (Adams, 2012). Interactions that are not compatible with the clients' worldviews can be harmful to the therapeutic relationship and the clients themselves. In light of the information collected in the preliminary assessment, practitioners have to consider whether they have the necessary skills to engage with the client in a culturally appropriate manner (Hodge, 2013). In situations where adequate skill levels do not exist, consultation or referral should be explored as possible solutions (APA, 2002; CPA, 2017; sections 2.11.2 and 2.12.1 of this thesis). In other situations, it may be necessary to employ certain tactics in order to effectively overcome low levels of competency (APA, 2002; CPA, 2017; sections 2.11.2, 2.12.1 and 2.11.3 of this thesis). Practitioners could, for instance, remind clients that their religious and spiritual practices are

personal, describe the benefits of a comprehensive assessment, explain how the information will be used, apologize in advance for questions that clients might find offensive, and stress that clients are under no obligation to provide answers (Hodge, 2013).

A comprehensive spiritual and religious assessment aims to obtain a more detailed understanding of the client's religious and spiritual beliefs, practices, and experiences and how these variables are related to clients' problems and solutions (Hodge, 2013). This includes determining how normative clients' religious and spiritual lives are in comparison to their religious reference group, the degree to which psychological problems are impairing clients' religious and spiritual functioning and exploring how clients' spiritual and religious beliefs and practices function as resources to ameliorate problems or constitute constraints to treatment (Hodge, 2013; 2015).

Several dynamic and comprehensive techniques and instruments are created for comprehensively exploring spirituality and religion. Clients and practitioners alike have a diverse range of requirements and areas of interest. The amount of time available for assessment, the nature of the problem presented, the client's communication style and cultural background, and other elements are different from one instance to the next. Therapists should, ideally, use the approach that works best in the given therapeutic scenario. One of the most widely used methods of conducting a comprehensive assessment is a spiritual and religious history, a completely verbally based approach analogous to conducting a family history (Canda et al., 2019; Hodge, 2001; 2013). Other popular approaches like religious and spiritual life maps (Hodge, 2005), genograms (Hodge, 2001) and eco-maps (Hodge, 2000) are other popular approaches that are diagrammatic in nature. As the nature of religious and spiritual issues at this stage is more intense compared to those that may appear as peripheral and act as ancillary to other

psychological issues, addressing them must be done through interventions and techniques modified to explicitly religious content and interventions that integrate religious and spiritual actions and behaviours derived from religious and spiritual practices (Pargament, 2013).

Practical strategies at this stage may take shape in a variety of forms. One form is secular techniques modified to include religion and spirituality, such as spiritual goals and adoptive therapeutic approaches. Or they may be in the form of interventions that utilize actions and behaviours from religious practices, for example, collaborative treatment approach. Another form is exclusively religious therapeutic approaches infused with psychological ontologies like Islamic Psychotherapy. As described by Jastrzębski (2023), the spiritual goal is when the client and clinician are both aware that the entire therapeutic process is spiritually oriented. Therapy in this context has a spiritual horizon. Alternatively, religiously adopted therapeutic approaches offer clinicians and practitioners the ability to integrate religion and spirituality using their primary theoretical modalities. Spiritual perspectives and interventions have been incorporated into most mainstream theoretical orientations, including the psychoanalytic tradition (Shafranske, 2004), Adlerian therapy (Watts, 2000), behaviour therapy (Martin & Booth, 1999), cognitive therapy (Propst, 1996), rational-emotive behaviour therapy (Nielson et al., 2001), person-centred therapy (West, 2004), existential-humanistic therapy (Mahrer, 1996), gestalt therapy (Harris, 2000), constructivism (Steinfeld, 2000), and transactional analysis (Trautmann, 2003). Though many of these adaptations are not for Muslim clients, they nonetheless provide clinicians and practitioners with valuable insights and therapeutic strategies.

Compared to existing religious and spiritual models, the advantages provided by the collaborative treatment approach suggested by Breuninger and colleagues (2014) is both novel and consistent. The client's experience of the positive benefits of religious and spiritual

engagement, the mutual enhancement (and reduction in resistance to treatment) that simultaneous interventions foster and the mitigation of psychologists' propensity toward being less religious than their clients are three benefits associated with this treatment model. Another advantage of the collaborative treatment approach is that it enables non-religious therapists to connect with and treat religious clients without neglecting or downplaying a key aspect of the client's life (Breuninger et al., 2014). Therapists can deal with clients of any religious tradition or denomination using this methodology, even if they do not personally subscribe to those principles or have a religious connection of their own. Even though most of the research on this model is carried out within the context of the Christian faith tradition, making use of collaborative relationships with members of the clergy, it is possible to successfully adapt the model to the Islamic faith tradition as well by making use of collaborative professional relationships with Imams and other spiritual leaders.

There is also a considerable amount of literature published on exclusively spiritual approaches to counselling within the Christian faith tradition in the form of Pastoral Counselling, which is primarily focused on dimensions of human life infused with faith, religiosity, and spirituality (Jibiliza, 2021). Although exclusively spiritual counselling approaches offer meaningful insights to therapists and mental health professionals who work with Muslim clients, they fall short in offering an all-inclusive counselling approach that integrates Muslim clients' religious and spiritual beliefs (Sytner, 2018). Nonetheless, researchers in psychology are increasingly shifting their focus to developing an exclusively religious therapeutic model that can address the needs of highly religious Muslim clients. A promising effort was undertaken by Abdallah Eric David Rothman (2019; 2023) to investigate the ontological underpinnings of psychology from an Islamic perspective, as well as the ways in which these

fundamental assumptions about human nature might guide the implementation of Islamic psychotherapy in the practical environment. The model proposed by the author represents a uniquely Islamic approach to psychotherapy that is rooted in an Islamic perspective on human nature and offers a framework for Islamic psychology and a preliminary model for a theoretical orientation to Islamic psychotherapy. However, the need for practical interventions in a clinical context remains immanent; becoming familiar with the proposed model is worthwhile for clinicians who find themselves in therapeutic relationships with highly religious clients.

4.6.3. Client Outside Therapy Room

Integrative approaches toward religion and spirituality are discussed in detail in previous sections. However, two areas of concern in this regard that may further define the place of religion outside the therapy room for clients are therapist competency and client vulnerability. While researchers and culturally responsive practitioners make a compelling case for the inclusion of clients' religion and spirituality in their therapeutic process (see sections 2.10 and 2.11 of this thesis), mental healthcare providers are often not trained theologians or Imams in the context of this study. Mental healthcare professionals are also mandated to do no harm and practice within their area of expertise (see section 2.10.1 of this thesis). They are often not equipped to offer spiritual advice or counsel. They, nonetheless, must seek the good of their clients and ensure that their clients have access to adequate resources that can meet their needs.

Working to address the above-mentioned ethical responsibilities by therapists may be particularly essential for clients with higher degrees of religiosity or spirituality, for whom religion and spirituality play a central role in their life (Pargament, 2013). These clients may have a different worldview compared to the professionals they work with. They may also need assistance from trained religious professionals or theologians on aspects of their life with a direct

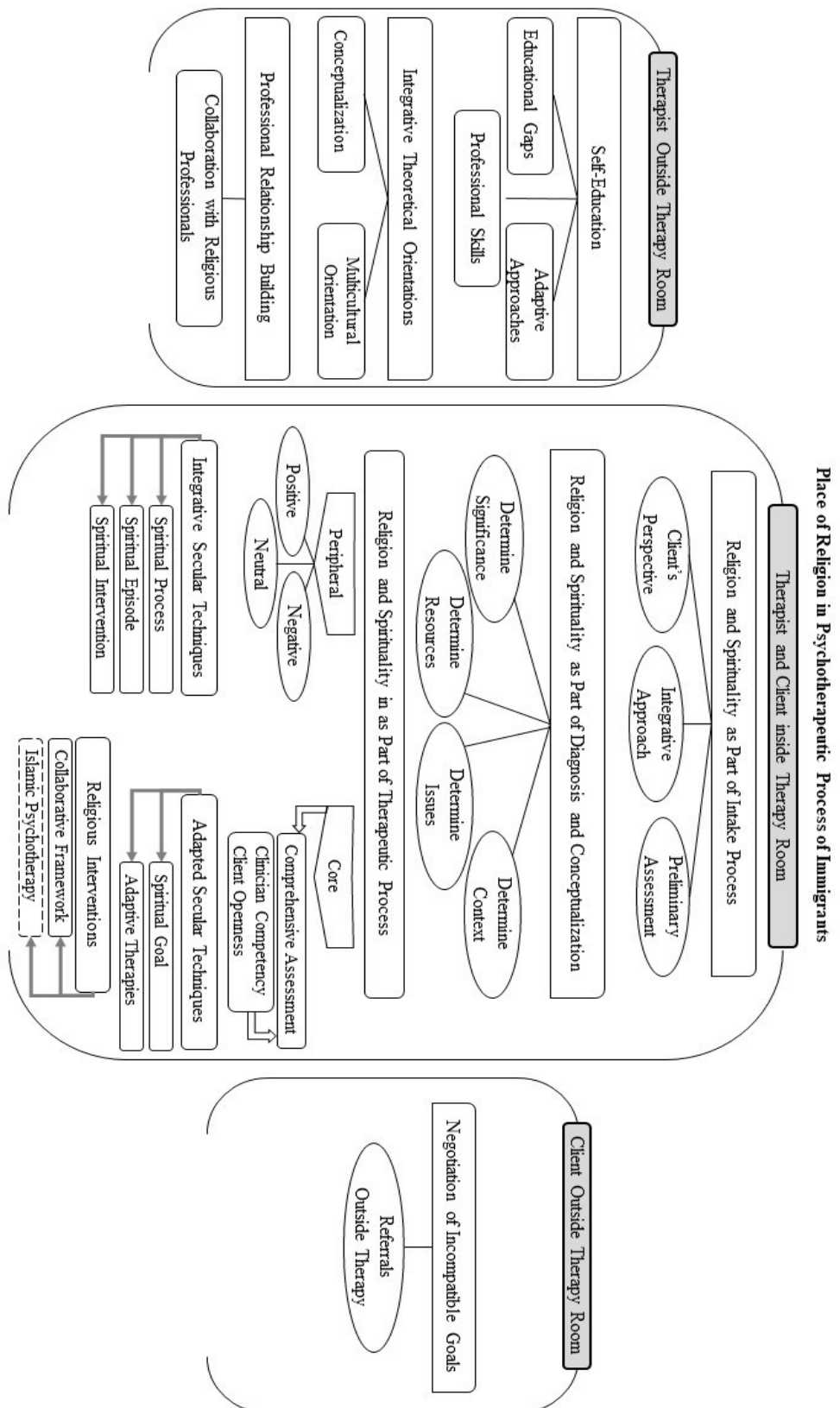
impact on their presenting issues in the therapeutic context, yet that are outside the professional capacity of their clinicians. Unfortunately, research suggests that religious professionals are not called on as frequently as may be necessary (Freire et al., 2019; Smith et al., 2018). At the same time, therapist self-education provides them with an understanding of who they are as individuals and can mitigate the negative impact of misunderstandings stemming from fundamental differences in worldview with their clients. Additionally, engagement with the client's religion and spirituality as part of the intake process through preliminary assessment further facilitates the clinician's understanding of the compatibility and vulnerabilities of their clients. By utilizing the information gathered, clinicians can initiate a meaningful discussion on the role of religion and spirituality inside and outside the therapy room, with the intention to clarify potential areas of engagement with the client's beliefs and areas where the client may decide to engage outside the therapy room.

Recent studies on alliance research (Doran et al., 2017; Lee & Kealy, 2018) propose the idea of negotiation in the therapeutic context that is related to culturally charged topics and goals in the therapeutic process. While similar concepts are widely studied under the umbrella of alliance rupture, Doran and colleagues (2017), in particular, focus on the in-session process of therapy agenda between the client and therapist, which can predict the post-session outcomes. Using the concept of negotiation of goals, clinicians and their clients can collaboratively identify goals that can be pursued inside the therapy room and agree on goals that clients outside the therapy room can address. However, the clinician's alliance with the client may still be beneficial to the client's efforts in addressing goals outside the therapy room. For example, therapists can offer referrals to religious professionals or Imams that they already have professional relationships with and find them a suitable match for the client. Nonetheless, clinicians must also

ensure that client autonomy is respected by obtaining informed consent from their clients before making any referrals or communications with other professionals, Imams, or spiritual leaders.

Acquiring informed consent in this aspect must always be a continuous process. Figure 8 illustrates the emergent model and its components.

Figure 8. Model of the Place of Religion in the therapeutic process



Summary of Chapter

The analysis and discussion chapter of this thesis delves into a comprehensive examination and interpretation of collected data, shedding light on key findings and insights grounded in the data. The study employed a qualitative research method through a grounded theory approach to collect data and analyze it for major categories and themes. Furthermore, descriptive relationships between categories and themes allowed the researcher to infer meaningful connections between themes to answer the two main research questions.

The first goal of the analysis was to investigate the role of religion and spirituality in the lives of Afghan immigrants and shed light on the impact of integration of their religious and spiritual selves into the psychotherapeutic process. Insights drawn from the participants with lived experiences as immigrants in Canada and clinicians who work with Afghan clients in their professional capacities allowed the researcher to develop a nuanced understanding of the role religion and spirituality plays in the lives of Afghan immigrants from a psychological point of view. Analysis of initial themes and subthemes in response to the first research goal, in turn, paved the way to gather information from Afghan immigrants and clinicians to examine the place of religion and spirituality in the therapeutic processes of immigrants. The place of religion and spirituality was analyzed from the perspective of clients, as well as clinicians who were trained in secular methods of therapy. Analysis of data showed that religion played an integral part in the lives of Afghan immigrants and highlighted that integration of client belief systems into their therapeutic processes is essential to the success of their therapeutic journey and outcomes. The analysis also showed that clinicians who work with religious and spiritual clients find it challenging to integrate their belief systems into therapy, despite knowing the importance of it to the success of therapy and a holistic approach to the client-therapist relationship.

Lack of adequate education and professional skills and gaps in research on practical approaches to integrating religion and spirituality into the therapeutic process were found to be significant contributors to clinician hesitancy and ambivalence about client belief systems. On the other hand, therapists' lack of interest and ambivalence led clients to perceive their therapists as less interested in religion as part of therapeutic processes. The interplay between client expectations and clinicians' hesitancy and ambivalence often resulted in reduced satisfaction with the therapeutic process and negatively contributed to the help-seeking behaviour of immigrant clients.

A multidimensional study of the relationships between emerging themes through discussion of outcomes resulted in the development of a model for effectively integrating religion and spirituality into the therapeutic process. The proposed model considers client expectations and clinician abilities, challenges, and ways to address educational gaps. The emergent model guides clinicians to seek self-education as an approach to address gaps in their formal education and expand their theoretical orientations to multiculturally oriented approaches. Consequently, clinicians can integrate clients' belief systems into their case conceptualization and treatment approach. The model also recognizes professional role limitations and encourages clinicians to establish professional relationships with like-minded religious professionals and grassroots organizations as collaborators in working with clients.

The model further highlights multiple levels of integrating religion and spirituality into the therapeutic process inside the therapy room and proposes the inclusion of preliminary religious assessment as part of the intake process. Such inclusion will not only provide clinicians with relevant information about the client's belief system and its impact on presenting issues but

will also signal to clients that their therapists are open to integrating religion and spirituality into the therapeutic process and are welcoming of the client in a holistic fashion.

Integrating religion and spirituality in therapy may take an explicit form where the client and therapist actively engage with the client's faith and spiritual worldviews, or it may be an implicit factor in the clinician's conceptualization of their client and the presenting issue. However, the model does not assume that integration of religion and spirituality into the client's therapeutic journey will always be possible and acknowledges the presence of differing incompatible worldviews between the client and their therapist. In such scenarios, the model presents the option of negotiation over goals that are compatible with the therapeutic alliance and goals that the client may explore outside the therapeutic room. The clinician in such a situation is tasked with exploring suitable options for the client after obtaining their informed consent and embarking on referral processes to ensure the client's goals are met in a healthy and meaningful way. The emergent model proposes a response to the two core questions and offers practical strategies to a multitude of challenges that may be present in the integration process. Despite its significant contribution to furthering the effort on integrative approaches and offering clinicians a practical approach, the model has limitations and requires further study. The following chapter will discuss the limitations and future direction of the outcomes of this study in detail.

Chapter Five:

5. Conclusion

The aim of this research is to explore the place of religion and spirituality in the lives and therapeutic processes of immigrants. The study focused on Afghan immigrants in particular to address the two main research questions of the role of religion and spirituality in the lives of Afghan immigrants and the place of religion in therapeutic process through a grounded theory approach. The findings of this research suggest that religion and spirituality plays an important role in the lives of immigrants and can take different directional effects. Religion and spirituality can play a positive role as a resource in lives of immigrants or can play a negative role and be a source of distress. Religion can also change form and become a self-directed spiritual practice.

The prominent role of religion and spirituality in the lives of immigrants further suggests that it has a significant role in their therapeutic process. Findings of the study suggests that religion and spirituality occupy an important place in the therapeutic process in three environments associated with therapy and mental health support. Religion and spirituality are integral, yet poorly addressed in professional competency and development. Religion and spirituality must be part of educational programs that train professional of mental health. However, a lack of spiritually oriented or spiritually inclusive educational programs make it challenging for mental health professional to take an integrative approach in their theoretical orientations. This lack of education and professional competency directly impacts the therapeutic relationship of the client to their therapist, thus resulting in neglecting the role of religion and spirituality in a client's life and their therapeutic process. The emergent model of the place of religion and spirituality in therapeutic process highlights practical ways of integrating religion and spirituality in the therapeutic process across all stages and addresses the gaps currently

present in the provision of mental health support to immigrants. The model addresses educational gaps and the need for professional development outside the therapeutic room by inviting mental health professionals to engage in self-education on integrative perspectives and building meaningful relationships. The model further addresses the neglect of religion and spirituality inside the therapy room by integrating religious and spiritual assessment as part of the intake process to allow clinicians and clients to recognize the value of religion and spirituality in a client's life and the role it may play. The therapeutic relationship can then be guided through integrative paradigms and can address religion and spirituality as a core issue or as a construct in the periphery of other issues presented by clients. However, the model does not limit the place of religion to only the therapist and client. It also recognizes that religion and spirituality may continue to play a role in a client's life beyond the therapy room and regardless of its relevance to the therapeutic relationship. To address religion and spirituality outside the therapy room, the model utilizes the trusting relationship and therapeutic alliance of the clinician and the client and empowers the client to address issues and concerns related to their religion and spirituality outside the therapy room.

The model presented in this research is unique because it places religion and spirituality within the predominantly secular models of therapy and mental health support. The presented model conceptualizes the role of religion and spirituality as part of the Western, secular therapeutic process, rather than putting it at the centre of therapeutic interventions (i.e., spiritual counselling, pastoral care). The model also takes a progressive approach wherein the level of integration is guided by information gathering and collective decision making as part of the therapeutic process between the client and their therapist. At the same time, it presents therapists with a step-by-step guide to the use of integrative approaches.

The proposed model addresses prevailing gaps in culturally responsive service delivery, especially concerning Muslim immigrants within the Western context, with a particular emphasis on Canada. By focusing on integrating religious beliefs and practices, the model enhances the quality of counselling for Muslim immigrants and actively bridges the cultural disconnect that has often been experienced within therapeutic interactions. Notably, a substantial portion of studies within the domain of religion in counselling predominantly revolves around a Christian-centric perspective. This emphasis on Christian-focused studies has inadvertently led to an imbalance in the representation of diverse religious and cultural backgrounds, particularly within counselling. This misalignment has resulted in the underrepresentation of non-Christian perspectives and their specific requirements, subsequently limiting the efficacy of counselling practices for non-Christian individuals, such as Muslim immigrants. The current research, however, marks a pivotal departure from this norm, shedding light on the unique challenges, expectations, and needs of Muslim immigrants within therapeutic processes. By delving into their distinct religious and cultural dynamics, the study enriches the understanding of how to engage with Muslim immigrants effectively and offers crucial insights into tailoring therapeutic approaches that align with their values and expectations.

This research significantly contributes to the practical enhancement of counselling services for Muslim immigrants and the broader academic dialogue about the need for more inclusive, culturally sensitive approaches in the counselling field. Through thoroughly examining religiously and culturally grounded counselling practices, this study ensures that Muslim immigrants' voices, experiences, and requirements are acknowledged and integrated into effective mental health support discourse.

Additionally, the present research and the emergent model offers a practical strategy of cultural responsiveness to practitioners, organizations and other stakeholders who are engaged in providing mental health services to Muslim immigrants. Professionals and practitioners can employ the emergent model in their service models and integrate client's religion and spirituality in their preferred theoretical frameworks and foundational conceptual positions. Professionals and practitioners can become culturally sensitive to the values and beliefs of their clients, and in particular the religious and spiritual values and beliefs of their Muslim immigrant clients, which can in turn foster a strong therapeutic alliance and create a safe space for Muslim immigrants and empower them to explore their concerns in therapy.

For Muslim immigrants who may face challenges related to acculturation, the integrative model can help them navigate the integration of their religious and cultural identity with their new environment. Therapists can assist clients in exploring how their religious and cultural background intersects with their personal growth, relationships, and overall well-being, facilitating a sense of balance and coherence in their identity. Ultimately, by acknowledging and validating the importance of religion and spirituality, the proposed model can empower Muslim immigrants to embrace their beliefs and values without feeling a need to compromise or downplay them. This validation can enhance their self-esteem, well-being, and overall mental health.

5.1. Limitations and Future Research

The present research provides meaningful insight into role of religion in the lives of Muslim immigrants and presents practitioners and clinicians with a practical model for integrating clients' values and belief system.

The present study is a qualitative study and has used a grounded theory approach. While the selected research methodology is essential to the development of an in-depth understanding of unknown and less explored phenomena, the findings may be limited in their potential generalizability. Validation studies of the model using quantitative methodologies with a higher degree of generalizability can address the potential gap in literature as well as provide a stronger empirical base for the application of the proposed model in other immigrant faith communities.

Furthermore, although the focus of the research is on religious and spiritual integration, the study is primarily conducted with Afghan Muslim immigrants, which limits the cultural generalizability of the research to other groups. Culture is often intertwined with religion and spirituality, and thus practitioners who utilize the model presented in this research are cautioned to be culturally humble and revert back to their clients and their families and communities for a nuanced cultural understanding of other Muslim immigrants. The interaction between culture and religion can further be explored through research with different immigrant communities who adhere to Islam but come from diverse cultural backgrounds. It is also worthwhile to explore the impact of different religious schools within Islam on client's mental health and study the applicability of the emergent model to the integration of different interpretative perspectives of Islam. An additional area of future research could explore how oppressive experiences of marginalized clients may interact with the role of religion and spirituality in their lives and their therapeutic processes.

From an application point of view, the emergent model of integrating religion and spirituality provides practical steps to address existing gaps in practitioner education. However, the proposed steps do not address the need for more inclusive curricula for practitioner education and their skill building to integrate religion and spirituality as part of educational programs, thus

putting the onus of self-education and skill-building solely on the practitioners. Lack of adequate resources and research on religiously accommodative therapeutic approaches and interventions can make it challenging for professionals and practitioners to address their educational gaps effectively and build professional skills. There is need for substantial research on the development of religiously integrative theoretical perspectives within the Western secular approach to mental health. There is also a significant need for change in educational programs that train mental health professionals and practitioners.

Lastly, the present study looks at the role of religion and spirituality in a holistic way and does not consider the nuanced ways religion and spirituality make an impact on a client's life. The study is also limited in its exploration of the contributing factors of changing attitudes towards religion post-migration. Future research is needed on the multidirectional and multidimensional role of religion and spirituality in the lives of immigrants from a clinical point of view.

Despite its limitations, the present study offers a model that can address the client's need for a culturally sensitive therapeutic approach, consider their religious and spiritual needs, and integrate multiple layers of their identities into their therapeutic process. The integrative model can help Muslim immigrants tap into their religious and spiritual resources to find meaning, cope with stressors, and develop resilience in the face of adversity. By acknowledging and validating the importance of religion and spirituality, the model proposed in this thesis can empower Muslim immigrants to embrace their beliefs and values without feeling a need to compromise or downplay them. This validation holds the capacity to elevate their self-worth, improve their state of well-being, and positively impact their overall mental health. The study also offers clinicians and practitioners an approach to work collaboratively with other professionals, such as Imams or

religious leaders, to ensure a holistic approach to therapy that considers the interplay between psychological, social, and spiritual dimensions of their client's life. Using the emergent model, practitioners can address the existing gaps in their professional education and skillset to assist clients in exploring how their religious and cultural background intersects with their personal growth, relationships, and overall mental health, facilitating a sense of balance and coherence in their identity.

References

- Abdel-Khalek, A. M. (2007). Religiosity, happiness, health, and psychopathology in a probability sample of Muslim adolescents. *Mental Health Religion and Culture, 10*, 571–583.
- Abu-Raiya, H., & Pargament, K. (2011). Empirically based psychology of Islam: Summary and critique of the literature. *Mental Health, Religion & Culture, 14*(2), 93-115.
- Abu-Raiya, H., & Pargament, K. I. (2010). Religiously integrated psychotherapy with Muslim clients: From research to practice. *Professional Psychology: Research and Practice, 41*(2), 181.
- Abu-Ras, W. (2003). Barriers to services for Arab immigrant battered women in a Detroit suburb. *Social Work Research and Evaluation, 3*(4), 49–66.
- Abu-Ras, W., Gheith, A., & Cournos, F. (2008). The imam's role in mental health promotion: A study at 22 mosques in New York City's Muslim Community. *Journal of Muslim Mental Health, 3*, 155-176. <http://dx.doi.org/10.1080/15564900802487576>
- Ackerman, S. J., & Hilsenroth, M. J. (2003). A review of therapist characteristics and techniques positively impacting the therapeutic alliance. *Clinical psychology review, 23*(1), 1-33.
- Adams, C. M., Puig, A., Baggs, A., & Wolf, C. P. (2015). Integrating religion and spirituality into counselor education: Barriers and strategies. *Counselor Education and Supervision, 54*(1), 44–56. <https://doi.org/10.1002/j.1556-6978.2015.00069.x>

- Adams, J. R. (2012). Spiritual issues in counseling: What do students perceive they are being taught?. *Counseling and Values, 57*(1), 66-80.
- Adams, M., & Joshi, K. Y. (2007). Religious oppression. *Teaching for diversity and social justice, 255-83*.
- Adamuti-Trache, M., Anisef, P., & Sweet, R. (2018). Differences in Language Proficiency and Learning Strategies Among Immigrant Women to Canada. *Journal of Language, Identity & Education, 17*(1), 16-33. doi:10.1080/15348458.2017.1390433
- Adida, C., Laitin, D., & Valfort, M. (2010). Identifying barriers to Muslim integration in France. *Proceedings of the National Academy of Sciences of the United States of America, 107*(52), 22384-22390. Retrieved from <http://www.jstor.org/stable/25770649>
- Afrouz, R., Crisp, B. R., & Taket, A. (2021). Experiences of domestic violence among newly arrived Afghan women in Australia, a qualitative study. *The British Journal of Social Work, 51*(2), 445-464.
- Ahmad, A. (2020). Ethnic discrimination against second-generation immigrants in hiring: empirical evidence from a correspondence test. *European societies, 22*(5), 659-681.
- Ahmad, F., Othman, N., & Lou, W. (2020). Posttraumatic stress disorder, social support and coping among Afghan refugees in Canada. *Community mental health journal, 56*, 597-605.

- Ahmad, S. S., McLaughlin, M. M., & Weisman de Mamani, A. (2022). Spiritual bypass as a moderator of the relationships between religious coping and psychological distress in Muslims living in the United States. *Psychology of religion and spirituality*.
- Ajrouch, K. (2004). Gender, Race, and Symbolic Boundaries: Contested Spaces of Identity among Arab American Adolescents. *Sociological Perspectives*, 47(4), 371-391.
- Akbas, Ö. Z., Aygül, H. H., Gürbüz, G., & Kurtuluş, S. (2022). The Religious Life of Afghan Migrants Before and After Migration: Protecting Their Religious Identity or Social Cohesion. *Ilahiyat Studies*, 13(2), 207-255.
- Akcapar, S. K. (2019). Religious conversions in forced migration: Comparative cases of Afghans in India and Iranians in Turkey. *Journal of Eurasian Studies*, 10(1), 61-74.
- Akter, N. (2010). *The religious lives of immigrant Muslim women in Canada: The case of Bangladeshi women in St. John's, Newfoundland* (Order No. MR68925). Available from ProQuest Dissertations & Theses Global. (821474892). Retrieved from <https://search.proquest.com/docview/821474892?accountid=14701>
- Alba, R., & Nee, V. (1997). Rethinking assimilation theory for a new era of immigration. *International Migration Review*, Xxi(4), 826-874.
- Alba, R., & Nee, V. (2005). *Remaking the American mainstream : Assimilation and contemporary immigration* (1st Harvard University Press pbk. ed.). Cambridge, Mass.: Harvard University Press.

- Alemi, Q., & Stempel, C. (2018). Discrimination and distress among Afghan refugees in northern California: The moderating role of pre- and post-migration factors. *PLoS ONE*, *13*(5), E0196822.
- Alemi, Q., James, S., & Montgomery, S. (2016). Contextualizing Afghan refugee views of depression through narratives of trauma, resettlement stress, and coping. *Transcultural Psychiatry*, *53*(5), 630-653.
- Alemi, Q., James, S., Cruz, R., Zepeda, V., & Racadio, M. (2014). Psychological Distress in Afghan Refugees: A Mixed-Method Systematic Review. *Journal of Immigrant and Minority Health*, *16*(6), 1247-1261.
- Alemi, Q., James, S., Siddiq, H., & Montgomery, S. (2015). Correlates and predictors of psychological distress among Afghan refugees in San Diego County. *International Journal of Culture and Mental Health*, 1-15.
- Alemi, Q., Montgomery, S., Smith, V., Stempel, C., Koga, P .M., Taylor, B., & Fisher, C. (2018). Examining help-seeking patterns within modern and traditional resources for support in Afghanistan. *Intervention*, *16*(3), 215-221.
- Alemi, Q., Panter-Brick, C., Oriya, S., Ahmady, M., Alimi, A. Q., Faiz, H., ... & Ventevogel, P. (2023). Afghan mental health and psychosocial well-being: thematic review of four decades of research and interventions. *BJPsych Open*, *9*(4), e125.

- Al-Hibri, A. (2000). Islam, law, and custom: redefining Muslim Women's rights. In *Women and International Human Rights Law* (pp. 379-420). Brill Nijhoff.
- Ali, O. M., & Milstein, G. (2012). Mental illness recognition and referral practices among imams in the United States. *Journal of Muslim Mental Health, 6*(2).
- Al-Krenawi, A. (2016). The role of the mosque and its relevance to social work. *International Social Work, 59*(3), 359-367.
- Allen, J., Balfour, R., Bell, R., & Marmot, M. (2014). Social determinants of mental health. *International Review of Psychiatry, 26*(4), 392-407.
- Aloud, N., & Rathur, A. (2009). Factors affecting attitudes towards seeking and using formal mental health and psychological services among Arab Muslim populations. *Journal of Muslim Mental Health, 4*, 79-103. <http://dx.doi.org/10.1080/15564900802487675>
- Alsehaimi, A., & Alanazi, A. (2015). The Nature of Domestic Violence against of Children in Saudi Arabia Systematic Literature Review. *Journal of Psychological Abnormalities in Children, 4*(03), 3-5.
- American Counseling Association. (2014). 2014 ACA code of ethics. <https://www.counseling.org/docs/default-source/default-document-library/2014-code-of-ethics-finaladdress.pdf>

American Psychological Association, Presidential Task Force on Evidence-Based Practice.

(2006). Evidence-based practice in psychology. *American Psychologist*, 61(4), 271–285. <https://doi.org/10.1037/0003-066X.61.4.271>

American Psychological Association. (2002). Ethical Principles of Psychologists and Code of Conduct. *American Psychologist*, 57(12), 1060–1073. <https://doi.org/10.1037/0003-066X.57.12.1060>

American Psychological Association. (2007). Resolution on religious, religion-based and/or religion-derived prejudice. *Washington, DC: American Psychological Association*.

Amiri, R., King, K. M., Heydari, A., Dehghan-Nayeri, N., & Vedadhir, A. A. (2019). Health-seeking behavior of Afghan women immigrants: an ethnographic study. *Journal of Transcultural Nursing*, 30(1), 47-54.

Amri, S., & Bemak, F. (2012). Mental health help-seeking behaviors of Muslim immigrants in the United States: Overcoming social stigma and cultural mistrust. *Journal of Muslim Mental Health*, 7(1), 43-63.

Annells, M. (1996). Grounded theory method: Philosophical perspectives, paradigm of inquiry, and postmodernism. *Qualitative Health Research*, 6(3), 379–393.

doi:10.1177/104973239600600306

- Ano, G. G., & Vasconcelles, E. B. (2005). Religious Coping and Psychological Adjustment to Stress: A Meta-Analysis. *Journal of Clinical Psychology, 61*(4), 461–480. <https://doi.org/10.1002/jclp.20049>
- Arai, M., Bursell, M., & Nekby, L. (2016). The reverse gender gap in ethnic discrimination: Employer stereotypes of men and women with Arabic names. *International Migration Review, 50*(2), 385-412.
- Araujo, B., & Borrell, L. (2006). Understanding the link between discrimination, mental health outcomes, and life chances among Latinos. *Hispanic Journal of Behavioral Sciences, 28*(2), 245-266. doi:10.1177/0739986305285825
- Arnold, R. M., Avants, S. K., Margolin, A., & Marcotte, D. (2002). Patient attitudes concerning the inclusion of spirituality into addiction treatment. *Journal of Substance Abuse Treatment, 23*(4), 319–326. [https://doi.org/10.1016/S0740-5472\(02\)00282-9](https://doi.org/10.1016/S0740-5472(02)00282-9)
- Arnold, R., van Teijlingen, E., Ryan, K., & Holloway, I. (2014). Understanding Afghan healthcare providers: a qualitative study of the culture of care in a Kabul maternity hospital. *BJOG: an international journal of obstetrics and gynaecology, 122*(2), 260-7.
- Association for Spiritual, Ethical, & Religious Values in Counseling. (n.d.). Mission and Vision. Retrieved from <http://www.aservic.org/counseling-and-values/>.
- Aune, K. (2011). Much less religious, a little more spiritual: The religious and spiritual views of third-wave feminists in the UK. *Feminist Review, 97*(1), 32-55.

- Baggs, A., Wolf, C. P., Moro, R. D., Puig, A., & Fukuyama, M. (2011). Integrating spiritual competencies into multicultural counseling: A mix-method course evaluation study. ACA 2011 Conference & Exposition, USA.
- Bakal, D. (1999). *Minding the body*. New York: Guilford Press.
- Bakker, L., Dagevos, J., & Engbersen, G. (2014). The importance of resources and security in the socio-economic integration of refugees. A study on the impact of length of stay in asylum accommodation and residence status on socio-economic integration for the four largest refugee groups in the Netherlands. *Journal of International Migration and Integration*, 15(3), 431-448. doi:10.1007/s12134-013-0296-2
- Bambra, C., Gibson, M., Sowden, A., Wright, K., Whitehead, M., & Petticrew, M. (2010). Tackling the wider social determinants of health and health inequalities: Evidence from systematic reviews. *Journal of Epidemiology and Community Health* (1979), 64(4), 284-291. Retrieved from <http://www.jstor.org/stable/20721190>
- Barlas, A. (2019). *Believing women in Islam: Unreading patriarchal interpretations of the Qur'an*. University of Texas Press.
- Bartoli, E. (2007). Religious and spiritual issues in psychotherapy practice: Training the trainer. *Psychotherapy: Theory, Research, Practice, Training*, 44(1), 54-65. <http://dx.doi.org/10.1037/0033-3204.44.1.54>

- Beg, N. (2005). *A qualitative study on the factors influencing the cultural, economic and social integration of Afghan women in Canada* (Doctoral dissertation, Carleton University).
- Beiser, M., & Hou, F. (2016). Mental Health Effects of Premigration Trauma and Postmigration Discrimination on Refugee Youth in Canada. *The Journal of Nervous and Mental Disease*, 204(6), 464-470.
- Bemak, F., Chung, R. C. Y., & Pedersen, P. (2003). *Counseling refugees: A psychosocial approach to innovative multicultural interventions* (No. 40). Greenwood Publishing Group.
- Bhanji, M. R. (2011). *Resiliency amidst the fragmented lives of afghan refugee women* (Doctoral dissertation).
- Bhugra, D. (2004), Migration and mental health. *Acta Psychiatrica Scandinavica*, 109: 243-258.
doi:10.1046/j.0001-690X.2003.00246.x
- Bhugra, D., & Gupta, S. (Eds.). (2010). *Migration and Mental Health*. Cambridge: Cambridge University Press. doi:10.1017/CBO9780511760990
- Bhugra, D., Craig, T. K. J., & Bhui, K. (2010). *Mental health of refugees and asylum seekers*. Oxford: Oxford University Press.
- Bhugra, D., Gupta, S., Schouler-Ocak, M., Graeff-Calliess, I., Deakin, N. .A., Qureshi, A., Dales, J., Moussaoui, D., Kastrup, M., Tarricone, I., Till, A., Bassi, M., Carta, M. (2014). EPA Guidance mental health care of migrants. *European Psychiatry*, 29(2), 107-115.

- Bhugra, D., Mallett, R., & Leff, J. (1999). Schizophrenia and African-Caribbean: a conceptual model of aetiology. *International Review of Psychiatry*, 11(2), 145–52.
- Biernacki, P., & Waldorf, D. (1981). Snowball sampling. *Sociological Methods and Research*, 10, 141-163.
- Bockrath, M. F., Pargament, K. I., Wong, S., Harriott, V. A., Pomerleau, J. M., Homolka, S. J., ... & Exline, J. J. (2021). Religious and spiritual struggles and their links to psychological adjustment: A meta-analysis of longitudinal studies. *Psychology of Religion and Spirituality*.
- Bogic, M., Ajdukovic, D., Bremner, S., Franciskovic, T., Galeazzi, G., Kucukalic, A., . . . Priebe, S. (2012). Factors associated with mental disorders in long-settled war refugees: Refugees from the former Yugoslavia in Germany, Italy and the UK. *The British Journal of Psychiatry : The Journal of Mental Science*, 200(3), 216-223.
- Bogic, M., Njoku, A., & Priebe, S. (2015). Long-term mental health of war-refugees: A systematic literature review. *BMC International Health and Human Rights*, 15 doi:10.1186/s12914-015-0064-9
- Braswell, G. W. (2000). *What you need to know about Islam & Muslims*. B&H Publishing Group.
- Braveman, P., & Gottlieb, L. (2014). The Social Determinants of Health: It's Time to Consider the Causes of the Causes. *Public Health Reports*, 129(Supp 2), 19-31.

Briggs, M. K., & Rayle, A. D. (2005). Incorporating spirituality into core counseling courses:

Ideas for classroom application. *Counseling and Values, 50*(1), 63-75.

Brislin, R. W. (1980). Translation and content analysis of oral and written material. In: Triandis,

H.C. and Berry, J. W. (Eds.) *Handbook of cross-cultural psychology: Methodology*, Allyn and Bacon, Boston, 389-444.

Brislin, R. W. (2000). *Understanding Culture's Influence on Behavior*.(2nd Revised ed.).

Wadsworth Publishing.

Bronstein, I., Montgomery, P., & Dobrowolski, S. (2012). PTSD in asylum seeking male

adolescents from Afghanistan. *Journal of Traumatic Stress, 25*, 551–557.

doi:10.1002/jts.21740

Brubaker, R. (2013). Categories of analysis and categories of practice: A note on the study of

Muslims in European countries of immigration. *Ethnic and racial studies, 36*(1), 1-8.

Butts, C. M., & Gutierrez, D. (2018). Expanding intake assessment to incorporate spirituality

using five functional tasks. *Counseling and Values, 63*(2), 147-163.

Byrow, Y., Pajak, R., Specker, P., & Nickerson, A. (2020). Perceptions of mental health and

perceived barriers to mental health help-seeking amongst refugees: A systematic

review. *Clinical psychology review, 75*, 101812.

- Cadge, W., & Davidman, L. (2006). Ascription, Choice, and the Construction of Religious Identities in the Contemporary United States. *Journal for the Scientific Study of Religion*, 45(1), 23-38.
- Caidi, N., & MacDonald, S. (2008). Information practices of Canadian Muslims post 9/11. *Government Information Quarterly*, 25(3), 348–378.
- Camic, P. M. (2021). *Qualitative research in psychology: Expanding perspectives in methodology and design* (pp. xiii-323). American Psychological Association.
- Canadian Institutes of Health Research, Natural Sciences and Engineering Research Council of Canada, and Social Sciences and Humanities Research Council, Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans, December 2018.
- Canadian Psychological Association. (2017). 2017 Canadian Code of Ethics for Psychologists – Fourth Edition. https://cpa.ca/docs/File/Ethics/CPA_Code_2017_4thEd.pdf
- Canda, E. R., Furman, L. D., & Canda, H. J. (2019). *Spiritual diversity in social work practice: The heart of helping*. Oxford University Press, USA.
- Captari, L. E., Hook, J. N., Hoyt, W., Davis, D. E., McElroy-Heltzel, S. E., & Worthington Jr, E. L. (2018). Integrating clients' religion and spirituality within psychotherapy: A comprehensive meta-analysis. *Journal of Clinical Psychology*, 74(11), 1938-1951.

- Captari, L. E., Sandage, S. J., & Vandiver, R. A. (2022). Spiritually integrated psychotherapies in real-world clinical practice: Synthesizing the literature to identify best practices and future research directions. *Psychotherapy, 59*(3), 307.
- Cardozo, B. L., Bilukha, O. O., Crawford, C. A. G., Shaikh, I., Wolfe, M. I., Gerber, M. L., & Anderson, M. (2004). Mental health, social functioning, and disability in postwar Afghanistan. *The Journal of the American Medical Association, 292*(5), 575-584.
- Carpusor, A. G., & Loges, W. E. (2006). Rental discrimination and ethnicity in names 1. *Journal of applied social psychology, 36*(4), 934-952.
- Carroll, J., Epstein, R., Fiscella, K., Volpe, E. M., Diaz, K. A., & Omar, S. (2007). Knowledge and beliefs about health promotion and preventive health care among Somali women in the United States. *Health care for women international, 28* 4, 360-80 .
- Carter, J. D., & Narramore, B. (1979). *The integration of psychology and theology: An introduction*. Zondervan.
- Cashwell, C. S., & Swindle, P. J. (2020). When religion hurts: Supervising cases of religious abuse. In *Trauma-Informed Supervision* (pp. 180-203). Routledge.
- Cashwell, C. S., & Watts, R. E. (2010). The new ASERVIC competencies for addressing spiritual and religious issues in counseling. *Counseling and Values, 55*(1), 2-5.

Castaneda, H., Holmes, S. M., Madrigal, D. S., Young, M. D., Beyeler, N., & Quesada, J. (2015).

Immigration as a social determinant of health. *Annual Review of Public Health, 36*, 375-

392. doi:10.1146/annurev-publhealth-032013-182419

Castelli, F. (2018). Drivers of migration: why do people move? *Journal of Travel Medicine, 25*(1).

<https://doi.org/10.1093/jtm/tay040>

Castillo-Montoya, M. (2016). Preparing for interview research: The interview protocol refinement

framework. *The qualitative report, 21*(5), 811-831.

Central Intelligence Agency. (2018). Afghanistan. *In The world factbook*. Retrieved from

<https://www.cia.gov/library/publications/the-world-factbook/geos/af.html>

Cepeda-Benito, A., & Short, P. (1998). Self-concealment, avoidance of psychological services,

and perceived likelihood of seeking professional help. *Journal of Counseling Psychology,*

45(1), 58–64. <https://doi.org/10.1037/0022-0167.45.1.58>

Chang, L., Pengtao, G., & Xiyao, Z. (2022). Power hedging and faith fetters: The factors of tribe

and religion in Afghanistan's state building. *Frontiers in Political Science, 4*, 976833.

Chappell, N. L., & Lai, D. W. L. (1998). Healthcare service use by Chinese seniors in British

Columbia. *Journal of Cross-Cultural Gerontology, 13*(1), 21–37.

doi:10.1023/A:1006543117301

Charmaz, K. (2001). Qualitative interviewing and grounded theory analysis. In Gubrium, J. F., & Holstein, J. A. *Handbook of interview research* (pp. 675-694). : SAGE Publications, Inc.

doi: 10.4135/9781412973588

Charmaz, K. (2006), *Constructing grounded theory*, Sage, London.

Charmaz, K. (2014). *Constructing grounded theory* (2nd ed., Introducing qualitative methods).

London ; Thousand Oaks, Calif.: Sage.

Chaze, F., Thomson, M. S., George, U., & Guruge, S. (2015). Role of cultural beliefs, religion, and spirituality in mental health and/or service utilization among immigrants in Canada: A scoping review. *Canadian Journal of Community Mental Health, 34*(3), 87-101.

Chen, W., Hall, B. J., Ling, L., & Renzaho, A. M. (2017). Pre-migration and post-migration factors associated with mental health in humanitarian migrants in Australia and the moderation effect of post-migration stressors: Findings from the first wave data of the BNLA cohort study. *The Lancet Psychiatry, 4*(3), 218-229. doi:10.1016/s2215-0366(17)30032-9

Chiang, Y. C., Lee, H. C., Chu, T. L., Han, C. Y., & Hsiao, Y. C. (2020). A spiritual education course to enhance nursing students' spiritual competencies. *Nurse Education in Practice, 49*, 102907.

- Chiu, L., Ganesan, S., Clark, N., & Morrow, M. (2005). Spirituality and treatment choices by South and East Asian women with serious mental illness. *Transcultural Psychiatry* 42(4), 630–656. doi:10.1177/1363461505058920
- Chouinard, J. A., & Cram, F. (2019). *Culturally responsive approaches to evaluation: Empirical implications for theory and practice*. Sage Publications.
- Chung, A. 2011. Canadians less tolerant after 9/11: Poll. September 7. *Vancouver Sun*.
<http://www.vancouversun.com/news/9-11-anniversary/Canadians+less+tolerant+after+Poll/5366720/story.html> (Accessed January 16, 2020).
- Churchland, P. (2002). *Brain-wise : Studies in neurophilosophy*. Cambridge, Mass.: MIT Press.
- Ciftci, A., Jones, N., & Corrigan, P. W. (2013). Mental health stigma in the Muslim community. *Journal of Muslim Mental Health*, 7(1).
- Clapham, A., Robinson, M., 2009. *Realizing the Right to Health*, Zurich: Rüffer & Rub.
- Clarke, A. (2012). Feminism, grounded theory, and situational analysis revisited. In Hesse-Biber, S. N. *Handbook of feminist research: Theory and praxis* (pp. 388-412). Thousand Oaks, CA: SAGE Publications, Inc. doi: 10.4135/9781483384740
- Clarke, A. E., Friese, C., & Washburn, R. S. (2018). *Situational analysis: Grounded theory after the postmodern turn*. Los Angeles: Sage.

- Cleary, M., Horsfall, J., O'Hara-Aarons, M., Jackson, D., & Hunt, G. E. (2011). The views of mental health nurses on continuing professional development. *Journal of Clinical Nursing, 20*(23-24), 3561-3566.
- Coe, J. H., & Hall, T. W. (2010). *Psychology in the spirit: Contours of a transformational psychology*. InterVarsity Press.
- College of Registered Psychotherapists of Ontario. (2011). 2011 College of Registered Psychotherapists of Ontario code of ethics. <https://www.crpo.ca/code-of-ethics/>
- College of Registered Psychotherapists of Ontario. (n.d.). *Standard 1.2 use of terms, titles, and designations*. College of Registered Psychotherapists of Ontario. <https://www.crpo.ca/standard-1-2/>
- Commission on Social Determinants of Health. (2008). *Closing the gap in a generation: Health equity through action on the social determinants of health*. Retrieved from World Health Organization. http://whqlibdoc.who.int/publications/2008/9789241563703_eng.pdf
- Copolov, C., & Knowles, A. (2023). "Everything was stuck in my inside and I just wanted to get it out": Psychological distress, coping, and help-seeking for young adult Australian Hazaras from refugee backgrounds. *Transcultural Psychiatry, 60*(1), 114-124.
- Corbin, J., & Strauss, A. L. (2015). *Basics of qualitative research : Techniques and procedures for developing grounded theory* (Fourth ed.).

- Coyle, A. (2008). Qualitative methods and ‘the (partly) ineffable’ in psychological research on religion and spirituality. *Qualitative Research in Psychology*, 5(1), 56–67.
doi:10.1080/14780880701863583
- Coyle, A. (2016). Introduction to qualitative psychological research. In E. Lyons & A. Coyle (Eds), *Analysing qualitative data in psychology* (2nd ed.) (pp. 9-30). London: SAGE.
- Crawley, H., Duvell, F., Sigona, N., McMahon, S., & Jones, K. (2016) Unpacking a rapidly changing scenario: migration flows, routes and trajectories across the Mediterranean
<http://www.medmig.info/research-brief-01-unpacking-arapidly-changing-scenario/>
- Creswell, J. W., & Poth, C. N. (2018). *Qualitative inquiry & research design : Choosing among five approaches (4th ed.)*. California, SAGE: Thousand Oaks.
- Cross, T. (2002). Spirituality and mental health: A Native American perspective. *Focal Point*, 16(1), 22-24.
- Cuijpers, P., Reijnders, M., & Huibers, M. J. (2019). The role of common factors in psychotherapy outcomes. *Annual review of clinical psychology*, 15, 207-231.
- Cummings, J., & Pargament, K. I. (2010). Anchored by Faith: Religion as a Resilience Factor. In J. W. Reich, A. J. Zautra, & J. S. Hall, (Eds.). *Handbook of adult resilience*. New York. Guilford Publications. Retrieved from <https://ebookcentral.proquest.com>
- Curtis, J. B., Aten, J. D., Smith, W., Davis, E. B., Hook, J. N., Davis, D. E., Van Tongeren, D. R., Shannonhouse, L., DeBlaere, C., Ranter, J., & Cuthbert, A. D. (2017). Collaboration

- between clergy and mental health professionals in postdisaster contexts: Lessons from the Upper Big Branch Mine disaster. *Spirituality in Clinical Practice*, 4(3), 193–204. <https://doi.org/10.1037/scp0000129>
- Czymara, C. S., & Eisentraut, M. (2020). A threat to the occident? Comparing human values of Muslim immigrants, Christian, and non-religious natives in Western Europe. *Frontiers in Sociology*, 5, 538926.
- Dancygier, R. M., & Laitin, D. D. (2014). Immigration into Europe: Economic discrimination, violence, and public policy. *Annual Review of Political Science*, 17, 43-64.
[doi:10.1146/annurev-polisci-082012-115925](https://doi.org/10.1146/annurev-polisci-082012-115925)
- Davies, A., Basten, A., & Frattini, C. (2006). Migration: A Social Determinant of the Health of Migrants (Working paper). Brussels: International Organization for Migration (IOM). ISBN 978 92 9068 355 1
- Davis, D. E., DeBlaere, C., Owen, J., Hook, J. N., Rivera, D. P., Choe, E., ... & Placeres, V. (2018). The multicultural orientation framework: A narrative review. *Psychotherapy*, 55(1), 89.
- Dawi, A. (2023, May 9). Canada on track to host largest Afghan Resettlement Program. VOA. <https://www.voanews.com/a/canada-on-track-to-host-largest-afghan-resettlement-program-/7085788.html#:~:text=More%20than%2030%2C600%20Afghans%20have,under%20the%20new%20Taliban%20regime.>

- de Abreu Costa, M., & Moreira-Almeida, A. (2021). Religion-Adapted Cognitive Behavioral Therapy: A review and description of techniques. *Journal of religion and health*, 1-24.
- Dein, S. (2006) Religion, spirituality and depression: Implications for research and treatment. *Primary Care & Community Psychiatry*, 11, 67–72.
- Del Amo, J., Jarrín, I., García-Fulgueiras, A., Ibáñez-Rojo, V., Alvarez, D., Rodríguez-Arenas, M. Á., ... & Llácer, A. (2011). Mental health in Ecuadorian migrants from a population-based survey: the importance of social determinants and gender roles. *Social psychiatry and psychiatric epidemiology*, 46, 1143-1152.
- Delara, M. (2016). Social Determinants of Immigrant Women’s Mental Health. *Advances in Public Health*, 10+. Retrieved from <http://link.galegroup.com/apps/doc/A513124352/AONE?u=otta77973&sid=AONE&xid=79059a74>
- Delphin, M. E., & Rowe, M. (2008). Continuing education in cultural competence for community mental health practitioners. *Professional Psychology: Research and Practice*, 39(2), 182.
- Demirkaya, N. (2014). *The Influence of Islam on the Mental Health of Muslims living in the West*[Scholarly project]. In *Grin.com*. Retrieved June 10, 2019, from <https://www.grin.com/document/293786>
- Denzin, N. K., & Lincoln, Y. S. (2011). *The SAGE Handbook of Qualitative Research*. Thousand Oaks, CA: Sage.

- DeShaw, P. (2006). Use of the emergency department by Somali immigrants and refugees. *Minnesota Medicine*, 89(8), 42–45.
- Dezorzi, L. W., Raymundo, M. M., Goldim, J. R., & de Oliveira, C. A. V. (2019). Spirituality in the continuing education of healthcare professionals: An approach to palliative care. *Palliative & Supportive Care*, 17(6), 662-667.
- Dhakal, K. (2022). NVivo. *Journal of the Medical Library Association*, 110(2), 270-272.
- Doane, M. J., Elliott, M., & Dyrenforth, P. S. (2014). Extrinsic religious orientation and well-being: Is their negative association real or spurious?. *Review of Religious Research*, 56, 45-60.
- Dobmeier, R. A., & Reiner, S. M. (2012). Spirituality in the counselor education curriculum: A national survey of student perceptions. *Counseling and Values*, 57(1), 47-65.
- Donahue, M. J. (1985). Intrinsic and extrinsic religiousness: Review and meta-analysis. *Journal of Personality and Social Psychology*, 48(2), 400–419.
- Doran, J. M., Safran, J. D., & Muran, J. C. (2017). An investigation of the relationship between the alliance negotiation scale and psychotherapy process and outcome. *Journal of Clinical Psychology*, 73(4), 449-465.
- Dossa, P. (2008). Creating politicized spaces: Afghan immigrant women's stories of migration and displacement. *Affilia*, 23(1), 10-21.

- Duckham, B. C., & Schreiber, J. C. (2016). Bridging worldviews through phenomenology. *Social work and Christianity*, 43(4), 55.
- Duggal, C., & Sriram, S. (2022). Locating the sacred within the therapeutic landscape: Influence of therapists' religious and spiritual beliefs on psychotherapeutic practice. *Spirituality in Clinical Practice*, 9(3), 186.
- Dupper, D. R., Forrest-Bank, S., & Lowry-Carusillo, A. (2015). Experiences of religious minorities in public school settings: Findings from focus groups involving Muslim, Jewish, Catholic, and Unitarian Universalist youths. *Children & Schools*, 37(1), 37-45.
- Dürlinger, F., & Pietschnig, J. (2022). Meta-analyzing intelligence and religiosity associations: Evidence from the multiverse. *Plos one*, 17(2), e0262699.
- Durrant, E. J. (2005). 'Corporal Punishment: Prevalence, Predictors and Implications for Child Behaviour and Development'. In S. N. Hart, J. Durrant, P. Newell, and F. C. Power. (ed). *Eliminating Corporal Punishment: The Way Forward to Constructive Child Discipline*. Paris: UNESCO Publications.
- Durrant, R., & Poppelwell, Z., (2017). The dark side of religion? prejudice, inter-group conflict, and War. In R. Durrant, & Z. Poppelwell. (Eds). *Religion, Crime and Punishment: An Evolutionary Perspective*, 89-126. Palgrave Macmillan, Cham.
- https://doi.org/10.1007/978-3-319-64428-8_4

- Ebaugh, H. R., & Chafetz, J. S. (2000). *Religion and the new immigrants: Continuities and adaptations in immigrant congregations*. Walnut Creek, CA: AltaMira Press.
- Eck, B. E. (1996). Integrating the integrators: An organizing framework for a multifaceted process of integration. *Journal of Psychology and Christianity, 15*(2), 101–115.
- Edwards, S. D. (2013). Holistic psychology: A brief primer. *Journal of Psychology in Africa, 23*(3), 531-537.
- Eid, M. (2014a) Perceptions about Muslims in Western Societies. In: Eid M., Karim K.H. (Eds) *Re-Imagining the Other*. Palgrave Macmillan, New York.
- Eid, M. (2014b) Public Policy and Muslims in Western Societies. In: K. H. Karim, M. Eid (eds) *Engaging the Other*. Palgrave Macmillan, New York.
- El-Geledi, S., & Bourhis, R. Y. (2012). Testing the impact of the Islamic veil on intergroup attitudes and host community acculturation orientations toward Arab Muslims. *International Journal of Intercultural Relations, 36*(5), 694-706.
- Elshahat, S., & Moffat, T. (2022). Mental health triggers and protective factors among Arabic-speaking immigrants and refugees in North America: a scoping review. *Journal of Immigrant and Minority Health, 24*(2), 489-505.
- Emadi, H. (2005). *Culture and customs of Afghanistan*. Westport, CT: Greenwood Press.
- Emel, G. E. N. Ç. (2022). Anti-Muslim Hatred in the US: Couple Therapy Implications for Discriminated Muslim Couples. *Spiritual Psychology and Counseling, 7*(1), 7-21.

Ennaji, M. (2016). *New Horizons of Muslim Diaspora in North America and Europe*. Palgrave Macmillan US.

Environics Institute. (2016). *Focus Canada report: Canadian public opinion about immigration and multiculturalism*. Toronto, ON. Retrieved from https://www.environicsinstitute.org/docs/default-source/project-documents/focus-canada-spring-2019/environics-institute---focus-canada-spring-2019-survey-on-immigration-and-refugees---final-report.pdf?sfvrsn=8dd2597f_2

Erickson, C. D., & Al-Timimi, N. R. (2001). Providing mental health services to Arab Americans: Recommendations and considerations. *Cultural Diversity and Ethnic Minority Psychology*, 7, 308–327. <http://dx.doi.org/10.1037/1099-9809.7.4.308>

Exline, J. J., & Rose, E. (2005). Religious and Spiritual Struggles. In R. F. Paloutzian & C. L. Park (Eds.), *Handbook of the psychology of religion and spirituality* (pp. 315–330). The Guilford Press.

Exline, J. J., & Rose, E. D. (2014). Religious and spiritual struggles. In R. F. Paloutzian, & C. L. Park (Eds.), *Handbook of the psychology of religion and spirituality* (pp. 380– 398). New York: Guilford Publications.

Falicov, C .J. (2007). Working with transnational immigrants: expanding meanings of family, community, and culture. *Family process*, 46 2, 157-71.

- Falicov, C. J. (2009). Religion and spiritual traditions in immigrant families: Significance for Latino health and mental health. In F. Walsh (Ed.), *Spiritual resources in family therapy* (pp. 156-173). New York, NY, US: Guilford Press.
- Fallot, R. D., & Blanch, A. K. (2013). Religious and spiritual dimensions of traumatic violence. In K. I. Pargament, A. Mahoney & E. P. Shafranske (Eds.), *APA handbook of psychology, religion, and spirituality (vol 2): An applied psychology of religion and spirituality*. (pp. 371-387). Washington: American Psychological Association, American Psychological Association, Washington, DC. doi:<http://dx.doi.org.proxy.bib.uottawa.ca/10.1037/14046-019>
- Fazel, M., Wheeler, J., & Danesh, J. (2005). Prevalence of serious mental disorder in 7000 refugees resettled in western countries: A systematic review. *The Lancet*, 365(9467), 1309-1314. doi:10.1016/S0140-6736(05)61027-6
- Feldmann, C. T., Bensing, J. M., & de Ruijter, A. (2007). Worries are the mother of many diseases: General practitioners and refugees in the Netherlands on stress, being ill and prejudice. *Patient Education and Counseling*, 65(3), 369-380.
doi:10.1016/j.pec.2006.09.005
- Fiddian-Qasmiyeh, E., & Qasmiyeh, Y. M. (2010). Muslim asylum-seekers and refugees: Negotiating identity, politics and religion in the UK. *Journal of Refugee Studies*, 23(3), 294-314.

- Fisher-Borne, M., Cain, J. M., & Martin, S. L. (2015). From mastery to accountability: Cultural humility as an alternative to cultural competence. *Social Work Education, 34*(2), 165–181.
<http://dx.doi.org/10.1080/02615479.2014.977244>
- Fleuridas, C., & Krafcik, D. (2019). Beyond four forces: The evolution of psychotherapy. *Sage Open, 9*(1), 2158244018824492.
- Flynn, P. M., Betancourt, H., Emerson, N. D., Nunez, E. I., & Nance, C. M. (2020). Health professional cultural competence reduces the psychological and behavioral impact of negative healthcare encounters. *Cultural Diversity and Ethnic Minority Psychology, 26*(3), 271.
- Franklin, M. D., Schlundt, D. G., & Wallston, K. A. (2008). Development and validation of a religious health fatalism measure for the African-American faith community. *Journal of Health Psychology, 13*(3), 323-335.
- Fransen, S., & De Haas, H. (2022). Trends and patterns of global refugee migration. *Population and Development Review, 48*(1), 97-128.
- Freire, J., Moleiro, C., Rosmarin, D. H., & Freire, M. (2019). A call for collaboration: Perception of religious and spiritual leaders on mental health (A Portuguese sample). *Journal of Spirituality in Mental Health, 21*(1), 55-75.
- Frunza, M., Frunza, S., & Grad, N. O. (2019). The role of spirituality in therapeutic practices. *Journal for the Study of Religions and Ideologies, 18*(53), 60-74.

- Fuller, A. (2008). *Psychology and religion : Classical theorists and contemporary developments* (4th ed.). Lanham, Md.: Rowman & Littlefield.
- Fuller, A. R. (1994). *Psychology and religion: Eight points of view* (3rd ed.). Lanham, MD: Littlefield Adams Quality Paperbacks.
- Fung, K., & Guzder, J. (2021). Canadian immigrant mental health. *Mental Health, Mental Illness and Migration*, 187-207.
- Fung, K., & Wong, Y.-L. R. (2007). Factors Influencing Attitudes Towards Seeking Professional Help Among East and Southeast Asian Immigrant and Refugee Women. *International Journal of Social Psychiatry*, 53(3), 216–231. <https://doi.org/10.1177/0020764006074541>
- Gabbert, F., Hope, L., Luther, K., Wright, G., Ng, M., & Oxburgh, G. (2021). Exploring the use of rapport in professional information-gathering contexts by systematically mapping the evidence base. *Applied Cognitive Psychology*, 35(2), 329-341.
- Gall, T. L., & Guirguis-Younger, M. (2013). Religious and spiritual coping: Current theory and research.
- Gallup, A. (1999). *The Gallup poll cumulative index : Public opinion, 1935-1997*. Wilmington, Del.: Scholarly Resources.
- Garrusi, B., Garrusi, S., Amirkafi, A., Moqaddasi Amiri, M., & Baneshi, M. R. (2022). Mental Disorders in Iranian and Afghan Immigrant Women: the impact of acculturation. *Journal of Kerman University of Medical Sciences*, 29(3), 226-236.

- Garssen, B., Visser, A., & Pool, G. (2021). Does spirituality or religion positively affect mental health? Meta-analysis of longitudinal studies. *The International Journal for the Psychology of Religion, 31*(1), 4-20.
- Gartner, J., Larson, D., & Allen, G. (1991). Religious commitment and mental health: A review of the empirical literature. *Journal of Psychology and Theology, 19*, 6–25.
- Gauthier, K., Christopher, A., & Walter, M. (2006). Religiosity, religious doubt, and the need for cognition: Their interactive relationship with life satisfaction. *Journal of Happiness Studies, 7*, 139–154.
- George, M. (2012). Migration Traumatic Experiences and Refugee Distress: Implications for Social Work Practice. *Clinical Social Work Journal, 40*(4), 429-437. doi:10.1007/s10615-012-0397-y
- Gerritsen, A. A. M., Bramsen, I., Devillé, W., Willigen, L. H. M., Hovens, J. E., & Ploeg, H. M. (2006). Physical and mental health of afghan, Iranian and Somali asylum seekers and refugees living in the Netherlands. *Social Psychiatry and Psychiatric Epidemiology, 41*(1), 18-26. doi:10.1007/s00127-005-0003-5
- Ghaffar-Kucher, A. (2015). ‘Narrow-minded and oppressive’ or a ‘superior culture’? Implications of divergent representations of Islam for Pakistani-American youth. *Race Ethnicity and Education, 18*(2), 202-224.

- Gilchrist, V. J. (1992). Key informant interviews. In B. F. Crabtree & W. L. Miller (Eds.), *Doing qualitative research* (pp. 70–89). Thousand Oaks, CA: Sage Publications, Inc.
- Gladding, S. T., & Crockett, J. E. (2019). Religious and spiritual issues in counseling and therapy: Overcoming clinical barriers. *Journal of Spirituality in Mental Health, 21*(2), 152-161.
- Gladwell, C., & Elwyn, H. (2012). Broken Futures: Young Afghan asylum seekers in the UK and in their country of origin. *London: Refugee Support Network*.
- Glaser, B. G. (1992). *Emergence vs forcing: Basics of Grounded Theory analysis*. Mill Valley, CA: Sociology Press.
- Glaser, B. G., & Strauss, A. L. (1967). *Discovery of Grounded Theory: Strategies for qualitative research*. Aldine Transaction. London. UK
- Glock, C. Y. (1962). On the study of religious commitment. *Religious Education, 57*(4, Res. Suppl.), 98–110. <https://doi.org/10.1080/003440862057S407>
- Goforth, A. N., Denis, D. J., Oka, E. R., & Leong, F. T. (2014). Acculturation, acculturative stress, religiosity and psychological adjustment among Muslim Arab American adolescents. *Journal of Muslim Mental Health, 8*(2), 3-19.
- Gokani, R., Wiebe, S., Sherzad, H., & Akesson, B. (2023). “We’re Looking for Support from Allah”: A Qualitative Study on the Experiences of Trauma and Religious Coping among Afghan Refugees in Canada Following the August 2021 Withdrawal. *Religions, 14*(5), 645.

- Gold, J. M. (2013). Spirituality and self-actualization: considerations for 21st-century counselors. *The Journal of Humanistic Counseling, 52*(2), 223-234.
- Golnaraghi, G., & Dye, K. (2016). Discourses of contradiction: A postcolonial analysis of Muslim women and the veil. *International Journal of Cross Cultural Management, 16*(2), 137-152.
- Golnaraghi, G., & Mills, A. J. (2013). Unveiling the myth of the Muslim woman: a postcolonial critique. *Equality, Diversity and Inclusion: An International Journal, 32*(2), 157-172.
- Gone, J. P. (2007). “We never was happy living like a Whiteman”: Mental health disparities and the postcolonial predicament in American Indian communities. *American Journal of Community Psychology, 40*(3-4), 290–300. <https://doi.org/10.1007/s10464-007-9136-x>
- Gong, F., Xu, J., Fujishiro, K., & Takeuchi, D. T. (2011). A life course perspective on migration and mental health among Asian immigrants: The role of human agency. *Social Science & Medicine, 73*(11), 1618-1626. doi:10.1016/j.socscimed.2011.09.014
- Gonsiorek, J. C., Richards, P. S., Pargament, K. I., & McMinn, M. R. (2009). Ethical challenges and opportunities at the edge: Incorporating spirituality and religion into psychotherapy. *Professional Psychology: Research and Practice, 40*, 385–395.
- Goodman, M. A., & Dyer, W. J. (2023). How Does Religious Faith Impact Positive Youth Outcomes. *Religions, 14*(7), 881.

Government of Canada, R. and C. C. (2023, May 26). Government of Canada. Canada.ca.

<https://www.canada.ca/en/immigration-refugees-citizenship/services/refugees/afghanistan.html>

Government of Ontario. (2023, May 6). Children's aid societies. Government of Ontario.

<https://www.ontario.ca/page/childrens-aid-societies#:~:text=Children%27s%20aid%20societies%20provide%20child,taking%20steps%20to%20protect%20them>

Graham, J. R., Bradshaw, C., & Trew, J. L. (2009). Adapting social work in working with Muslim clients. *Social Work Education, 28*(5), 544-561.

Graham, J. R., Bradshaw, C., & Trew, J. L. (2010). Cultural considerations for social service agencies working with Muslim clients. *Social Work, 55*(4), 337-346.

Gray, L. M., Wong-Wylie, G., Rempel, G. R., & Cook, K. (2020). Expanding qualitative research interviewing strategies: Zoom video communications. *The qualitative report, 25*(5), 1292-1301.

Griner, D., & Smith, T. B. (2006). Culturally adapted mental health intervention: A meta-analytic review. *Psychotherapy: Theory, research, practice, training, 43*(4), 531.

Guest, G., Namey, E., & Mitchell, M. (2013). *Collecting qualitative data*. 55 City Road, London: SAGE Publications, Ltd doi: 10.4135/9781506374680

- Gülşen, C., Knipscheer, J., & Kleber, R. (2010). The impact of forced migration on mental health: A comparative study on posttraumatic stress among internally displaced and externally migrated Kurdish women. *Traumatology, 16*(4), 109-116.
- Gunnerson, K. C. (2021). *The Effect of Religiosity and Counselor Responsivity on the Process and Outcome of Counseling* (Doctoral dissertation, The University of Utah).
- Guntrip, H. (1969). Religion in relation to personal integration. *British Journal of Medical Psychology, 42*(4), 323–333. <https://doi.org/10.1111/j.2044-8341.1969.tb02086.x>
- Haasen, C., Sinaa, M., & Reimer, J. (2008). Alcohol Use Disorders Among Afghan Migrants in Germany. *Substance Abuse, 29*(3), 65-70.
- Hackney, C. H., & Sanders, G. S. (2003). Religiosity and mental health: A metanalysis of recent studies. *Journal for the Scientific Study of Religion, 42*, 43–55.
- Hage, S. M., Hopson, A., Siegel, M., Payton, G., & DeFanti, E. (2006). Multicultural training in spirituality: An interdisciplinary review. *Counseling and Values, 50*(3), 217-234.
- Hainmueller, J., Hangartner, D., & Lawrence, D. (2016). When lives are put on hold: Lengthy asylum processes decrease employment among refugees. *Science Advances, 2*(8), E1600432.
- Hall, T. W., & Fujikawa, A. M. (2013). God image and the sacred. In K. I. Pargament, J. J. Exline, & J. W. Jones (Eds.), *APA handbook of psychology, religion, and spirituality* (Vol. 1):

Context, theory, and research (pp. 277–292). American Psychological Association. <https://doi.org/10.1037/14045-015>

Hameed, S., Sadiq, A., & Din, A. U. (2018). The increased vulnerability of refugee population to mental health disorders. *Kansas journal of medicine, 11*(1), 20.

Hamidi, F., Bagherzadeh, Z., & Gafarzadeh, S. (2010). The Role of Islamic Education in Mental Health. *Procedia - Social and Behavioral Sciences, 5*, 1991-1996.

Hamrah, M. S., Hoang, H., Mond, J., Pahlavanzade, B., Charkazi, A., & Auckland, S. (2021). The prevalence and correlates of symptoms of post-traumatic stress disorder (PTSD) among resettled Afghan refugees in a regional area of Australia. *Journal of Mental Health, 30*(6), 674-680.

Hansson, E., Tuck, A., Lurie, S., & McKenzie, K., for the Task Group of the Services Systems Advisory Committee, Mental Health Commission of Canada. (2009). *Improving mental health services for immigrant, refugee, ethno- cultural and racialized groups: Issues and options for service improvement*. Retrieved from the Mental Health Commission of Canada website:
https://www.mentalhealthcommission.ca/sites/default/files/Diversity_Issues_Options_Report_ENG_0_1.pdf

Haque, A. (2004). Religion and Mental Health: The Case of American Muslims. *Journal of Religion and Health, 43*(1), 45-58.

- Harris, E. S. (2000). God, Buber and the practice of Gestalt therapy. *Gestalt Journal*, 23(1), 39-62.
- Harris, E. S. (2000). God, Buber and the practice of gestalt therapy. *Gestalt Journal*, 23, 39-62.
- Harris, K. A., Randolph, B. E., & Gordon, T. D. (2016). What do clients want? Assessing spiritual needs in counseling: A literature review. *Spirituality in Clinical Practice*, 3(4), 250.
- Harwood, A. (1981). *Ethnicity and medical care*. Cambridge, Mass: Harvard University Press.
- Hasan, N., Mitschke, D. B., & Ravi, K. E. (2018). Exploring the role of faith in resettlement among Muslim Syrian refugees. *Journal of Religion & Spirituality in Social Work: Social Thought*, 37(3), 223-238.
- Hassan, A. N., Ragheb, H., Malick, A., Abdullah, Z., Ahmad, Y., Sunderji, N., & Islam, F. (2021). Inspiring Muslim minds: Evaluating a spiritually adapted psycho-educational program on addiction to overcome stigma in Canadian Muslim communities. *Community mental health journal*, 57, 644-654.
- Hassan, G., Kirmayer, L. J., Mekki-Berrada, A., Quosh, C., El Chammay, R., Deville-Stoetzel, J. B., . . . Ventevogel, P. (2015). *Culture, context and the mental health and psychosocial wellbeing of Syrians: A review for mental health and psychosocial support staff working with Syrians affected by armed conflict*. Retrieved from the UN High Commissioner for Refugees website: <https://www.unhcr.org/55f6b90f9.pdf>

Haverkamp, B. E., & Young, R. A. (2007). Paradigms, purpose, and the role of the literature:

Formulating a rationale for qualitative investigations. *The Counseling Psychologist*, 35(2),

265–294. doi:10.1177/0011000006292597

Heeren, M., Wittmann, L., Ehlert, U., Schnyder, U., Maier, T., & Müller, J. (2014).

Psychopathology and resident status – comparing asylum seekers, refugees, illegal

migrants, labor migrants, and residents. *Comprehensive Psychiatry*, 55(4), 818-825.

doi:10.1016/j.comppsy.2014.02.003

Heim, E., & Kohrt, B. A. (2019). Cultural adaptation of scalable psychological

interventions. *Clinical Psychology in Europe*, 1(4), 1-22.

Helly, D. 2004. Are Muslims discriminated against in Canada since September 2001? *Journal of*

Canadian Studies 36(1): 24-47.

Henwood, K. L., & Pidgeon, N. F. (1992). Qualitative research and psychological

theorizing. *British journal of psychology*, 83(1), 97-111.

Henwood, K., & Pidgeon, N. (2003). Grounded theory in psychological research. In P. M. Camic,

J. E. Rhodes & L. Yardley (Eds.), *Qualitative research in psychology: Expanding*

perspectives in methodology and design; qualitative research in psychology: Expanding

perspectives in methodology and design. (pp. 131-155, Chapter xvi, 315 Pages

Herberg, W. (1983). *Protestant, Catholic, Jew : An essay in American religious sociology*.

Chicago: University of Chicago Press.

- Hernandez, E. I., & Sandman, A. R. (2012). The gatekeepers: Clergy involvement in referrals and collaboration with mental health and substance abuse professionals. *Journal of Social Work and Christianity, 27*.
- Hill, P. C., Pargament, K. I., Hood, R. W., McCullough, J. M. E., Swyers, J. P., Larson, D. B., & Zinnbauer, B. J. (2000). Conceptualizing religion and spirituality: Points of commonality, points of departure. *Journal for the theory of social behaviour, 30*(1), 51-77.
- Hirschman, C. (2004). The Role of Religion in the Origins and Adaptation of Immigrant Groups in the United States. *International Migration Review, 38*(3), 1206-1233.
- Hodge, D. R. (2000). Spiritual ecomaps: A new diagrammatic tool for assessing marital and family spirituality. *Journal of Marital and Family Therapy, 26*(2), 217-228.
- Hodge, D. R. (2001). Spiritual assessment: A review of major qualitative methods and a new framework for assessing spirituality. *Social Work, 46*(3), 203–214. <https://doi.org/10.1093/sw/46.3.203>
- Hodge, D. R. (2001). Spiritual assessment: A review of major qualitative methods and a new framework for assessing spirituality. *Social work, 46*(3), 203-214.
- Hodge, D. R. (2001). Spiritual genograms: A generational approach to assessing spirituality. *Families in Society, 82*(1), 35-48.
- Hodge, D. R. (2004). Why conduct a spiritual assessment? A theoretical foundation for assessment. *Advances in Social Work, 5*(2), 183-196.

- Hodge, D. R. (2005). Spiritual lifemaps: A client-centered pictorial instrument for spiritual assessment, planning, and intervention. *Social work, 50*(1), 77-87.
- Hodge, D. R. (2013). Assessing spirituality and religion in the context of counseling and psychotherapy. In K. I. Pargament, A. Mahoney, & E. P. Shafranske (Eds.), *APA handbook of psychology, religion, and spirituality (Vol. 2): An applied psychology of religion and spirituality* (pp. 93–123). American Psychological Association. <https://doi.org/10.1037/14046-005>
- Hodge, D. R. (2015). *Spiritual assessment in social work and mental health practice*. Columbia University Press.
- Hodge, D. R., Zidan, T., & Husain, A. (2016). Depression among Muslims in the united states: Examining the role of discrimination and spirituality as risk and protective factors. *Social Work, 61*(1), 45-52. doi:10.1093/sw/swv055
- Hodge, D., Baughman, L., & Cummings, J. (2006). Moving Toward Spiritual Competency. *Journal of Social Service Research, 32*(4), 211-231.
- Hoffman, L., Cleare-Hoffman, H., & Jackson, T. (2014). Humanistic psychology and multiculturalism. *The handbook of humanistic psychology*, 41-55.
- Holmberg, Å., Jensen, P., & Ulland, D. (2017). To make room or not to make room: Clients' narratives about exclusion and inclusion of spirituality in family therapy practice. *Australian and New Zealand Journal of Family Therapy, 38*(1), 15-26.

- Hook, J. N., Davis, D. E., Owen, J., Worthington, E. L., Jr., & Utsey, S. O. (2013). Cultural humility: Measuring openness to culturally diverse clients. *Journal of Counseling Psychology, 60*(3), 353–366. <http://dx.doi.org/10.1037/a0032595>
- Hook, J. N., Davis, D., Owen, J., & DeBlaere, C. (2017). *Cultural humility: Engaging diverse identities in therapy*. American Psychological Association.
- Hook, J. N., Worthington, E. L., Jr., Davis, D. E., Gartner, A. L., Jennings, D. J., II, & Hook, J. P. (2010). Empirically supported religious and spiritual therapies. *Journal of Clinical Psychology, 66*, 46–72.
- Hook, J. N., Worthington, E. L., Jr., Davis, D. E., Jennings, D. J. II, Gartner, A. L., & Hook, J. P. (2010). Empirically supported religious and spiritual therapies. *Journal of Clinical Psychology, 66*(1), 46–72.
- Hope, E. C., Brugh, C. S., & Nance, A. (2019). In search of a critical stance: Applying qualitative research practices for critical quantitative research in psychology. *Community Psychology in Global Perspective, 5*(2), 63-69.
- Humam, F., McBryde-Redzovic, A., Mahoui, I., Ali, S., Abolaban, H., Zia, B., & Awaad, R. (2023). The Role of Muslim Religious Leaders in Mental Health: A Community-Based Participatory Research Study in the San Francisco Bay Area. *Pastoral Psychology, 1-18*.
- Husain, A., & Howard, S. (2017). Religious microaggressions: A case study of Muslim Americans. *Journal of Ethnic & Cultural Diversity in Social Work, 26*(1-2), 139-152.

- Hutchison, A., Johnston, L., & Breckon, J. (2011). Grounded Theory-Based Research within Exercise Psychology: A Critical Review. *Qualitative Research in Psychology, 8*(3), 247-272.
- Hynie, M. (2018). The Social Determinants of Refugee Mental Health in the Post-Migration Context: A Critical Review. *The Canadian Journal of Psychiatry, 63*(5), 297-303.
- Hynie, M., Korn, A., & Tao, D. (2016). Social context and social integration for Government Assisted Refugees in Ontario, Canada. In M. Poteet & S. Nourpanah (Eds.), *After the flight: The dynamics of refugee settlement and integration* (pp. 183–227). Newcastle upon Tyne, UK: Cambridge Scholars.
- Ibrahim, M., & Mojab, F. (2023). Healing Through Faith: The Role of Spiritual Healers in Providing Psychosocial Support to Canadian Muslims. *Journal of Muslim Mental Health, 17*(1)..
- Idler, E. L. (1987). Religious involvement and the health of the elderly: Some hypotheses and an initial test. *Social Forces, 66*, 226-238.
- Idler, E. L., Musick, M. A., Ellison, C. G., George, L. K., Krause, N., Ory, M. G., Pargament, K. I., Powell, L. H., Underwood, L. G., & Williams, D. R. (2003). Measuring multiple dimensions of religion and spirituality for health research: Conceptual background and findings from the 1998 General Social Survey. *Research on Aging, 25*(4), 327–365. <https://doi.org/10.1177/0164027503025004001>

Ifversen, J. (2008). Who are the Westerners?. *International Politics*, 45, 236-253.

Immigration and Refugee Board of Canada. (2018). Retrieved February 15, 2018, from

<http://www.irb-cisr.gc.ca/eng/Pages/index.aspx>

Immigration, Refugees and Citizenship Canada. (2023, April 12). Canada marks significant milestone, welcoming over 30,000 vulnerable Afghans. [Press release].

<https://www.canada.ca/en/immigration-refugees-citizenship/news/2023/04/canada-marks-significant-milestone-welcoming-over-30000vulnerable-afghans.html>

Institute for Health Metrics and Evaluation. (2017). *Afghanistan*. Retrieved from

<http://www.healthdata.org/afghanistan>.

International Organization for Migration (2004). *Migrant Health for the Benefit of All*

(Information document - 88th Session of the Council MC/INF/275). Retrieved from

http://governingbodies.iom.int/system/files/jahia/webdav/shared/shared/mainsite/about_iom/en/council/88/MC_INF_275.pdf

International Organization for Migration. (2019). Retrieved April, 2019, from

<https://www.iom.int/>

IOM. (2017). Social Determinants of Migrant Health. Retrieved May 10, 2019, from

<https://www.iom.int/social-determinants-migrant-health>

Ipsos. (2016). *Global Views on Immigration and the Refugee Crisis*(Rep.). Paris: IPSOS.

Retrieved April 17, 2019, from <https://www.ipsos.com/sites/default/files/migrations/en->

uk/files/Assets/Docs/Polls/ipsos-global-advisor-immigration-and-refugees-2016-charts.pdf.

ISIN code FR0000073298.

Isgandarova, N. (2014). The evolution of Islamic spiritual care and counseling in Ontario in the context of the college of registered psychotherapists and registered mental health therapists of Ontario. *Journal of Psychology & Psychotherapy*, 4(3), 1.

Islam, F., Qasim, S., Ali, M., Hynie, M., Shakya, Y., & McKenzie, K. (2023). South Asian youth mental health in Peel Region, Canada: Service provider perspectives. *Transcultural Psychiatry*, 60(2), 368-382.

Islam, N. S., Khan, S., Kwon, S., Jang, D., Ro, M., & Trinh-Shevrin, C. (2010). Methodological issues in the collection, analysis, and reporting of granular data in Asian American populations: historical challenges and potential solutions. *Journal of health care for the poor and underserved*, 21(4), 1354-81.

Jacinto, L. (2006). Abandoning the wardrobe and reclaiming religion in the discourse on Afghan women's Islamic rights. *Signs: Journal of Women in Culture and Society*, 32(1), 9-14.

Jacob, E. (1987). Qualitative Research Traditions: A Review. *Review of Educational Research*, 57(1), 1-50.

Jahed, M. (2023). A Trauma-Informed Lens to Support Afghan Refugee Mental Health Needs: a Student's Perspective. *Academic Psychiatry*, 47(1), 104-105.

- Jarvis, G. E., Kirmayer, L. J., Weinfeld, M., & Lasry, J. (2005). Religious practice and psychological distress: The importance of gender, ethnicity and immigrant status. *Transcultural Psychiatry*, 42(4), 657–675.
- Jastrzębski, A. (2021). Models of Psycho-Spiritual Care: Responding to the Spiritual Needs of Our Contemporaries. *Studia Elckie*, 23(2), 173-188.
- Jastrzębski, A. K. (2022). The challenging task of defining spirituality. *Journal of Spirituality in Mental Health*, 24(2), 113-131.
- Jastrzębski, A. K. (2023). *Integrating Spirituality Into Counseling: Methods and Practices*. Taylor & Francis.
- Jewish Family Services of Ottawa. (2022, December 14). *Home*. JFS Ottawa.
<https://www.jfsottawa.com/>
- Jibiliza, X. (2021). The Evolution of Pastoral Care Ministry through the Ages. *Pharos Journal of Theology*, 102.
- Johnson, E. L., & Jones, S. L. (2000). *Psychology & Christianity: Four views*. InterVarsity Press.
- Johnson, E. L., & Jones, S. L. (Eds.). (2000). *Psychology & Christianity: Four views*. InterVarsity Press.
- Johnson, J. C. (1990). *Selecting ethnographic informants* (Vol. 22). Thousand Oaks, CA: Sage Publications, Inc.

Johnson, J. L., Bottorff, J. L., Balneaves, L. G., Grewal, S., Bhagat, R., Hilton, B. A., & Clarke, H.

(1999). South Asian women's' views on the causes of breast cancer: Images and

explanations. *Patient Education and Counseling*, 37(3), 243-254.

[http://dx.doi.org/10.1016/S0738-3991\(98\)00118-9](http://dx.doi.org/10.1016/S0738-3991(98)00118-9)

Jones, J. (2008). *Blood that cries out from the earth: The psychology of religious terrorism*. New

York, NY: Oxford University Press. doi:10.1093/acprof:oso/9780195335972.001.0001

Jones, R. S. (2019). *Spirit in session: Working with your client's spirituality (and your own) in*

psychotherapy. Templeton Foundation Press.

Jones-Smith, E. (2019). *Theories of counseling and psychotherapy: An integrative approach*. Sage

Publications.

Kahn, S. (2015). Experiences of faith for gender role non-conforming Muslims in resettlement:

Preliminary considerations for social work practitioners. *The British Journal of Social*

Work, 45(7), 2038-2055.

Kale, E., & Syed, H. R. (2010). Language barriers and the use of interpreters in the public health

services. A questionnaire-based survey. *Patient Education and Counseling*, 81(2), 187-

191. doi:10.1016/j.pec.2010.05.002

Karim, K. H. (2009). Changing perceptions of Islamic authority among Muslims in Canada, the

United States and the United Kingdom. *IRPP Choices*, 15(2), 1-30.

- Karim, K., & Eid, M. (Eds.). (2014). *Engaging the other : Public policy and Western-Muslim intersections* (First ed.). New York. Palgrave Macmillan. DOI <https://doi.org/10.1057/9781137403698>
- Kasmani, I. (2017). *Global Trends: Forced Displacement in 2016* (Rep.). Geneva: United Nations High Commission for Refugees.
- Kay, W., & Francis, L. (2006). Suicidal ideation among young people in the UK: Churchgoing as an inhibitory influence? *Mental Health, Religion & Culture*, 9, 127–140.
- Kenny, M., & Fourie, R. (2014). Tracing the history of Grounded Theory methodology: From formation to fragmentation. *The Qualitative Report; Fort Lauderdale*, 19(52), 1–9
- Keyes, E. (2000). Mental Health Status In Refugees: An Integrative Review Of Current Research. *Issues in Mental Health Nursing*, 21(4), 397-410.
- Khan, A., Khanlou, N., Stol, J., & Tran, V. (2018). Immigrant and refugee youth mental health in Canada: A scoping review of empirical literature. *Today's youth and mental health: Hope, power, and resilience*, 3-20.
- Khan, E., & Aftab, S. (2019). Intrinsic and Extrinsic Religious Orientation and Mental Health. *Pakistan Journal of Psychology*, 50(1).
- Khanlou, N., Koh, J. G., & Mill, C. (2008). Cultural identity and experiences of prejudice and discrimination of Afghan and Iranian immigrant youth. *International Journal of Mental Health and Addiction*, 6, 494-513.

- Khosravi, S. (2012). White masks/Muslim names: Immigrants and name-changing in Sweden. *Race & class*, 53(3), 65-80.
- Koenig, H. (1994). *Aging and God : Spiritual pathways to mental health in midlife and later years* . New York: Routledge, <https://doi.org/10.4324/9781315820422>
- Koenig, H. G. (1997). Is religion good for your health?: The effects of religion on physical and mental health. New York: Haworth Pastoral Press.
- Koenig, H. G. (1998). *Handbook of Religion and Mental Health*. San Diego: Academic Press.

doi:<https://doi.org/10.1016/B978-0-12-417645-4.X5064-0>
- Koenig, H. G. (Ed.). (1998). *Handbook of religion and mental health*. Academic Press.
- Koenig, H. G., King, D. E., & Carson, V. B. (2012). *Handbook of religion and health*. New York: Oxford University Press.
- Koenig, H. G., King, D. E., & Carson, V. B. (2012). *Handbook of Religion and Health*(2nd ed.). New York: Oxford University Press.
- Koenig, H. G., King, D., & Carson, V. B. (2012). *Handbook of religion and health*. Oxford University Press.
- Koenig, H. G., McCullough, M. E., & Larson, D. B. (2001). *Handbook of religion and health*. Oxford University Press. <https://doi.org/10.1093/acprof:oso/9780195118667.001.0001>

- Koenig, H. G., Zaben, F. A., & Khalifa, D. A. (2012). Religion, spirituality and mental health in the west and the middle east. *Asian Journal of Psychiatry*, *5*(2), 180-182.
doi:10.1016/j.ajp.2012.04.004
- Kohlenberger, J., Buber-Ennsner, I., Rengs, B., Leitner, S., & Landesmann, M. (2019). Barriers to health care access and service utilization of refugees in Austria: Evidence from a cross-sectional survey. *Health Policy*, *123*(9), 833-839.
- Korzinski, D. (2023, March 20). Islamophobia in Canada: Four mindsets indicate negativity is nationwide, most intense in Quebec. <https://angusreid.org/islamophobia-canada-quebec/>
- Krause, N., & Tran, T. V. (1989). Stress and religious involvement among older blacks. *Journal of Gerontology: Social Sciences*, *44*, S4-S13.
- Kurien, P. (2001). Religion, ethnicity and politics: Hindu and Muslim Indian immigrants in the United States. *Ethnic and Racial Studies*, *24*(2), 263-293.
- Laban, C. J., Gernaat, H. B., Komproe, I. H., Schreuders, B. A., & De Jong, J. T. (2004). Impact of a Long Asylum Procedure on the Prevalence of Psychiatric Disorders in Iraqi Asylum Seekers in The Netherlands. *The Journal of Nervous and Mental Disease*, *192*(12), 843-851.
- Lancy, D. F. (1993). *Qualitative research in education: an introduction to the major traditions*. New York: Longman.

- Larimore, W. L., Parker, M., & Crowther, M. (2002). Should clinicians incorporate positive spirituality into their practices? What does the evidence say? *Annals of Behavioral Medicine*, 24(1), 69–73. https://doi.org/10.1207/S15324796ABM2401_08
- Lavdas, M., Guribye, E., & Sandal, G. M. (2023). “Of course, you get depression in this situation”: Explanatory Models (EMs) among Afghan refugees in camps in Northern Greece. *BMC psychiatry*, 23(1), 125.
- Leavey, G., Loewenthal, K., & King, M. (2007). Challenges to sanctuary: The clergy as a resource for mental health care in the community. *Social science & medicine*, 65(3), 548-559.
- Lebrun, L. (2012). Effects of length of stay and language proficiency on health care experiences among Immigrants in Canada and the United States. *Social Science & Medicine*, 74(7), 1062-1072.
- Lee, E. (1966). A Theory of Migration. *Demography*, 3(1), 47-57. Retrieved from <http://www.jstor.org/stable/2060063>
- Lee, E., & Kealy, D. (2018). Developing a working model of cross-cultural supervision: A competence-and alliance-based framework. *Clinical Social Work Journal*, 46, 310-320.
- LeJeune, J., & Luoma, J. B. (2019). *Values in therapy: A clinician's guide to helping clients explore values, increase psychological flexibility, and live a more meaningful life*. New Harbinger Publications.

- Lesniak, K., Rudman, W., & Rector, M. (2006). Psychological distress, stressful life events, and religiosity in younger African American adults. *Mental Health, Religion & Culture, 9*, 15–28.
- Levin, J. S., & Chatters, L. M. (1998). Research on religion and mental health: An overview of empirical findings and theoretical issues. In H. G. Koenig (Ed), *Handbook of Religion and Mental Health*. Burlington: Academic Press.
- Levin, J. S., & Chatters, L. M. (1998). Research on religion and mental health: An overview of empirical findings and theoretical issues. *Handbook of religion and mental health*, 33-50.
- Levin, J. S., & Schiller, E. L. (1987). Is there a religious factor in health? *Journal of Religion and Health, 26*, 9-36.
- Levin, J. S., & Vanderpool, H. Y. (1992). Religious factors in physical health and the prevention of illness. In K. I. Pargament, K. I. Maton, & R. E. Hess (Eds.), *Religion and prevention in mental health: Research, vision, and action* (pp. 83-103). New York: Haworth.
- Levin, J. S., (1996). How religion influences morbidity and health: Reflections on natural history, salutogenesis and host resistance. *Social Science and Medicine, 43*, 849-864.
- Levin, J. S., Chatters, L. M., & Taylor, R. J. (1995). Religious effects on health status and life satisfaction among black Americans. *Journal of Gerontology: Social Sciences, 50B*, S154-S 163.

- Lindencrona, F., Ekblad, S., & Hauff, E. (2008). Mental health of recently resettled refugees from the Middle East in Sweden: The impact of pre-resettlement trauma, resettlement stress and capacity to handle stress. *Social Psychiatry and Psychiatric Epidemiology*, *43*(2), 121-131.
- Lindlof, T. R., & Bryan, T. C. (Eds.). (2002). *Qualitative communication research methods* (2nd. Ed.). Thousand Oaks: Sage.
- Lipson, J. (1991). Afghan Refugee Health: Some Findings and Suggestions. *Qualitative Health Research*, *1*(3), 349-369.
- Lipson, J. (1993). Afghan Refugees in California: Mental Health Issues. *Issues in Mental Health Nursing*, *14*(4), 411-423.
- Lipson, J., & Omidian, P. (1992). Health issues of Afghan refugees in California. *Western Journal of Medicine*, *157*(3), 271-275.
- Lipson, J., & Omidian, P. (1997). Afghan Refugee Issues in the U.S. Social Environment. *Western Journal of Nursing Research*, *19*(1), 110-126.
- Litalien, M., Atari, D. O., & Obasi, I. (2021). The influence of religiosity and spirituality on health in Canada: A systematic literature review. *Journal of Religion and Health*, 1-42.
- Loewenthal, K. (2007). *Religion, culture, and mental health*. New York: Cambridge University Press.

- Lopez, S. J., & Snyder, C. R. (Eds.). (2003). Positive psychological assessment: A handbook of models and measures. American Psychological Association. <https://doi.org/10.1037/10612-000>
- Lucchetti, G., Góes, L. G., Amaral, S. G., Ganadjian, G. T., Andrade, I., Almeida, P. O. D. A., ... & Manso, M. E. G. (2021). Spirituality, religiosity and the mental health consequences of social isolation during Covid-19 pandemic. *International Journal of Social Psychiatry*, 67(6), 672-679.
- Madill, A., Jordan, A., & Shirley, C. (2000). Objectivity and reliability in qualitative analysis: Realist, contextualist and radical constructionist epistemologies. *British Journal of Psychology*, 91(1), 1–20. doi:10.1348/000712600161646
- Magnusson, D. (2000). The individual as the organizing principle in psychological inquiry: A holistic approach. In *Developmental science and the holistic approach* (pp. 43-58). Routledge.
- Maher, A. R. (1996). Existential-humanistic psychotherapy and the religious person. In E. P. Shafranske (Ed), *Religion and the clinical practice of psychology* (pp. 433- 460). Washington, DC: American Psychological Association.
- Mahoney, A. (2010). Religion in families 1999–2009: A relational spirituality framework. *Journal of Marriage and Family*, 72, 805–827. doi:10.1111/j.1741- 3737.2010.00732.x

- Mahoney, A. (2013). The spirituality of us: Relational spirituality in the context of family relationships. In K. I. Pargament, J. J. Exline, & J. W. Jones (Eds.), *APA handbook of psychology, religion, and spirituality (Vol. 1): Context, theory, and research* (pp. 365–389). American Psychological Association. <https://doi.org/10.1037/14045-020>
- Mahrer, A. R. (1996). Existential-humanistic psychotherapy and the religious person. In E. P. Shafranske (Ed.), *Religion and the clinical practice of psychology* (pp. 433-460). Washington, DC: American Psychological Association.
- Maliepaard, M., & Schacht, D. D. (2020). The relation between religiosity and Muslims' social integration: a two-wave study of recent immigrants in three European countries. In *Migration and Race in Europe* (pp. 82-103). Routledge.
- Maliepaard, M., Lubbers, M., & Gijsberts, M. (2014). Generational differences in ethnic and religious attachment and their interrelation. A study among Muslim minorities in the Netherlands. In *Methods and Contexts in the Study of Muslim Minorities* (pp. 216-237). Routledge.
- Malinakova, K., Tavel, P., Meier, Z., van Dijk, J. P., & Reijneveld, S. A. (2020). Religiosity and mental health: A contribution to understanding the heterogeneity of research findings. *International journal of environmental research and public health*, 17(2), 494.
- Mandelkow, L., Austad, A., & Freund, H. (2022). Stepping carefully on sacred ground: religion and spirituality in psychotherapy. *Journal of Spirituality in Mental Health*, 24(3), 288-308.

Marchand, K., Siegel, M., Kuschminder, K., Majidi, N., Vanore, M., & Buil, C.

(2014). *Afghanistan Migration Profile* (Rep.). Kabul: International Organization for Migration (IOM).

Marmot, M., Friel, S., Bell, R., Houweling, T. A. J., & Taylor, S., on behalf of the Commission on

Social Determinants of Health. (2008). Closing the gap in a generation: Health equity through action on the social determinants of health. *The Lancet*, 372(9650), 1661-1669.

doi:10.1016/S0140-6736(08)61690-6

Marshall, B., Cardon, P., Poddar, A., & Fontenot, R. (2013). Does sample size matter in

qualitative research?: A review of qualitative interviews in is research. *Journal of*

Computer Information Systems, 54(1), 11–22. doi:10.1080/08874417.2013.11645667

Marshall, E. A., Butler, K., Roche, T., Cumming, J., & Taknint, J. T. (2016). Refugee youth: A

review of mental health counselling issues and practices. *Canadian*

Psychology/psychologie canadienne, 57(4), 308.

Marshall, M. N. (1996). Sampling for qualitative research. *Family Practice*, 13(6), 522–526.

doi:10.1093/fampra/13.6.522

Martin, J. E. & Booth, J. (1999). Behavioral approaches to enhance spirituality. In W. R. Miller

(Ed.), *Integrating spirituality into treatment: Resources for practitioners* (pp.161-175).

Washington, DC: American Psychological Association.

- Martin, J. E., & Booth, J. (1999). Behavioral approaches to enhance spirituality. In W. R. Miller (Ed.), *Integrating spirituality into treatment: Resources for practitioners* (pp. 161-175). Washington, DC: American Psychological Association.
- Martin, M. (2015). Perceived Discrimination of Muslims in Health Care. *The Journal of Muslim Mental Health, 9*(2), 41-69.
- Mathai, J., & North, A. (2003). Spiritual history of parents of children attending a child and adolescent mental health service. *Australasian Psychiatry, 11*(2), 172–174. <https://doi.org/10.1046/j.1039-8562.2003.00511.x>
- Maximo, S. I. (2019). A scoping review of ethical considerations in spiritual/religious counseling and psychotherapy. *Journal of Pastoral Care & Counseling, 73*(2), 124-133.
- Maxwell, J. (2013). *Qualitative research design: An interactive approach* (3rd ed.). Thousand Oaks, CA: Sage.
- McCallister, B. J. (1995). Cognitive theory and religious experience. In R. W. Hood, Jr. (Ed.), *Handbook of religious experience* (pp. 312–352). Birmingham, AL: Religious Education Press.
- McColl, H., McKenzie, K., & Bhui, K. (2008). Mental healthcare of asylum-seekers and refugees. *Advances in Psychiatric Treatment, 14*(6), 452-459.
doi:10.1192/apt.bp.107.005041

- McCullough, M. E. (1999). Research on religion accommodative counseling: Review and meta-analysis. *Journal of Counseling Psychology*, 46, 92–98. doi:10.1037/0022-0167.46.1.92
- McCullough, M. E. (1999). Research on religion-accomodative counseling: Review and meta-analysis. *Journal of Counseling Psychology*, 46(1), 92–98. <https://doi.org/10.1037/0022-0167.46.1.92>
- McGregor, S. L. T., & Murnane, J. A. (2010). Paradigm, methodology and method: intellectual integrity in consumer scholarship. *International Journal of Consumer Studies*, 34(4), 419–427. doi:10.1111/j.1470-6431.2010.00883.x
- McNeill, W. H. (1997). What we mean by the west. *Orbis*, 41(4), 513-525.
- Mehrabi, N. (2002). Counselling Afghanistan Torture and Trauma Survivors. *Psychotherapy in Australia*, 8(3).
- Memaryan, N., Rassouli, M., & Mehrabi, M. (2016). Spirituality concept by health professionals in Iran: A qualitative study. *Evidence-Based Complementary and Alternative Medicine*, 2016.
- Mental Health Commission of Canada. (2016). *The case for diversity: Building the case to improve mental health services for immigrant, refugee, ethno-cultural and racialized populations*. Retrieved from https://www.mentalhealthcommission.ca/sites/default/files/2016-10/case_for_diversity_oct_2016_eng.pdf

Merriam-Webster. (n.d.). LGBTQ+. In Merriam-Webster.com dictionary. Retrieved July 13, 2023, from <https://www.merriam-webster.com/dictionary/LGBTQ%2B>

Merriam-Webster's collegiate dictionary (11th ed.). (2016). Springfield, MA: Merriam-Webster Incorporated.

MFSO. (n.d.). Home. <https://mfso.ca>

Midgette, E., & González, J. (2023). Trauma-Informed Teaching of Literature to Multilingual Learner Refugees: In Search for Balance between Cultural Responsiveness and Curriculum Sensitivity. *Journal of Multilingual Education Research*, 12(1), 11.

Miller, A. D., Nash, T., & Fetty, D. G. (2014). Fostering community: Explicating commonalities between counseling psychology and humanistic psychology. *Journal of Humanistic Psychology*, 54(4), 476-493.

Miller, K. E., & Rasco, L. M. (2004). An Ecological Framework for Addressing the Mental Health Needs of Refugee Communities. In K. E. Miller, & L. M. Rasco (Eds.), *The mental health of refugees: Ecological Approaches to Healing and Adaptation* (pp. 1-64). New York: Routledge, <https://doi.org/10.4324/9781410610263>

Miller, K. E., Omidian, P., Rasmussen, A., Yaqubi, A., & Daudzai, H. (2008). Daily stressors, war experiences, and mental health in Afghanistan. *Transcultural Psychiatry*, 45(4), 611-638.

- Miremadi, S., Ganesan, S., & McKenna, M. (2011). Pilot study of the prevalence of alcohol, substance use and mental disorders in a cohort of Iraqi, Afghani, and Iranian refugees in Vancouver. *Asia-Pacific Psychiatry*, 3(3), 137-144.
- Mlambo, M., Silén, C., & McGrath, C. (2021). Lifelong learning and nurses' continuing professional development, a metasynthesis of the literature. *BMC nursing*, 20, 1-13.
- Moffatt, K. M., & Oxhandler, H. K. (2018). Religion and spirituality in master of social work education: Past, present, and future considerations. *Journal of Social Work Education*, 54(3), 543-553.
- Moffatt, K. M., Oxhandler, H. K., & Ellor, J. W. (2021). Religion and spirituality in graduate social work education: A national survey. *Journal of social work education*, 57(2), 287-298.
- Moghissi, H., & Ghorashi, H. (2016). *Muslim diaspora in the West: Negotiating gender, home and belonging*. London: Routledge. doi:<https://doi.org/10.4324/9781315597058>
- Moghissi, H., Goodman, M. J., & Rahnema, S. (2009). *Diaspora by design: Muslims in Canada and beyond*. Toronto: University of Toronto Press.
- Moghissi, H., Rahnema, S., & Goodman, M. J. (2009). *Diaspora by design: Muslims in Canada and beyond*. University of Toronto Press.
- Mohamed, E., & Bastug, M. (2021). Syrian refugees in Canada and transculturalism: Relationship between media, integration and identity. *Journal of Refugee Studies*, 34(1), 219-240.

- Momartin, S., Steel, Z., Coello, M., Aroche, J., Silove, D., & Brooks, R. (2006). A comparison of the mental health of refugees with temporary versus permanent protection visas. *Medical Journal of Australia*, 185(7), 357-361.
- Montgomery, P., & Bailey, P. (2007). Field Notes and Theoretical Memos in Grounded Theory. *Western Journal of Nursing Research*, 29(1), 65-79.
- Moore, L. E., Tambling, R. B., & Anderson, S. R. (2013). The intersection of therapy constructs: The relationship between motivation to change, distress, referral source, and pressure to attend. *The American Journal of Family Therapy*, 41(3), 245-258.
- Muhibbu-Din, M. O. (2019). Feminism and modern Islamic politics: The fact and the fallacy. *International Journal of Islamic Thought*, 15, 44-59.
- Naeem, F. (2019). Cultural adaptations of CBT: a summary and discussion of the special issue on cultural adaptation of CBT. *The Cognitive Behaviour Therapist*, 12, e40.
- Nageeb, S., Vu, M., Malik, S., Quinn, M. T., Cursio, J., & Padela, A. I. (2018). Adapting a religious health fatalism measure for use in Muslim populations. *Plos one*, 13(11), e0206898.
- Nahum, D., Alfonso, C. A., & Sönmez, E. (2019). Common factors in psychotherapy. *Advances in psychiatry*, 471-481.

- Nakash, O., Lambez, T., Cohen, M., & Nagar, M. (2019). Religiosity and barriers to mental healthcare: A qualitative study among clients seeking community mental health services. *Mental Health, Religion & Culture*, 22(5), 437-452.
- National Statistical and Information Authority (NSIA), (2019). *Afghanistan Statistical Year Book 2018-19*. (Issue No. 40). Kabul. Afghanistan. Retrieved from https://www.nsia.gov.af:8080/wp-content/uploads/2019/11/Afghanistan-Statistical-Yearbook-2018-19_compressed_2.pdf
- Neuman, L. W. (2011). Analysis of Qualitative Data. In Mahmoud Eid (Ed.), *Research Methods in Communication* (pp. 341-375). Canada: Pearson
- Nielsen, S. L., Johnson, W. B., & Ellis, A. (2001). *Counseling and psychotherapy with religious persons: A rational emotive behavior therapy approach*. Mahwah, New Jersey: Lawrence Erlbaum.
- Nielsen, S. L., Johnson, W. B., & Ellis, A. (2001). *Counseling and psychotherapy with religious persons: A rational emotive behavior therapy approach*. Mahwah, NJ: Erlbaum.
- Norquay, R. (2004). *Immigrant Identity and the Non-profit: A Case study of the Afghan Women's Organization* (CERIS working paper ; no. 29, February 2004). Toronto, Ont.: CERIS - The Ontario Metropolis Centre.
- O'Connor, S., & Vandenberg, B. (2005). Psychosis or faith? Clinicians' assessment of religious beliefs. *Journal of Consulting and Clinical Psychology*, 73, 610-616.

- O'Mahony, J. M., Donnelly, T. T., Bouchal, S. R., & Este, D. (2013). Cultural background and socioeconomic influence of immigrant and refugee women coping with postpartum depression. *Journal of Immigrant Minority Health, 15*, 300–314. doi:10.1007/s10903-012-9663-x.
- Ochocka, J., & Janzen, R. (2008). Immigrant parenting: A new framework of understanding. *Journal of Immigrant & Refugee Studies, 6*(1), 85-111.
- OCISO. (n.d.). *About us*. OCISO. <https://ociso.org/>
- Odunukan, O. W., Abdulai, R. M., Hagi Salaad, M. F., Lahr, B. D., Flynn, P. M., & Wieland, M. L. (2015). Provider and Interpreter Preferences Among Somali Women in a Primary Care Setting. *Journal of Primary Care & Community Health, 105–110*. <https://doi.org/10.1177/2150131914552846>
- OMCS. (n.d.). *About Us*. OMCS. <https://omcs.ca/>
- Omeri, A., Lennings, C., & Raymond, L. (2006). Beyond Asylum: Implications for Nursing and Health Care Delivery for Afghan Refugees in Australia. *Journal of Transcultural Nursing, 17*(1), 30-39.
- Ontario College of Social Workers and Social Service Workers. (2018). 2008 Code of Ethics and Standards of Practice Handbook Second Edition. <https://www.ocswssw.org/wp-content/uploads/Code-of-Ethics-and-Standards-of-Practice-September-7-2018.pdf>

Ontario College of Social Workers and Social Service Workers. (n.d.). *The Ontario College of Social Workers and social service workers use of Use of Title and Holding Out Provisions.*

Ontario College of Social Workers and Social Service Workers.

<https://www.ocswssw.org/wp-content/uploads/Use-of-Title-and-Holding-Out-Provisions.pdf>

Oriya, S., & Alekozai, T. (2022). The impact of persons with mental health problems on family members and their coping strategies in Afghanistan. *Intervention, 20*(1), 28.

Ortega, D. M. L. (2023). The Influence of Therapeutic Alliance in Psychotherapy. *Aportes, 1*(34), 169-176.

Owen, J., Tao, K. W., Drinane, J. M., Hook, J., Davis, E. D., & Kune, N. F. (2016). Client perceptions of therapists' multicultural orientation: Cultural (missed) opportunities and cultural humility. *Professional Psychology: Research and Practice, 47*(1), 30–37.

<http://dx.doi.org/10.1037/pro0000046>

Oxhandler, H. K., Moffatt, K. M., & Giardina, T. D. (2019). Clinical helping professionals' perceived support, barriers, and training to integrate clients' religion/spirituality in practice. *Spirituality in Clinical Practice, 6*(4), 279–

291. <https://doi.org/10.1037/scp0000189>

- Padela, A. I., & Zaidi, D. (2018). The Islamic tradition and health inequities: A preliminary conceptual model based on a systematic literature review of Muslim health-care disparities. *Avicenna journal of medicine*, 8(1), 1–13. doi:10.4103/ajm.AJM_134_17
- Padela, A. I., Gunter, K., Killawi, A., & Heisler, M. (2012). Religious Values and Healthcare Accommodations: Voices from the American Muslim Community. *Journal of General Internal Medicine*, 27(6), 708-715. doi:10.1007/s11606-011-1965-5
- Padela, A. I., Killawi, A., Forman, J., DeMonner, S., & Heisler, M. (2012). American Muslim perceptions of healing key agents in healing, and their roles. *Qualitative Health Research*, 22, 846-858. <http://dx.doi.org/10.1177/1049732312438969>
- Paloutzian, R. F., & Park, C. L. (Eds.). (2014). *Handbook of the psychology of religion and spirituality*. Guilford Publications.
- Pargament, K. (2007). *Spiritually integrated psychotherapy : understanding and addressing the sacred* . New York, NY: Guilford Press.
- Pargament, K. I. (1997). *The psychology of religion and coping: Theory, research, practice*. New York, NY: Guilford Press.
- Pargament, K. I. (2002). The bitter and the sweet: An evaluation of the costs and benefits of religiousness. *Psychological Inquiry*, 13, 168–181. doi:10.1207/ S15327965PLI1303_02

- Pargament, K. I. (2002). The bitter and the sweet: An evaluation of the costs and benefits of religiousness. *Psychological Inquiry*, 13(3), 168–181. https://doi.org/10.1207/S15327965PLI1303_02
- Pargament, K. I. (2009). The psychospiritual character of psychotherapy and the ethical complexities that follow. *Professional Psychology: Research and Practice*, 40(4), 391-393.
- Pargament, K. I. (Ed.), & Mahoney, A., & Exline, J. J., Jones, J. W. (Eds.), & Shafranske, E. P. (2013). Envisioning an integrative paradigm for the psychology of religion and spirituality. In K. I. Pargament, J. J. Exline, & J. W. Jones (Eds.), *APA handbook of psychology, religion, and spirituality (Vol. 1): Context, theory, and research (pp. 3–19)*. American Psychological Association. <https://doi.org/10.1037/14045-001>
- Pargament, K. I., & Abu-Raiya, H. (2007). A decade of research on the psychology of religion and coping: Things we assumed and lessons we learned. *Psyke and Logos*, 28, 742–766.
- Pargament, K. I., & Mahoney, A. (2005). Sacred matters: Sanctification as a vital topic for the psychology of religion. *The International Journal for the Psychology of Religion*, 15, 179–198. [doi:10.1207/s15327582ijpr1503_1](https://doi.org/10.1207/s15327582ijpr1503_1)
- Pargament, K. I., Exline, J. J., & Jones, J. W. (2013). *APA handbook of psychology, religion, and spirituality (Vol 1)*. American Psychological Association. <http://dx.doi.org.proxy.bib.uottawa.ca/10.1037/14045-000>

- Pargament, K. I., Mahoney, A., & Shafranske, E. P. (2013). Envisioning an integrative paradigm for the psychology of religion and spirituality. In K. I. Pargament, J. J. Exline & J. W. Jones (Eds.), *APA handbook of psychology, religion, and spirituality (vol 1): Context, theory, and research*, (pp. 3-19). Washington: American Psychological Association, American Psychological Association, Washington, DC.
- doi:<http://dx.doi.org.proxy.bib.uottawa.ca/10.1037/14045-001>
- Pargament, K., Feuille, M., & Burdzy, D. (2011). The Brief RCOPE: Current Psychometric Status of a Short Measure of Religious Coping. *Religions*, 2(1), 51-76.
- Pargament, K., Smith, B., Koenig, H., & Perez, L. (1998). Patterns of positive and negative religious coping with major life stressors. *Journal for the Scientific Study of Religion*, 37(4), 710-724.
- Park, C. L., & Folkman, S. (1997). Meaning in the context of stress and coping. *Review of general psychology*, 1(2), 115-144.
- Pate, R. H., & Hall, M. P. (2005). One approach to a counseling and spirituality course. *Counseling and Values*, 49(2), 155-160.
- Patton, M. Q. (2002). Two decades of developments in qualitative inquiry: A personal, experiential perspective. *Qualitative social work*, 1(3), 261-283.
- Patton, M. (2002). *Qualitative research and evaluation methods* (3rd ed.). Thousand Oaks, CA: Sage.

- Paul Victor, C. G., & Treschuk, J. V. (2020). Critical literature review on the definition clarity of the concept of faith, religion, and spirituality. *Journal of Holistic Nursing, 38*(1), 107-113.
- Pavli, D., & Maltezou, D. (2017). Health problems of newly arrived migrants and refugees in Europe. *Journal of Travel Medicine, 24*(4). <https://doi.org/10.1093/jtm/tax016>
- Payne, I., Bergin, A., Bielema, K., & Jenkins, P. (1991). Review of religion and mental health: Prevention and the enhancement of psychosocial functioning. *Prevention in Human Services 9*, 11–40.
- Payne, S. (2016). Grounded Theory. In E Lyons & A. Coyle. (Eds.), *Analysing Qualitative Data in Psychology* (pp. 119–146). SAGE Publications, Ltd
- Pearce, M. J. (2013). Addressing religion and spirituality in health care systems. In K. I. Pargament, A. Mahoney, & E. P. Shafranske (Eds.), *APA handbook of psychology, religion, and spirituality (Vol. 2): An applied psychology of religion and spirituality* (pp. 527–541). American Psychological Association. <https://doi.org/10.1037/14046-027>
- Pew Research Center. (2012). Muslim Americans: No signs of growth in alienation or support for extremism. Retrieved from <http://www.people-press.org/2011/08/30/muslim-americans-no-signs-of-growth-in-alienation-or-support-for-extremism/>
- Phillimore, J. (2011). Refugees, acculturation strategies, stress and integration. *Journal of Social Policy, 40*(3), 575-593.

- Piedmont, R. L., & Wilkins, T. A. (2020). *Understanding the psychological soul of spirituality: A guidebook for research and practice*. Routledge.
- Plante, T. G. (2009). *Spiritual practices in psychotherapy: Thirteen tools for enhancing psychological health*. American Psychological Association.
- Plumb, A. M. (2011). Spirituality and counselling: Are counsellors prepared to integrate religion and spirituality into therapeutic work with clients?. *Canadian Journal of Counselling and Psychotherapy*, 45(1).
- Polanski, P. J. (2003). Spirituality in supervision. *Counseling and Values*, 47(2), 131-141.
- Porter, M., & Haslam, N. (2005). Predisplacement and Postdisplacement Factors Associated With Mental Health of Refugees and Internally Displaced Persons: A Meta-analysis. *JAMA*, 294(5), 602-612.
- Post, B. C., & Wade, N. G. (2009). Religion and spirituality in psychotherapy: A practice-friendly review of research. *Journal of Clinical Psychology*, 65(2), 131–146. <https://doi.org/10.1002/jclp.20563>
- Predelli, L. (2004). Interpreting gender in Islam: A case study of immigrant Muslim women in Oslo, Norway. *Gender & Society*, 18(4), 473-493. doi:10.1177/0891243204265138
- Priester, P. E., Khalili, S., & Luvathingal, J. E. (2009). Placing the Soul Back into Psychology: Religion in the Psychotherapy Process. In S. Eshun, R. A. Gurung, (Eds), *Culture and*

mental health: Sociocultural influences, theory, and practice. (pp. 91-114). Chichester, U.K. ; Malden, MA: Wiley-Blackwell. doi:10.1002/9781444305807.ch6

Priester, P. E., Khalili, S., & Luvathingal, J. E. (2009). Placing the Soul Back into Psychology:

Religion in the Psychotherapy Process. In Eshuan, S., Gurung, R. A. R. (Eds.). *Culture and Mental Health* (pp. 91–114). Wiley-Blackwell.

<https://doi.org/10.1002/9781444305807.ch6>

Propst, L. R. (1996). Cognitive-behavioral therapy and the religious person. In E. P. Shafranske

(Ed.), *Religion and the clinical practice of psychology* (pp. 391-407). Washington, DC:

American Psychological Association.

Propst, L. R. (1996). Cognitive-behavioral therapy and the religious person. In E. P. Shafranske

(Ed.), *Religion and the clinical practice of psychology* (pp. 391–407). Washington, DC:

American Psychological Association.

Purgato, M., Carswell, K., Tedeschi, F., Acarturk, C., Anttila, M., Au, T., ... & Barbui, C. (2021).

Effectiveness of self-help plus in preventing mental disorders in refugees and asylum

seekers in Western Europe: a multinational randomized controlled trial. *Psychotherapy and*

psychosomatics, 90(6), 403-414.

Qamar, A. H. (2013). The concept of the ‘evil’ and the ‘evil eye’ in Islam and Islamic faith-healing

traditions. *Journal of Islamic Thought and Civilization*, 3(2), 44-53.

- Qasqas, M. J., & Jerry, P. (2014). Counselling Muslims: A culture-infused antidiscriminatory approach. *Canadian Journal of Counselling and Psychotherapy*, 48(1), 57–76. Retrieved from <http://cjc-rcc.ucalgary.ca/cjc/index.php/rcc/article/view/960>
- Qasqas, M. J., & Jerry, P. (2014). Counselling Muslims: A culture-infused antidiscriminatory approach. *Canadian Journal of Counselling and Psychotherapy*, 48(1).
- Qureshi, A., Collazos, F., Sobradie, N., Eiroa-Orosa, F. J., Febrel, M., Revollo-Escudero, H. W., ... & García-Campayo, J. (2013). Epidemiology of psychiatric morbidity among migrants compared to native born population in Spain: a controlled study. *General hospital psychiatry*, 35(1), 93-99.
- Radford, D., & Hetz, H. (2021). Aussies? Afghans? Hazara refugees and migrants negotiating multiple identities and belonging in Australia. *Social Identities*, 27(3), 377-393.
- Rassool, G. H. (2000). The crescent and Islam: Healing, nursing, and the spiritual dimension: Some considerations towards an understanding of the Islamic perspectives on caring. *Journal of Advanced Nursing*, 32, 1476-1484. <http://dx.doi.org/10.1046/j.1365-2648.2000.01614.x>
- Rathod, S., Phiri, P., & Naeem, F. (2019). An evidence-based framework to culturally adapt cognitive behaviour therapy. *The Cognitive Behaviour Therapist*, 12, e10.
- Ratts, M. J., Singh, A. A., Nassar-McMillan, S., Butler, S. K., & McCullough, J. R. (2015). *Multicultural and social justice counseling competencies*. Retrieved from:

http://www.multiculturalcounseling.org/index.php?option=com_content&view=article&id=205:amcd-endorsesmulticultural-and-social-justice-counseling-competencies&catid=1:latest&Itemid=123

Redcay, A., Luquet, W., & Huggin, M. E. (2019). Immigration and asylum for lesbian, gay, bisexual, and transgender individuals. *Journal of Human Rights and Social Work, 4*, 248-256.

Rennie, D. L. (1996). Fifteen years of doing qualitative research on psychotherapy. *British Journal of Guidance & Counselling, 24*(3), 317–327. doi:10.1080/03069889608253016

Richards, P. S., & Bergin, A. E. (1997). A spiritual strategy for counseling and psychotherapy. American Psychological Association. <https://doi.org/10.1037/10241-000>

Richards, P. S., & Bergin, A. E. (Eds.). (2000). Handbook of psychotherapy and religious diversity. American Psychological Association. <https://doi.org/10.1037/10347-000>

Robertson, L. A. (2010). The Spiritual Competency Scale. *Counseling and Values, 55*, 6–24.

Rose, E. M., Westefeld, J. S., & Ansely, T. N. (2001). Spiritual issues in counseling: Clients' beliefs and preferences. *Journal of Counseling Psychology, 48*(1), 61–71. <https://doi.org/10.1037/0022-0167.48.1.61>

Rose, E. M., Westefeld, J. S., & Ansley, T. N. (2008). Spiritual issues in counseling: Clients' beliefs and preferences. *Psychology of Religion and Spirituality, S*(1), 18–33. <https://doi.org/10.1037/1941-1022.S.1.18>

- Rosenberg, J., Leung, J. K., Harris, K., Abdullah, A., Rohbar, A., Brown, C., & Rosenthal, M. S. (2022). Recently-arrived Afghan refugee parents' perspectives about parenting, education and pediatric medical and mental health care services. *Journal of Immigrant and Minority Health, 24*(2), 481-488.
- Rosenblatt, P. C. (2016). Cultural competence and humility. In D. L. Harris & T. C. Bordere (Eds.), *Handbook of social justice in loss and grief: Exploring diversity, equity, and inclusion* (pp. 67–74). New York, NY: Routledge.
- Rosmarin, D. H., & Koenig, H. G. (Eds.). (2020). *Handbook of spirituality, religion, and mental health*. Academic Press.
- Ross, D. (2014). Spirituality in supervision: A phenomenological study (thesis). Georgia State University. <https://doi.org/10.57709/4847459>
- Rostami-Povey, E. (2007). Gender, agency and identity, the case of Afghan women in Afghanistan, Pakistan and Iran. *The Journal of Development Studies, 43*(2), 294-311.
- Rothman, A. E. D. (2019). *Building an Islamic psychology and psychotherapy: a grounded theory study* (Doctoral dissertation, Kingston University).
- Rothman, A., & Coyle, A. (2023). The clinical scope of Islamic psychotherapy: A grounded theory study. *Spirituality in Clinical Practice, 10*(1), 419. <https://doi.org/10.1037/scp0000282>.

- Roulston, K., & Choi, M. (2018). Qualitative interviews. In U. Flick *The sage handbook of qualitative data collection* (pp. 233-249). 55 City Road, London: SAGE Publications Ltd
doi: 10.4135/9781526416070.n15
- Rousseau, C., Crépeau, F., Foxen, P., & Houle, F. (2002). The complexity of determining
refugeehood: a multidisciplinary analysis of the decision-making process of the Canadian
immigration and refugee board. *Journal of refugee studies*, 15(1), 43-70.
- Ruiz, P. (2004). Psychopathology and migration. In *Psiquiatria 2004. III symposium Almirall*,
Libro de Resumenes, pp. 47-60.
- Ruiz, P., & Bhugra, D. (2010). Refugees and asylum seekers: conceptual issues. *Mental health of
refugees and asylum seekers*, 1-21.
- Runion, M. (2017). *The history of Afghanistan* (Second ed., Greenwood histories of the modern
nations).
- Russo, A., Lewis, B., Joyce, A., Crockett, B., & Luchters, S. (2015). A qualitative exploration of
the emotional wellbeing and support needs of new mothers from Afghanistan living in
Melbourne, Australia. *BMC Pregnancy and Childbirth*, 15(1). doi:10.1186/s12884-015-
0631-z
- Sabry, W. M., & Vohra, A. (2013). Role of Islam in the management of Psychiatric
disorders. *Indian journal of psychiatry*, 55(Suppl 2), S205–S214. doi:10.4103/0019-
5545.105534

- Sachdej, R. (2021). LGBTQ global mental health: Ethical challenges and clinical considerations. In *Global mental health ethics* (pp. 305-317). Cham: Springer International Publishing.
- Sadat, M. H. (2008). Hyphenating Afghaniyat (Afghan-ness) in the Afghan diaspora. *Journal of Muslim Minority Affairs*, 28(3), 329-342.
- Saeed, A. (2017). *Freedom of religion, apostasy and Islam*. Routledge.
- Saidi, S. (2019). Migration and redefining self: negotiating religious identity among Hazara women in Germany. *Anthropology of the Middle East*, 14(2), 77-96.
- Saleem, F., & Martin, S. L. (2018). "Seeking help is difficult:" Considerations for providing mental health services to Muslim women clients. *Canadian Journal of Counselling and Psychotherapy*, 52(2).
- Saxena, S., Thornicroft, G., Knapp, M., & Whiteford, H. (2007). Resources for mental health: scarcity, inequity, and inefficiency. *The Lancet*, 370(9590), 878-889.
- Schlosser, L. Z., Ali, S. R., Ackerman, S. R., & Dewey, J. J. H. (2009). Religion, ethnicity, culture, way of life: Jews, Muslims, and multicultural counseling. *Counseling and Values*, 54(1), 48-64.
- Scholte, W. F., Olf, M., Ventevogel, P., de Vries, G. J., Jansveld, E., Cardozo, B. L., & Gotway Crawford, C. A. (2004). Mental health symptoms following war and repression in eastern Afghanistan. *The Journal of the American Medical Association*, 292(5), 585-593.

Schouler-Ocak, M., Bhugra, D., Kastrup, M. C., Dom, G., Heinz, A., Küey, L., & Gorwood, P.

(2021). Racism and mental health and the role of mental health professionals. *European Psychiatry*, 64(1), e42.

Schrier, A. C., de Wit, M. A., Rijmen, F., Tuinebreijer, W. C., Verhoeff, A. P., Kupka, R. W., ... &

Beekman, A. T. (2010). Similarity in depressive symptom profile in a population-based study of migrants in the Netherlands. *Social Psychiatry and Psychiatric Epidemiology*, 45, 941-951.

Schuster, L. (2016). Unmixing migrants and refugees. In A. Triandafyllidou,(Ed.). *Routledge*

Handbook of Immigration and Refugee Studies. London: Routledge,

<https://doi.org/10.4324/9781315759302> (pp.297-303)

Schwandt, T. A. (1997). *Qualitative inquiry: A dictionary of terms*. Thousand Oaks, CA, US: Sage

Publications, Inc.

Schwandt, T. A. (1997). *Qualitative inquiry: A dictionary of terms*. Sage Publications, Inc.

Sevunts, L. (2016, March 21). *Majority of Canadians have negative views of Muslims: Survey*.

Radio Canada International. Retrieved from

<https://www.rcinet.ca/en/2016/03/21/majority-of-canadians-have-negative-views-of-muslims-survey/>

- Shafranske, E. P. (2004). A psychodynamic case study. In P. S. Richards (Ed.), *Casebook for a spiritual strategy in counseling and psychotherapy* (pp. 153-170). Washington, DC: American Psychological Association.
- Shafranske, E. P. (2005). A psychoanalytic approach to spiritually oriented psychotherapy.
- Shafranske, E. P. (2005). The Psychology of Religion in Clinical and Counseling Psychology. In R. F. Paloutzian & C. L. Park (Eds.), *Handbook of the psychology of religion and spirituality* (pp. 496–514). The Guilford Press.
- Shah, K., & Culbertson, P. (2011). Mental Health Awareness among Imams Serving New Zealand's Muslim Population. *New Zealand Journal of Counselling, 31*(1).
- Shah, S. M., Ayash, C., Pharaon, N. A., & Gany, F. M. (2008). Arab American immigrants in New York: Health care and cancer knowledge, attitudes, and beliefs. *Journal of Immigrant and Minority Health, 10*, 429-436. <http://dx.doi.org/10.1007/s10903-007-9106-2>
- Shakya, Y. B., Guruge, S., Hynie, M., Akbari, A., Malik, M., Htoo, S., ... & Alley, S. (2010). Aspirations for higher education among newcomer refugee youth in Toronto: Expectations, challenges, and strategies. *Refuge, 27*, 65.
- Shaw, S. A., Peacock, L., Ali, L. M., Pillai, V., & Husain, A. (2019). Religious coping and challenges among displaced Muslim female refugees. *Affilia, 34*(4), 518-534.
- Shedlin, M., Decena, C., Noboa, H., & Betancourt, Ó. (2014). Sending-country violence and receiving-country discrimination: Effects on the health of Colombian refugees in

Ecuador. *Journal of Immigrant and Minority Health*, 16(1), 119-124. doi:10.1007/s10903-013-9777-9

Sheikh, A., & Gatrad, A. R. (2000). *Caring for Muslim patients* (2nd ed.). Oxford ; New York: Radcliffe.

Shibre, T., Negash, A., Kullgren, G., Kebede, D., Alem, A., Fekadu, A., & Jacobsson, L. (2001). Perception of stigma among family members of individuals with schizophrenia and major affective disorders in rural Ethiopia. *Social Psychiatry and Psychiatric Epidemiology*, 36, 299-303. <http://dx.doi.org/10.1007/s001270170048>

Shirazi, M., Shirazi, A., & Bloom, J. (2015). Developing a culturally competent faith-based framework to promote breast cancer screening among Afghan immigrant women. *Journal of religion and health*, 54(1), 153–159. doi:10.1007/s10943-013-9793-z

Shishehgar, S., Gholizadeh, L., DiGiacomo, M., & Davidson, P. (2015). The impact of migration on the health status of Iranians: An integrative literature review. *BMC International Health and Human Rights*, 15(1), 20.

Shishehgar, S., Gholizadeh, L., DiGiacomo, M., Green, A., & Davidson, P. (2017). Health and Socio-Cultural Experiences of Refugee Women: An Integrative Review. *Journal of Immigrant and Minority Health*, 19(4), 959-973.

- Silberman, I., Higgins, E., & Dweck, C. (2005). Religion and world change: Violence, terrorism versus peace. *Journal of Social Issues, 61*, 761–784. doi:10.1111/j.1540-4560.2005.00431.x
- Sim, A., Puffer, E., Ahmad, A., Hammad, L., & Georgiades, K. (2023). Resettlement, mental health, and coping: a mixed methods survey with recently resettled refugee parents in Canada. *BMC Public Health, 23*(1), 386.
- Simich, L., Beiser, M., & Mawani, F. N. (2003). Social support and the significance of shared experience in refugee migration and resettlement. *Western journal of nursing research, 25*(7), 872-891.
- Slater, W., Hall, T. W., & Edwards, K. J. (2001). Measuring religion and spirituality: Where are we and where are we going?. *Journal of psychology and theology, 29*(1), 4-21.
- Slewa-Younan, S., Guajardo, M. G. U., Yaser, A., Mond, J., Smith, M., Milosevic, D., ... & Jorm, A. F. (2017). Causes of and risk factors for posttraumatic stress disorder: the beliefs of Iraqi and Afghan refugees resettled in Australia. *International Journal of Mental Health Systems, 11*, 1-11.
- Slife, B. D., & Reber, J. S. (2009). Is there a pervasive implicit bias against theism in psychology?. *Journal of Theoretical and Philosophical Psychology, 29*(2), 63.

- Smith, A. E., Riding-Malon, R., Aspelmeier, J. E., & Leake, V. (2018). A qualitative investigation into bridging the gap between religion and the helping professions to improve rural mental health. *Journal of Rural Mental Health, 42*(1), 32.
- Smith, T. B., & Silva, L. (2011). Ethnic identity and personal well-being of people of color: a meta-analysis. *Journal of counseling psychology, 58*(1), 42.
- Smith, T. B., Bartz, J. D., & Richards, P. S. (2007). Outcomes of religious and spiritual adaptations to psychotherapy: A meta-analytic review. *Psychotherapy Research, 17*, 643–655. doi:10.1080/10503300701250347
- Smith, T. B., Bartz, J., & Richards, P. S. (2007). Outcomes of religious and spiritual adaptations to psychotherapy: A meta-analytic review. *Psychotherapy Research, 17*(6), 643–655. <https://doi.org/10.1080/10503300701250347>
- Solhkhah, R., Galanter, M., Dermatis, H., Daly, J., & Bunt, G. (2008). Spiritual orientation among adolescents in a drug-free residential therapeutic community. *Journal of Child & Adolescent Substance Abuse, 18*(1), 57–71. <https://doi.org/10.1080/15470650802541129>
- Soltan, H. (2023). *Acculturation Gaps among Afghan Refugee Families in Canada: Implications for Family Relationships, Adaptation Outcomes and Subjective Wellbeing of Emerging Adults* (Doctoral dissertation, University of Guelph).

- Song, S., Kaplan, J., Tol, C., Subica, W., & Jong, A. (2015). Psychological distress in torture survivors: Pre- and post-migration risk factors in a US sample. *Social Psychiatry and Psychiatric Epidemiology*, *50*(4), 549-560.
- Souza, K. Z. (2002). Spirituality in counseling: What do counseling students think about it?. *Counseling and Values*, *46*(3), 213-217.
- Spännäri, J., & Laceulle, H. (2021). Meaning making in a retirement migrant community: Religion, spirituality, and social practices of daily lives. *Frontiers in Psychology*, *12*, 707060.
- Sperry, L. (2012). *Spirituality in clinical practice: Theory and practice of spiritually oriented psychotherapy*. Routledge.
- Srivastava, R. (2009). *The healthcare professional's guide to clinical cultural competence*. Toronto: Mosby Elsevier.
- Stack, J. A., & Iwasaki, Y. (2009). The role of leisure pursuits in adaptation processes among Afghan refugees who have immigrated to Winnipeg, Canada. *Leisure Studies*, *28*(3), 239-259.
- Statistics Canada, G. O. (2016). Immigrant population in Canada, 2016 Census of Population. Retrieved July 08, 2018, from <http://www.statcan.gc.ca/pub/11-627-m/11-627-m2017028-eng.htm>

- Statistics Canada, G. of C. (2022, November 14). *Ethnocultural and religious diversity – 2021 census promotional material*. Government of Canada, Statistics Canada. Retrieved April 26, 2023, from <https://www.statcan.gc.ca/en/census/census-engagement/community-supporter/ethnocultural-and-religious-diversity>
- Statistics Canada, G. of C. (2022, October 26). Immigrants make up the largest share of the population in over 150 years and continue to shape who we are as Canadians. The Daily - Statistics Canada. Retrieved April 26, 2023, from <https://www150.statcan.gc.ca/n1/daily-quotidien/221026/dq221026a-eng.htm>
- Statistics Canada. (2014). Population growth: Migratory increase overtakes natural increase (Catalogue No. 11-630-X2014001). Retrieved from <https://www150.statcan.gc.ca/n1/en/catalogue/11-630-X2014001>
- Statistics Canada. (2015, December 22). *2011 National household survey: Immigration and ethnocultural diversity* (Catalogue no. 99-010-X). Ottawa, ON: Author. <http://www12.statcan.gc.ca/nhs-enm/2011/as-sa/99-010-x/99-010-x2011001-eng.pdf>
- Steinfeld, G. J. (2000). Spiritual psychology and psychotherapy: Is there theoretical and empirical support? *Journal of contemporary psychotherapy*, 30(4), 353-380.
- Steinfeld, G. J. (2000). Spiritual psychology and psychotherapy: Is there theoretical and empirical support? *Journal of Contemporary Psychotherapy*, 30, 353-380.

- Steinhausen, H. C., Bearth-Carrari, C., & Winkler Metzke, C. (2009). Psychosocial adaptation of adolescent migrants in a Swiss community survey. *Social psychiatry and psychiatric epidemiology, 44*, 308-316.
- Stern, J. (2003). *Terror in the name of God*. New York, NY: Ecco Press.
- Stompe, T., Holzer, D., Friedmann, A., & Bhugra, D. (2010). Pre-migration, personality and precipitating factors. In D. Bhugra & S. Gupta (Eds.), *Migration and Mental Health* (pp. 68-78). Cambridge: Cambridge University Press. doi:10.1017/CBO9780511760990.007
- Strang, A., Baillot, H., & Mignard, E. (2018). 'I want to participate.' transition experiences of new refugees in Glasgow. *Journal of Ethnic and Migration Studies, 44*(2), 197-214.
- Strauss, A. L., & Corbin, J. (1994). Grounded theory methodology: An overview. In N. K. Denzin & Y. S. Lincoln (Eds.), *Handbook of qualitative research* (pp. 273–285). Thousand Oaks, CA: Sage Publications, Inc
- Strauss, A. L., & Corbin, J. M. (1990). *Basics of qualitative research: grounded theory procedures and techniques*. Thousand Oaks, CA: Sage Publications.
- Sue, D. W., Sue, D. (2008). *Counseling the culturally diverse: Theory and practice* (5th ed.). Hoboken, NJ: Wiley.
- Sulaiman-Hill, C. M., & Thompson, S. C. (2011). Sampling challenges in a study examining refugee resettlement. *BMC international health and human rights, 11*, 2.
doi:10.1186/1472-698X-11-2

- Sulaiman-Hill, C., & Thompson, S. (2012). Afghan and Kurdish refugees, 8-20 years after resettlement, still experience psychological distress and challenges to well being. *Australian And New Zealand Journal Of Public Health, 36*(2), 126-134.
- Swift, J. K., Bird, M. O., Penix, E. A., & Trusty, W. T. (2022). Client preference accommodation for religious/spiritual integration and psychotherapy outcomes in naturalistic practice settings. *Psychotherapy, 59*(3), 392.
- Syed, F., Keshavarzi, S., Sholapur, N., & Keshavarzi, H. (2020). A survey of Islamic clergy & community leaders regarding Muslim mental health first responder training. *Journal of Muslim Mental Health*.
- Sytner, A. (2018). Social work and pastoral counseling: Empowering each other. *Journal of Religion & Spirituality in Social Work: Social Thought, 37*(2), 202-219.
- Szaflarski, M., & Bauldry, S. (2019). The effects of perceived discrimination on immigrant and refugee physical and mental health. In *Immigration and health* (pp. 173-204). Emerald Publishing Limited.
- Tahir, H., & Safdar, S. (2022). Cultural similarity predicts social inclusion of Muslims in Canada: A vignette-based experimental survey. *Frontiers in Psychology, 13*, 973603.
- Tanhan, A., & Young, J. S. (2022). Muslims and mental health services: A concept map and a theoretical framework. *Journal of Religion and Health, 1-41*.

- Tesch, R. (1990). *Qualitative research : Analysis types and software tools*. New York: Falmer Press.
- Teunissen, E., Sherally, J., van den Muijsenbergh, M., Dowrick, C., van Weel-Baumgarten, E., & van Weel, C. (2014). Mental health problems of undocumented migrants (UMs) in the Netherlands: a qualitative exploration of help-seeking behaviour and experiences with primary care. *BMJ open*, *4*(11), e005738.
- The Bill Lane Center for the American West. (n.d.). *What is “the west”?* The Bill Lane Center for the American West. <https://west.stanford.edu/about/what-west>
- The Global Religious Landscape. (2018, September 27). Pew Research Center, Washington, D.C. Retrieved June 10, 2019, from <https://www.pewforum.org/2012/12/18/global-religious-landscape-exec/>
- Thomas, G., & James, D. (2006). Reinventing grounded theory: Some questions about theory, ground and discovery. *British Educational Research Journal*, *32*(6), 767–795.
doi:10.1080/01411920600989412
- Tiliouine, H., Cummins, R. A., & Davern, M. (2009). Islamic religiosity, subjective well- being and health. *Mental Health, Religion & Culture*, *12*(1), 55–74
- Toledano, A. (1996). Issues arising from intra-cultural family therapy. *Journal of family therapy*, *18*(3), 289-301.

- Tomasi, A. M., Slewa-Younan, S., Narchal, R., & Rioseco, P. (2022). Professional mental health help-seeking amongst Afghan and Iraqi refugees in Australia: Understanding predictors five years post resettlement. *International journal of environmental research and public health*, *19*(3), 1896.
- Trautmann, R. L. (2003). Psychotherapy and spirituality. *Transactional analysis Journal*, *33*(1), 32-36.
- Trautmann, R. L. (2003). Psychotherapy and spirituality. *Transactional Analysis Journal*, *33*, 32-36.
- Tribe, R. (2010). Migrants and mental health. In D. Bhugra & S. Gupta (Eds.), *Migration and Mental Health* (pp. 261-273). Cambridge: Cambridge University Press.
doi:10.1017/CBO9780511760990.022
- Trusty, W. T., Swift, J. K., Black, S. W., Dimmick, A. A., & Penix, E. A. (2022). Religious microaggressions in psychotherapy: A mixed methods examination of client perspectives. *Psychotherapy*, *59*(3), 351.
- Tseng, W. (2001). *Handbook of cultural psychiatry*. London: Academic Press.
- Tsui, M. S., O'Donoghue, K., & Ng, A. K. (2014). Culturally Competent and Diversity-Sensitive Clinical Supervision. *The Wiley international handbook of clinical supervision*, 238-254.
- Tudor, K. (2015). Humanistic psychology: A critical counter culture. In *Handbook of critical psychology* (pp. 127-136). Routledge.

U.S. Department of Justice. (2006). Terrorism: 2002–2005. Retrieved from

<http://www.fbi.gov/stats-services/publications/terrorism-2002-2005>

United Nations General Assembly, *Convention Relating to the Status of Refugees*, 28 July 1951,

United Nations, Treaty Series, vol. 189, p. 137, available at:

<https://www.refworld.org/docid/3be01b964.html> [accessed 15 January 2020]

United Nations High Commission for Refugees. (n.d.). *Afghanistan refugees: Facts & Crisis*

News: USA FOR UNHCR. Afghanistan Refugees: Facts & Crisis News | USA for

UNHCR.

<https://www.unrefugees.org/emergencies/afghanistan/#:~:text=It%20is%20estimated%20t>

[hat%2085,exacerbated%20displacement%20throughout%20the%20country](https://www.unrefugees.org/emergencies/afghanistan/#:~:text=It%20is%20estimated%20that%2085,exacerbated%20displacement%20throughout%20the%20country).

United Nations High Commissioner for Refugees (UNHCR), *UNHCR Master Glossary of Terms*,

June 2006, Rev.1, available at: <https://www.refworld.org/docid/42ce7d444.html> [accessed

15 January 2020]

Utržan, D. S., & Wieling, E. A. (2020). A phenomenological study on the experience of Syrian

asylum-seekers and refugees in the United States. *Family process*, 59(1), 209-228.

Van Audenhove, C., & Vertommen, H. (2000). A Negotiation Approach to Intake and Treatment

Choice. *Journal of Psychotherapy Integration*, 10(3), 287–299.

<https://doi.org/10.1023/A:1009401129920>

- Van Audenhove, C., & Vertommen, H. (2000). A negotiation approach to intake and treatment choice. *Journal of Psychotherapy Integration, 10*, 287-299.
- Van de Put, W. (2002). Addressing mental health in Afghanistan. *The Lancet, 360*, S41.
- Van Hook, M., Huguen, B., & Aguilar, M. A. (Eds.). (2001). *Spirituality within religious traditions in social work practice*. Brooks/Cole Publishing Company.
- Ventevogel, P., Azimi, S., Jalal, S., & Kortmann, F. (2002). Mental health care reform in Afghanistan. *Journal of Ayub Medical College, 14*(4), 1-3.
- Viruell-Fuentes, E. A., Miranda, P. Y., & Abdulrahim, S. (2012). More than culture: structural racism, intersectionality theory, and immigrant health. *Social science & medicine, 75*(12), 2099-2106.
- Walker, D. F., Gorsuch, R. L., & Tan, S. Y. (2004). Therapists' integration of religion and spirituality in counseling: A meta-analysis. *Counseling and values, 49*(1), 69-80.
- Waller, J. E. (2013). Religion and evil in the context of genocide. In K. I. Pargament, J. J. Exline & J. W. Jones (Eds.), *APA handbook of psychology, religion, and spirituality (vol 1): Context, theory, and research*, (pp. 477-493). Washington: American Psychological Association, American Psychological Association, Washington, DC.
- doi:<http://dx.doi.org.proxy.bib.uottawa.ca/10.1037/14045-026>
- Walsh, F. (2009). *Spiritual resources in family therapy* (2nd ed.). New York: Guilford Press.

- Watlington, C., & Murphy, C. (2006). The roles of religion and spirituality among African American survivors of domestic violence. *Journal of Clinical Psychology, 62*, 837–857.
- Watts, R. E. (2000). Biblically based Christian spirituality and Adlerian psychotherapy. *Journal of Individual Psychology, 56*, 316-328.
- Watts, R. E. (2000). Biblically based Christian spirituality and Adlerian psychotherapy. *Journal of individual psychology, 56*(3), 316-328.
- Weatherhead, S., & Daiches, A. (2010). Muslim views on mental health and psychotherapy. *Psychology and Psychotherapy: Theory, Research and Practice, 83*, 75–89.
- Weber, S. R., & Pargament, K. I. (2014). The role of religion and spirituality in mental health. *Current opinion in psychiatry, 27*(5), 358-363.
- Weed, M. (2017). Capturing the essence of grounded theory: The importance of understanding commonalities and variants. *Qualitative Research in Sport, Exercise and Health, 9*(1), 149– 156. doi:10.1080/2159676X.2016.1251701
- Weisenfeld, J. (2018). *New World A-Coming: Black Religion and Racial Identity during the Great Migration*. NYU Press.
- Welsh, E. A., & Brodsky, A. E. (2010). After every darkness is light: Resilient Afghan women coping with violence and immigration. *Asian American Journal of Psychology, 1*(3), 163–174. <https://doi.org/10.1037/a0020922>

- West, W. (2004). Humanistic integrative spiritual psychotherapy. In P. S. Richards (Ed.), *Casebook for a spiritual strategy in counseling and psychotherapy* (pp. 201-230). Washington, DC: American Psychological Association.
- Wheaton, B. (1985). Models of the stress-buffering functions of coping resources. *Journal of Health and Social Behavior*, 26, 352-364.
- Whitley, R. (2012). Religious competence as cultural competence. *Transcultural psychiatry*, 49(2), 245-260.
- Whitley, R., Kirmayer, L. J., & Groleau, D. (2006). Understanding immigrants' reluctance to use mental health services: A qualitative study from Montreal. *Canadian Journal of Psychiatry*, 51(1), 205–209. doi:10.1016/ S0084-3970(08)70465-1
- Widner, D., & Chicoine, S. (2011, December). It's all in the name: Employment discrimination against Arab Americans 1. In *Sociological Forum* (Vol. 26, No. 4, pp. 806-823). Oxford, UK: Blackwell Publishing Ltd.
- Wildt, H., Umanos, J., Khanzada, N. K., Saleh, M., Rahman, H. U., & Zakowski, S. G. (2017). Wartrauma, psychological distress, and coping among Afghan civilians seeking primary health care. *International Perspectives in Psychology: Research, Practice, Consultation*, 6(2), 81.
- Wilkinson, L., Othman, J. R., Veisman, N., Wong, K., & Ogoe, S. (2021). A BRIEF HISTORY OF AFGHAN REFUGEES IN CANADA. *Canadian Issues*, 1-5.

- Williams, M. T., Khanna Roy, A., MacIntyre, M. P., & Faber, S. (2022). The traumatizing impact of racism in Canadians of colour. *Current Trauma Reports, 8*(2), 17-34.
- Wilson, R., Murtaza, R., & Shakya, Y. (2010). Pre-Migration and Post-Migration Determinants of Mental Health for Newly Arrived Refugees in Toronto. *Canadian Issues, 45-49*.
- Winnicott, D. W. (1993). Transitional objects and transitional phenomena: A study of the first not-me possession. In G. H. Pollock (Ed.), *Pivotal papers on identification* (pp. 139–157). Madison, CT, US: International Universities Press.
- Wolcott, H. F. (1992). Posturing in qualitative research. In M. D. LeCompte, W. L. Millroy, & J. Preissle (Eds), *The handbook of qualitative research in education* (pp. 3-52). San Diego, CA. Academic Press.
- Wolf, M. M. (1978). Social validity: The case for subjective measurement or how applied behavior analysis is finding its heart. *Journal of Applied Behavior Analysis, 11*(2), 203–214. <https://doi.org/10.1901/jaba.1978.11-203>
- World Bank, World Development Indicators. (2018). *Afghanistan* [Data file]. Retrieved from <https://data.worldbank.org/country/afghanistan>
- World Health Organization. (2014). Social determinants of mental health. World Health Organization. <http://www.who.int/iris/handle/10665/112828>
- Worthington, E. L., Jr., & Sandage, S. J. (2001). Religion and spirituality. *Psychotherapy: Theory, Research, Practice, Training, 38*, 473–478. doi:10.1037/0033-3204.38.4.473

- Worthington, E. L., Jr., & Sandage, S. J. (2001). Religion and spirituality. *Psychotherapy: Theory, Research, Practice, Training*, 38(4), 473–478. <https://doi.org/10.1037/0033-3204.38.4.473>
- Worthington, E. L., Jr., & Sandage, S. J. (2001). Religion and spirituality. *Psychotherapy: Theory, research, practice, training*, 38(4), 473.
- Worthington, E. L., Jr., Hook, J. N., Davis, D. E., & McDaniel, M. A. (2011). Religion and spirituality. In J. C. Norcross (Ed.), *Psychotherapy relationships that work: Evidence-based responsiveness* (pp. 402–419). Oxford University Press. <https://doi.org/10.1093/acprof:oso/9780199737208.003.0020>
- Worthington, E. L., Jr., Hook, J. N., Davis, D. E., & McDaniel, M. A. (2011). Religion and spirituality. In J. Norcross (Ed.), *Psychotherapy relationships that work* (2nd ed., pp. 402–420). New York, NY: Oxford University Press.
[doi:10.1093/acprof:oso/9780199737208.003.0020](https://doi.org/10.1093/acprof:oso/9780199737208.003.0020)
- Worthington, E. L., Jr., Hook, J. N., Davis, D. E., Gartner, A. L., & Jennings, D. J. II. (2013). Conducting empirical research on religiously accommodative interventions. In K. I. Pargament, A. Mahoney, & E. P. Shafranske (Eds.), *APA handbook of psychology, religion, and spirituality* (Vol. 2): An applied psychology of religion and spirituality (pp. 651–669). American Psychological Association. <https://doi.org/10.1037/14046-034>

- Wylie, L., Van Meyel, R., Harder, H., Sukhera, J., Luc, C., Ganjavi, H., ... & Wardrop, N. (2018). Assessing trauma in a transcultural context: challenges in mental health care with immigrants and refugees. *Public health reviews*, *39*, 1-19.
- Yarhouse, M. A., & Johnson, V. (2013). Value and ethical issues: The interface between psychology and religion. In K. I. Pargament, A. Mahoney, & E. P. Shafranske (Eds.), *APA handbook of psychology, religion, and spirituality (Vol. 2): An applied psychology of religion and spirituality* (pp. 43–70). American Psychological Association. <https://doi.org/10.1037/14046-003>
- Yatim, A. M., Jusoh, A. J., Saper, N., & Mukti, T. A. (2015). Agape Love Counseling Module. *The International Journal of Social Science*, *37*, 128-132.
- Young, J. S., Wiggins-Frame, M., & Cashwell, C. S. (2007). Spirituality and counselor competence: A national survey of American Counseling Association members. *Journal of Counseling & Development*, *85*, 47–52.
- Youssef, J., & Deane, F. P. (2006). Factors influencing mental-health help-seeking in Arabic-speaking communities in Sydney, Australia. *Mental Health, Religion & Culture*, *9*, 43-66. <http://dx.doi.org/10.1080/13674670512331335686>
- Ypinazar, V. A., & Margolis, S. A. (2006). Delivering culturally sensitive care: The perceptions of older Arabian gulf Arabs concerning religion, health, and disease. *Qualitative Health Research*, *16*, 773-787. <http://dx.doi.org/10.1177/1049732306288469>

- Zia, B., Abdulrazaq, S., & Mackenzie, C. S. (2022). Mental health service utilization and psychological help-seeking preferences among Canadian Muslims. *Canadian Journal of Community Mental Health, 41*(1), 35-45.
- Zine, J. (Ed.). (2012). *Islam in the hinterlands: Muslim cultural politics in Canada*. UBC Press.
- Zinnbauer, B. J. (2013). Models of healthy and unhealthy religion and spirituality. In K. I. Pargament, A. Mahoney, & E. P. Shafranske (Eds.), *APA handbook of psychology, religion, and spirituality (Vol. 2): An applied psychology of religion and spirituality* (pp. 71–89). American Psychological Association. <https://doi.org/10.1037/14046-004>
- Zotova, N. (2018). Religion and mental health among central Asian muslim immigrants in Chicago metropolitan area. *Migration Letters, 15*(3), 361-376.

Appendices

Annex I: Consent Form

Title of the study: Place of Religion in Psychotherapy of Muslim Immigrants - Case of First-Generation Afghan Immigrants in Canada.

Name of researcher: Samoon Tasmim, MA, PhD (Candidate).

Phone number: 343-998-6246

Email address: stasm032@uottawa.ca

Name of supervisor: Buuma Maisha, Ph.D.

Phone number: : 613-236-1393, ext.: 2461

Email address: bmaisha@ustpaul.ca

Name of co-supervisor: Aliaa Dakroury, Ph.D.

Phone number: : 613-236-1393, ext.: 2618

Email address: adakroury@ustpaul.ca

Invitation to Participate: I am invited to participate in the abovementioned research study conducted by Samoon Tasmim under the supervision of Buuma Maisha and Aliaa Dakroury.

The purpose of the study is to investigate and understand the place of religion in psychotherapy and counselling of Muslim Afghan immigrants residing in Canada, as means to contribute to the literature providing mental health support to Afghan immigrants in Canada and further develop understanding of the role of religion in the lives of Afghan immigrants, with the intention of providing guidelines for mental health and counselling service providers.

Participation: My participation will consist essentially of answering a series of open-ended questions through an individual interview with the researcher. I will have the freedom to choose whom I feel more comfortable working with. The interview will be conducted in English, however, if I will be given the choice of speaking in either of the common languages of Afghanistan, namely, Pashto or Dari if I am not able to communicate in English. The individual interview questions will be guided by the study's objectives. The duration of the interview will vary from one individual to another; the session may last between 90-120 minutes. The researcher will use a safe and secure location to conduct interviews without jeopardizing my right to privacy and confidentiality. A few months after the initial interview, I will be asked for a follow-up interview to validate and clarify concerns that rose during the first set of interviews. All interviews will be audio recorded to help the researcher accurately capture insights in my own words. Given the sensitive, personal and confidential nature of our discussions, I will be guaranteed anonymity and confidentiality. A detailed explanation of how the research team will maintain the confidentiality of data with respect to any identifiable information and information shared during discussions will be discussed in-depth on the section titled confidentiality and anonymity.

Risks: My participation in this study will entail discussing some traumatic events and their meanings in detail. Sharing detail information on such a sensitive subject matter can be re-traumatizing for some individuals. I have received assurance from the researcher that every

effort will be made to minimize these risks. For example, counselling will be provided should I experience any traumatic reactions during or immediately after the interview.

Benefits: My participation in this study will personally benefit me, the society and scientific community as a whole by a) offering a platform to talk about experience, b) increasing awareness and understanding of culturally relevant issues by discussing religion and mental health c) increasing understanding of the expectations of Afghan immigrant mental health needs, d) increasing awareness and educating members of the mental health community and service providers as a way of providing culturally appropriate support, e) contributing to the advancement of our understanding of this phenomenon while offering an in-depth examination of the participant's perspective of and need for religion and mental health in their lives in Canada, f) and developing a culturally appropriate mental health services providing approach to immigrant communities.

Confidentiality and anonymity: I have received assurance from the researcher that the information I share will remain strictly confidential. I understand that the contents will be used only for the purpose of this research study and that my confidentiality will be protected. All identifiable information collected will be kept private. Any identifiable information will have a number on it instead of the name. Only the researcher will have knowledge about the numbers.

Anonymity: Information submitted will be published as a report; confidentiality and anonymity will be maintained through the removal of identifiers as described in the section above.

Conservation of data: The data collected (both hard copy and electronic data) will be stored in a password-protected file on the study computer as well as a secure cabinet at the office of the researcher. Only the researcher will have the key to access the secure cabinet. A duplicate copy of the research files will be created to safeguard it and enable recovery in case of a loss, corruption or infection by malware. Non-personal research data may be used for future research. I am assured that the confidentiality of my personal data will be upheld through the removal of identifiers.

Compensation: My participation in this study will involve no cost to me.

Voluntary Participation: I am under no obligation to participate and if I choose to participate, I can withdraw from the study at any time and/or refuse to answer any questions, without suffering any negative consequences. If I choose to withdraw, all data gathered until the time of withdrawal (including audio recording) will be destroyed and omitted from the final report.

Acceptance: I, _____, agree to participate in the above research study conducted by Samoon Tasmim of the Human Science Department, School of Counselling, Psychotherapy and Spirituality, Saint Paul University, which research is under the supervision of Buuma Maisha, Ph.D., and Aliaa Dakroury, Ph.D.

Using current data in future research studies: We would like to inform you that data collected from the present study might be used anonymously to support future research.

___ Yes, I consent for my personal information to be used in future research studies.

___ No, I do not consent for my personal information to be used in future research studies.

Secondary use of data:

The current thesis aims at knowing more about religion and its role in psychotherapy of Afghan immigrants in Canada. Information or materials collected from this study may be used in the future to increase community awareness and create educational programs to address the gap in the literature on culturally sensitive therapeutic approaches with immigrant populations.

If I have any questions about the study, I may contact the researcher or his supervisors.

If I have any questions regarding the ethical conduct of this study, I may contact the Office of Research and Ethics, Saint Paul University, 223 Main Street, Ottawa, ON K1S 1C4
Tel.: (613) 236-1393

There are two copies of the consent form, one of which is mine to keep.

Participant's signature: _____ Date: _____

Researcher's signature: _____ Date: _____

Annex II: Participant Recruitment form

Objective: Invitation to voluntary participation in a research study.

I am writing to invite you to participate in my research study about the Place of Religion in Psychotherapy of Muslim Immigrants - Case of First-Generation Afghan Immigrants in Canada. Your participation in this study will contribute to a noble cause toward raising awareness and potentially improving counselling and mental health services for Muslim Afghan Immigrants in the future.

If you decide to participate in this study, the researcher will be conducting interviews in a safe and confidential space at [Location depending on the city (i.e. Ottawa, Montreal, Toronto)]. Your identification will be protected through a coding system and only the researcher will have access to this information. The initial interview process will take approximately 90-120 minutes. Follow-up interviews will be conducted over the phone to clarify certain information. The interview process can be difficult and potentially trigger physical and emotional discomfort. Counselling will be provided should a participant experience any discomfort during or immediately after the interview.

I will like to re-emphasize that your participation is completely voluntary.

If you have any questions about the study, please email or contact me at:

Name of researcher: Samoon Tasmim, MA, Ph.D. (Candidate).

Phone number: 343-998-6246

Email address: stasm032@uottawa.ca

You can also contact my research supervisor at:

Name of supervisor: Buuma Maisha, Ph.D.

Phone number: 613-236-1393, ext.: 2461

Email address: bmaisha@ustpaul.ca

Please mark your name, signature and date below if you choose to participate.

First and Last name:

Signature:

Date:

____/____/____

Annex III: Interview Protocol**Group A****Script prior to interview:**

I would like to thank you once again for being willing to participate in the interview aspect of my study. As I have mentioned to you before, my study seeks to understand how religion can be used by mental health professionals to help their clients with life stressors, mental health struggles and psychological issues. The study also seeks to understand what clients who seek support of mental health professionals expect from them regarding their religious and spiritual beliefs and the role these beliefs play in managing their life stressors. The aim of this research is to shed light on effective ways of integrating religious beliefs into the process of counselling and psychotherapy.

Our interview today will last approximately one hour during which I will be asking you about immigration history, struggles you may have faced before, during and after immigrating to Canada and how you have used your beliefs to support yourself in the process. I will also ask you about your experience with mental health professionals, and what role your religious and spiritual beliefs play in the process of your therapy.

You have also completed a consent form indicating your willingness to voluntarily participate in this interview. I would like to reassure you that if you choose to withdraw from the study at any time in the process and/or refuse to answer any questions, you will not be suffering any negative consequences. Are you still willing to participate in this interview? ___Yes ___No?

As part of the consent form, I have your permission (or not) to audio record our conversation.

Are you still ok with me recording (or not) our conversation today? ___Yes ___No

If yes: Thank you! Please let me know if at any point you want me to turn off the recorder or keep something you said off the record.

If no: Thank you for letting me know. I will only take notes of our conversation.

Before we begin the interview, do you have any questions?

[Discuss questions]

If any questions (or other questions) arise at any point in this study, you can feel free to ask them at any time. I would be more than happy to answer your questions.

| Background Information | |
|--|--|
| <ul style="list-style-type: none"> - Name - Gender - Date of Birth - Highest level of Education - Occupation - Marital Status and Children - Disability (if any) - Current Employment - Current Legal Status in Canada - Legal status at the time of arrival to Canada - Date of first arrival to Canada - Place of first arrival to Canada | <p>Background Information Questions:</p> <ul style="list-style-type: none"> • Where were you born? Where did you grow up? • How do you describe your religious beliefs and practices? • Was there a reason you immigrated? (Typical reasons include the pursuit of economic or educational opportunities and escape from war and persecution.) • Who came with you? • What did you leave behind? (this includes relatives, belongings such as a home, profession, and social circle.) • When did you immigrate? Was time spent in a displaced location such as a refugee camp? What was that experience like? • Any future plan of returning to your country of origin? • Are there any difficulties revolving around your immigration status? |
| <p>Research Question 1: What role does religion play in lives of Afghan immigrants in Canada</p> | <p>Research Question 2: What is the place of religion in psychotherapeutic process of Afghan Immigrants?</p> |
| <p>Interview Questions:</p> <p><i>Initial Open-Ended Questions:</i></p> <ul style="list-style-type: none"> • Tell me about the role of religion in your life. • How, if at all, has religion helped you during your immigration journey? • What were the struggles you went through due to your religious views? <p><i>Intermediate Questions:</i></p> <ul style="list-style-type: none"> • How has Islam contributed, if at all, to your identity? <ul style="list-style-type: none"> ○ <i>Probing Questions to delve deep into:</i> | <p>Interview Questions:</p> <p><i>Initial Open-Ended Questions:</i></p> <ul style="list-style-type: none"> • Tell me about your experiences with mental health professionals. • How, if at all was your religion incorporated in your therapeutic experience(s)? <p><i>Intermediate Questions:</i></p> <ul style="list-style-type: none"> • How has your religion and religious views affected your mental health in the past? |

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| <ul style="list-style-type: none"> ▪ <i>Religion identification</i> ▪ <i>Religious practice</i> ▪ <i>Role and image of religious leaders</i> ▪ <i>Religious interpretations and their impact on life</i> ▪ <i>Perspective of religion towards mental health</i> • What are some of the religious beliefs and practices that you have? <ul style="list-style-type: none"> ○ <i>Probing Questions to delve deep into:</i> <ul style="list-style-type: none"> ▪ <i>What is practiced</i> ▪ <i>What can be practiced</i> ▪ <i>What is not practiced</i> ▪ <i>What should not be included as a practice</i> • How would you describe the role of Islam as a socially binding factor of the Muslim Community? <ul style="list-style-type: none"> ○ <i>Probing Questions to delve deep into:</i> <ul style="list-style-type: none"> ▪ <i>Is religion a source of support</i> ▪ <i>Is religion a source of identity in society</i> ▪ <i>When, if at all, is religiosity shown?</i> ▪ <i>When, if at all, is religiosity hidden?</i> ▪ <i>When, if at all, is religiosity irrelevant?</i> • How do your religious beliefs affect your day-to-day life here in Canada? <ul style="list-style-type: none"> ○ <i>Probing Questions to delve deep into:</i> <ul style="list-style-type: none"> ▪ <i>comfort seeking in religious practices?</i> • Do you have friends who practice your religion? Do you feel comfortable around them? <ul style="list-style-type: none"> ○ <i>Probing Questions to delve deep into:</i> <ul style="list-style-type: none"> ▪ <i>Religious identity as a means for social connection.</i> • Are you involved in any religious groups in your community? | <ul style="list-style-type: none"> ○ <i>Probing Questions to delve deep into:</i> <ul style="list-style-type: none"> ▪ <i>Positive and negative experiences in lights of pre, during and post migration period.</i> ▪ <i>Use of religion as a coping mechanism with life stressors</i> ▪ <i>Use of religion as a source of social support and belonging.</i> ▪ <i>Previous involvements in religious and community organizations to seek, or provide mental health support</i> • Are there any aspects of your religious beliefs that have helped you to seek mental health support? <ul style="list-style-type: none"> ○ <i>Probing Questions to delve deep into:</i> <ul style="list-style-type: none"> ▪ <i>Religious views in support of mental health help seeking.</i> • Are there any aspects of your religious beliefs that may have prevented you from seeking mental health support? <ul style="list-style-type: none"> ○ <i>Probing Questions to delve deep into:</i> <ul style="list-style-type: none"> ▪ <i>Religious views opposing mental health help seeking.</i> • How do you think religion can be used in the process of psychotherapy/counselling? <ul style="list-style-type: none"> ○ <i>Probing Questions to delve deep into:</i> <ul style="list-style-type: none"> ▪ <i>Religious therapy</i> ▪ <i>Religiously focused sessions</i> ▪ <i>Religiously focused interventions</i> ▪ <i>Religious inclusion in the process.</i> • What do you expect from a mental health professional when it comes to your religious views and practices? <ul style="list-style-type: none"> ○ <i>Probing Questions to delve deep into:</i> <ul style="list-style-type: none"> ▪ <i>Religious awareness of the professional</i> ▪ <i>Religious and cultural competency of the professional</i> |
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| <ul style="list-style-type: none"> ○ <i>Probing Questions to delve deep into:</i> <ul style="list-style-type: none"> ▪ <i>Is religion a source of support or distress?</i> • Tell me about your religious/spiritual resources for mental health. <ul style="list-style-type: none"> ○ <i>Probing Questions to delve deep into:</i> <ul style="list-style-type: none"> ▪ <i>Religious and spiritual activities and practices</i> <p><i>Ending Questions:</i></p> <ul style="list-style-type: none"> • Tell me about how your life in Canada has affected your religion, if at all. • Tell me about how your views and/or actions may have changed since you have come to Canada. • Tell me about the strengths you may have discovered and developed through your religious beliefs and practices. • After reflecting on your experiences with religion, is there something else you would like to add? • Is there anything you would like to ask me? | <ul style="list-style-type: none"> ▪ <i>Openness of the professional towards religious or religiously driven topics.</i> <ul style="list-style-type: none"> • How do you assess the religious and/or cultural competency of your mental health professional? <ul style="list-style-type: none"> ○ <i>Probing Questions to delve deep into:</i> <ul style="list-style-type: none"> ▪ <i>Basis for forming an opinion on religious and cultural competency</i> <p><i>Ending Questions:</i></p> <ul style="list-style-type: none"> • Tell me about any changes in your perspective after seeking mental health support. • Tell me about the strengths and weaknesses of the mental health support you received. • Having reflected upon the role of religion in your therapeutic journey, is there something else that you would like to add? • Is there anything you would like to ask me? |
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Interview Protocol
Group B

Script prior to interview:

I would like to thank you once again for being willing to participate in the interview aspect of my study. As I have mentioned to you before, my study seeks to understand how religion can be used by mental health professionals to help their clients with life stressors, mental health struggles and psychological issues. The study also seeks to understand what clients who seek support of mental health professionals expect from them regarding their religious and spiritual beliefs and the role these beliefs play in managing their life stressors. The aim of this research is to shed light on effective ways of integrating religious beliefs into the process of counselling and psychotherapy.

Our interview today will last approximately one hour during which I will be asking you about immigration history, struggles you may have faced before, during and after immigrating to Canada and how you have used your beliefs to support yourself in the process. I will also ask you about your experience with mental health professionals, and what role your religious and spiritual beliefs play in the process of your therapy.

You have also completed a consent form indicating your willingness to voluntarily participate in this interview. I would like to reassure you that if you choose to withdraw from the study at any time in the process and/or refuse to answer any questions, you will not be suffering any negative consequences. Are you still willing to participate in this interview? ___Yes ___No?

As part of the consent form, I have your permission (or not) to audio record our conversation. Are you still ok with me recording (or not) our conversation today? ___Yes ___No

If yes: Thank you! Please let me know if at any point you want me to turn off the recorder or keep something you said off the record.

If no: Thank you for letting me know. I will only take notes of our conversation.

Before we begin the interview, do you have any questions?

[Discuss questions]

If any questions (or other questions) arise at any point in this study, you can feel free to ask them at any time. I would be more than happy to answer your questions.

| Background Information | |
|--|--|
| <ul style="list-style-type: none"> - Name - Gender - Date of Birth - Highest level of Education - Occupation - Marital Status and Children - Disability (if any) - Current Employment - Current Legal Status in Canada - Legal status at the time of arrival to Canada - Date of first arrival to Canada - Place of first arrival to Canada | <p>Background Information Questions:</p> <ul style="list-style-type: none"> • Where were you born? Where did you grow up? • How do you describe your religious beliefs and practices? • Was there a reason you immigrated? (Typical reasons include the pursuit of economic or educational opportunities and escape from war and persecution.) • Who came with you? • What did you leave behind? (this includes relatives, belongings such as a home, profession, and social circle.) • When did you immigrate? Was time spent in a displaced location such as a refugee camp? What was that experience like? • Any future plan of returning to your country of origin? • Are there any difficulties revolving around your immigration status? |
| <p>Research Question 1: What role does religion play in lives of Afghan immigrants in Canada</p> | <p>Research Question 2: What is the place of religion in psychotherapeutic process of Afghan Immigrants?</p> |
| <p>Interview Questions:</p> <p><i>Initial Open-Ended Questions:</i></p> <ul style="list-style-type: none"> • Tell me about the role of religion in your life. • How, if at all, has religion helped you during your immigration journey? • What were the struggles you went through due to your religious views? <p><i>Intermediate Questions:</i></p> <ul style="list-style-type: none"> • How has Islam contributed, if at all, to your identity? <ul style="list-style-type: none"> ○ <i>Probing Questions to delve deep into:</i> <ul style="list-style-type: none"> ▪ <i>Religion identification</i> | <p>Interview Questions:</p> <p><i>Initial Open-Ended Questions:</i></p> <ul style="list-style-type: none"> • Tell me about your perspective towards mental health help seeking. • How, if at all was your religion incorporated in your view of mental health and mental health help seeking? <p><i>Intermediate Questions:</i></p> <ul style="list-style-type: none"> • How has your religion and religious views affected your mental health and psychological well-being in the past? <ul style="list-style-type: none"> ○ <i>Probing Questions to delve deep into:</i> |

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| <ul style="list-style-type: none"> ▪ <i>Religious practice</i> ▪ <i>Role and image of religious leaders</i> ▪ <i>Religious interpretations and their impact on life</i> ▪ <i>Perspective of religion towards mental health</i> • What are some of the religious belief systems and practices that you have? <ul style="list-style-type: none"> ○ <i>Probing Questions to delve deep into:</i> <ul style="list-style-type: none"> ▪ <i>What is practiced</i> ▪ <i>What can be practiced</i> ▪ <i>What is not practiced</i> ▪ <i>What should not be included as a practice</i> • How would you describe the role of Islam as a socially binding factor of the Muslim Community? <ul style="list-style-type: none"> ○ <i>Probing Questions to delve deep into:</i> <ul style="list-style-type: none"> ▪ <i>Is religion a source of support?</i> ▪ <i>Is religion a source of identity in society?</i> ▪ <i>When, if at all, is religiosity shown?</i> ▪ <i>When, if at all, is religiosity hidden?</i> ▪ <i>When, if at all, is religiosity irrelevant?</i> • How do your religious beliefs affect your day-to-day life here in Canada? <ul style="list-style-type: none"> ○ <i>Probing Questions to delve deep into:</i> <ul style="list-style-type: none"> ▪ <i>comfort seeking in religious practices.</i> • Do you have friends who practice your religion? Do you feel comfortable around them? <ul style="list-style-type: none"> ○ <i>Probing Questions to delve deep into:</i> <ul style="list-style-type: none"> ▪ <i>Religious identity as a means for social connection.</i> • Are you involved in any religious groups in your community? | <ul style="list-style-type: none"> ▪ <i>Positive and negative experiences in lights of pre, during and post migration period.</i> ▪ <i>Use of religion as a coping mechanism with life stressors</i> ▪ <i>Use of religion as a source of social support and belonging.</i> ▪ <i>Previous involvements in religious and community organizations to seek, or provide mental health support</i> • Are there any aspects of your religious beliefs that support the idea of seeking mental health support? <ul style="list-style-type: none"> ○ <i>Probing Questions to delve deep into:</i> <ul style="list-style-type: none"> ▪ <i>Religious views in support of mental health help seeking.</i> • Are there any aspects of your religious beliefs that may have prevented you from seeking mental health support? <ul style="list-style-type: none"> ○ <i>Probing Questions to delve deep into:</i> <ul style="list-style-type: none"> ▪ <i>Religious views opposing mental health help seeking.</i> • Where do you seek support when you face daily life stressors, or major psychological issues? <ul style="list-style-type: none"> ○ <i>Probing Questions to delve deep into:</i> <ul style="list-style-type: none"> ▪ <i>Sources of support (i.e., religious leaders, imams, religious text, other sources of support, if any)</i> • How do you think religion can be used in the process of psychotherapy/counselling? <ul style="list-style-type: none"> ○ <i>Probing Questions to delve deep into:</i> <ul style="list-style-type: none"> ▪ <i>Religious therapy</i> ▪ <i>Religiously focused sessions</i> ▪ <i>Religiously focused interventions</i> ▪ <i>Religious inclusion in the process.</i> |
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| <ul style="list-style-type: none"> ○ <i>Probing Questions to delve deep into:</i> <ul style="list-style-type: none"> ▪ <i>Is religion a source of support or distress?</i> ● Tell me about your religious/spiritual resources for mental health. <ul style="list-style-type: none"> ○ <i>Probing Questions to delve deep into:</i> <ul style="list-style-type: none"> ▪ <i>Religious and spiritual activities and practices</i> <p><i>Ending Questions:</i></p> <ul style="list-style-type: none"> ● Tell me about how your life in Canada has affected your religion, if at all. ● Tell me about how your views and/or actions may have changed since you have come to Canada. ● Tell me about the strengths you may have discovered and developed through your religious beliefs and practices. ● After reflecting on your experiences with religion, is there something else you would like to add? ● Is there anything you would like to ask me? | <ul style="list-style-type: none"> ● What do you expect from a mental health professional when it comes to your religious views and practices? <ul style="list-style-type: none"> ○ <i>Probing Questions to delve deep into:</i> <ul style="list-style-type: none"> ▪ <i>Religious awareness of the professional</i> ▪ <i>Religious and cultural competency of the professional</i> ▪ <i>Openness of the professional towards religious or religiously driven topics.</i> ● What is your understanding of religiously and culturally informed therapeutic process? ● How would you assess the religious and/or cultural competency of your mental health professional? <ul style="list-style-type: none"> ○ <i>Probing Questions to delve deep into:</i> <ul style="list-style-type: none"> ▪ <i>Basis for forming an opinion on religious and cultural competency</i> <p><i>Ending Questions:</i></p> <ul style="list-style-type: none"> ● Tell me about any changes in your perspective after reflecting on mental health support. ● Having reflected upon the role of religion in your therapeutic journey, is there something else that you would like to add? ● Is there anything you would like to ask me? |
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Interview Protocol

Group C

Script prior to interview:

I would like to thank you once again for being willing to participate in the interview aspect of my study. As I have mentioned to you before, my study seeks to understand how religion can be used by mental health professionals to help their clients with life stressors, mental health struggles and psychological issues. The study also seeks to understand what clients who seek support of mental health professionals expect from them regarding their religious and spiritual beliefs and the role these beliefs play in managing their life stressors. The aim of this research is to shed light on effective ways of integrating religious beliefs into the process of counselling and psychotherapy.

Our interview today will last approximately one hour during which I will be asking you about your professional experience with Afghan Immigrants, their struggles you may have helped them with before, during and after immigrating to Canada and how you have used, if at all, your therapeutic knowledge and understanding of their beliefs to support them in the process. I will also ask you about your perspective about the place and role of religion in mental health of clients seeking help and what role may religious and spiritual beliefs play in the process.

You have also completed a consent form indicating that I have your permission (or not) to audio record our conversation.

Are you still ok with me recording (or not) our conversation today? ___Yes ___No

If yes: Thank you! Please let me know if at any point you want me to turn off the recorder or keep something you said off the record.

If no: Thank you for letting me know. I will only take notes of our conversation.

Before we begin the interview, do you have any questions?

[Discuss questions]

If any questions (or other questions) arise at any point in this study, you can feel free to ask them at any time. I would be more than happy to answer your questions.

| Background Information | |
|--|--|
| <ul style="list-style-type: none"> - Name - Gender - Credentials - Professional Affiliation - Clientele: - Number of Afghan clients served - Organizational affiliations (if any) - Years in practice | <p>Background Information Questions:</p> <ul style="list-style-type: none"> • What is your theoretical psychotherapeutic orientation? • What is your treatment specialty/focus • Tell me about your Ethnic/cultural background • Tell me about your religious/ spiritual background • How many Afghan Clients have you worked with through the course of your career? How many were first generation Afghan immigrants? • I would like to get an idea about how you work with your clients. Please describe your work with a client wherein which religion or spirituality was an important factor in a critical event in the therapy process. When you do so, please omit any identifying information. • How did you conceptualize the client’s problem? • What types of interventions did you use? |
| <p>Research Question 1: What role does religion play in lives of Afghan immigrants in Canada</p> | <p>Research Question 2: What is the place of religion in psychotherapeutic process of Afghan Immigrants?</p> |
| <p>Interview Questions:</p> <p><i>Initial Open-Ended Questions:</i></p> <ul style="list-style-type: none"> • Tell me about your experience working with an Afghan client. When you do so, please omit any identifying information. • How, if at all, would you say religion helped your client in their immigration journey? • What in your opinion were the struggles your client went through due to their religious views? <p><i>Intermediate Questions:</i></p> <ul style="list-style-type: none"> • How important has religion been to your clients? | <p>Interview Questions:</p> <p><i>Initial Open-Ended Questions:</i></p> <ul style="list-style-type: none"> • Firstly, I would like to know your overall opinion about religion and spirituality in psychotherapy practice in general. <ul style="list-style-type: none"> ○ How do therapists typically approach religious or spirituality related issues in their practice? ○ How might therapists generally describe the psychotherapy process when working with religious or spiritual issues? ○ How do therapists describe the therapeutic relationship when religion or spirituality is salient (either for the client or the therapist)? |

- What forms did your client's religious practice take?
 - *Probing Questions to delve deep into:*
 - *Form of practice (private, worship attendance, personal religious reading, contact with religious leaders, observing religious rituals...)*
 - *Frequency of religious practice (daily, occasionally, when possible/feasible, when required,...)*
- How would you describe the philosophical role of religion in the lives of your clients?
 - *Probing Questions to delve deep into:*
 - *Religion as identity*
 - *Religion as a practice and way of life*
 - *Religion as a source of support*
 - *Religious interpretations and their impact on life*
 - *Perspective of religion towards mental health*
- What are some of the areas of your client's lives that are affected by religion?
 - *Probing Questions to delve deep into:*
 - *Religion in relation to societal factors (discrimination, generalizations, and marginalization)*
 - *Religion in relation to interpersonal factors (a source for sense of belonging, coping with stressors, interpersonal connections)*

Ending Questions:

- After reflecting on your experiences as a mental health professional, is there something else you would like to add?
- Is there anything you would like to ask me?

Intermediate Questions:

- How would you describe the relationship between mental health and religious and spiritual beliefs and practices for your clients?
 - *Probing Questions to delve deep into:*
 - *Positive relation of mental health and religion*
 - *Negative relation of mental health and religion*
- What in your perspective is the role of religion in making meaning of life?
 - *Probing Questions to delve deep into:*
 - *Role of religion in acceptance, coping and management of stressors*
 - .
- What do you consider religious/spiritual resources for mental health?
 - *Probing Questions to delve deep into:*
 - *Religious/ spiritual practices.*
- How do you think religion can be used in the process of psychotherapy/counselling?
 - *Probing Questions to delve deep into:*
 - *Religious therapy*
 - *Religiously focused sessions*
 - *Religiously focused interventions*
 - *Religious inclusion in the process.*
- What is your understanding of religiously and culturally informed therapeutic process?
- What is your perspective on "clinician's bias" and clinician's self-assessment, when it comes to religiously informed and sensitive therapeutic approach?
 - *Probing Questions to delve deep into:*

- *Clinicians' examination of their own biases and expectations that may affect the therapeutic process*
- *Clinicians' recognition of their own attitudes and beliefs that may influence their perceptions of and interactions with clients*

Ending Questions:

- Tell me about any changes in your perspective after reflecting on mental health support.
- Having reflected upon the role of religion in your therapeutic approach, is there something else that you would like to add?
- Is there anything you would like to ask me?

Annex IV: Back-Translation Attestation Letters

Rauf Karimi
Ottawa, ON
abrkarimi@gmail.com

August 31, 2021

Samoon Tasmim
Ph.D. (Candidate), Saint Paul University
Ottawa, ON.

Subject: Attestation Letter - Verification of Back-Translation Process for Interview Transcripts

Dear Samoon,

I am writing to provide an official attestation regarding the completion of the back-translation process for two interview transcripts as part of your doctoral thesis research. I, Rauf Karimi, as an independent reviewer of the translated documents, have played a role in overseeing and verifying the translation and back-translation stages to ensure their accuracy and reliability.

During the comparison and verification process, I ensured that the English translation was thoroughly compared with the original Dari interview transcript to ascertain that the intended meanings were accurately conveyed. Any discrepancies were noted and resolved collaboratively with the primary translator of Dari interview to English and back-translator of translated English transcript to Dari. Recognizing the importance of cultural context, I also verified that the English translation maintained cultural relevance and sensitivities, enabling the target audience to comprehend the content accurately.

Based on the rigorous verification process, I am pleased to confirm that the English translated version of the interview transcripts is reliable and can be used with confidence as part of the coding and analysis process. The accuracy and quality of the English translation have been upheld through the back-translation step, ensuring that the essence of the original interviews is faithfully preserved.

Should you have any questions, require further details, or need clarification regarding the back-translation process, please do not hesitate to contact me at abrkarimi@gmail.com or 514-546-4949.

Sincerely,



Rauf Karimi
abrkarimi@gmail.com

August-31, 2021

Ahmad Tariq
Kabul, Afghanistan
tariqsanizai89@gmail.com

August 15, 2021

Samoon Tasmim, RP
School of Counselling, Psychotherapy and Spirituality
Ottawa, ON

Subject: Attestation Letter - Back-Translation of Two Interview Scripts from English to Dari

Dear Samoon Tasmim,

I am writing this letter to provide an official attestation for my role as the back- translator responsible for the back-translation of two interview transcripts from English to Dari as part of the back-translation process for doctoral project “The Place of Religion in the Psychotherapy of Muslim Immigrants: The Case of First – Generation Afghan Immigrants in Canada”.

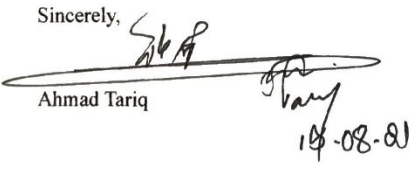
I, Ahmad Tariq, hereby confirm that the back-translation process from English to Dari has been completed in accordance with the guidelines and standards set forth by you as the primary researcher. It is my aim to validate the accuracy and quality of the back-translation, which is pivotal in maintaining the integrity of the original content while ensuring its suitability for Dari-speaking audiences.

I took utmost care to ensure that the Dari version of the transcript faithfully captures the content and meaning expressed in the English interview transcript. The intention was to maintain the essence of the dialogue while adhering to linguistic conventions and cultural nuances. As cultural variations exist between English and Dari, I endeavored to preserve the cultural context of the interview while making necessary adjustments to ensure cultural sensitivity and relevance.

Upon completing the initial back-translation, I conducted a thorough review and quality check to identify any potential linguistic or contextual discrepancies. This step was aimed at enhancing the overall quality of the Dari transcript.

I am pleased to state that the Dari transcript resulting from this back-translation process effectively represents the content of the English transcript provided to me for translation. Should you have any inquiries or require additional clarification regarding my involvement in the back-translation process, please feel free to contact me at tariqsanizai89@gmail.com.

Sincerely,


Ahmad Tariq

Mohammad Qasim Sadiq
Kabul, Afghanistan
mohammadqasimsadiq@gmail.co

July 23, 2021

Samoon Tasmim, RP
Ph.D. Candidate, Counselling and Spirituality
Saint Paul University, Ottawa, ON
Stasm032@uottawa.ca

Subject: Attestation Letter - Translator for Translation of Original Interview Transcript from Dari to English

Dear Samoon Tasmim,

I am writing this letter to formally attest to my role as the translator responsible for the translation of two interview transcript from Dari to English as part of your doctoral project "The Place of Religion in the Psychotherapy of Muslim Immigrants: The Case of First – Generation Afghan Immigrants in Canada". I hereby confirm that the translation process has been completed in compliance with the standards of accuracy and linguistic fidelity.

I, Mohammad Qasim Sadiq, served as the primary translator for the translation of the interview transcripts. I am proficient in both Dari and English languages. I hold graduate degree in Psychology and possess significant experience in translation and cultural nuances. I understand the significance of this translation in maintaining the integrity of the original interview content while ensuring its comprehensibility in English.

During the process of translation, the following key considerations were carefully addressed:

Accuracy: Every effort was made to ensure that the English version accurately captured the essence and meaning of the original Dari interview transcripts. Any discrepancies or ambiguities were carefully resolved to reflect the intentions of the interview participants.

Linguistic Fidelity: The translation process aimed to maintain linguistic fidelity to the source text while adhering to the conventions of the English language. This was achieved through careful selection of appropriate terminology and phrasing.

Cultural Nuances: Recognizing the cultural differences between Dari and English-speaking contexts, I took care to preserve the cultural nuances of the content to ensure that the translated transcript is culturally sensitive and relevant.

Review and Quality Check: After completing the initial translation, a thorough review and quality check were carried out to identify and rectify any potential linguistic, grammatical, or contextual discrepancies.

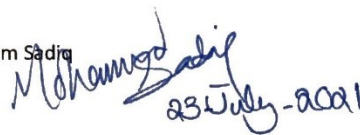
I am confident that the resulting English transcript accurately represents the content of the original Dari interview. This translation process aligns with the principles of accuracy and precision that are crucial to effective cross-linguistic communication.

Should you have any questions or require further clarification regarding my role in the back-translation process, please do not hesitate to contact me at mohammadqasimsadiq@gmail.co.

Thank you for entrusting me with this important task.

Sincerely,

Mohammad Qasim Sadiq



Mohammad Sadiq
23 July 2021

Annex V: Code Book

| Theme One: Role of religion and spirituality in the lives of Afghan immigrants |
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| Sub-Theme: Religion and spirituality as a source of distress |
| <p>Code Category: Convergent and divergent aspects of religion and culture</p> <p>Description: This code category explores the convergent and divergent facets of religion and culture, delving into the intricate interplay between these two fundamental aspects of Afghan and Muslim identity of immigrants in their home and host culture.</p> |
| <p>Codes:</p> |
| <ul style="list-style-type: none"> • Explore religion in therapy to understand its difference with culture • Differentiating religion from culture • Positive connection between religion and culture • Negative connection between religion and culture • Clients can distinguish religion and culture • Clinicians need to know the culture religion divide • For some Afghans, culture is negative, whereas religion is positive • Mix of religion and culture can result in trauma with clients • Religion and culture are hard to distinguish with Afghan clients • Therapists incorporate religion to address culture issues too • Abusive cultural practices justified as religious or cultural • Clients feel weak and powerless in religious aspect of their lives - especially women • Clients associate religion and religiousness with their traumatic experiences • Clinicians avoid pathologizing religion and culture • Religious practices and culture to justify abusive behavior • Religious practices as limiting for women - e.g., divorce • Cases of domestic violence and violence in general • Culture as the root of stigma against mental health, not religion • Mental health-related activities as being considered outside Islam • Mental health stigma associated with religion • Islam is supportive of mental health • Clients associate religion and religiousness with their traumatic experiences • Collaborative practice also addresses the stigma around mental health • Stigma can result in clients not seeking therapy as a first option but last |

- Using religion in therapy is a way to address mental health stigma for clients
- Therapists working collaboratively with clients to understand stigma and religion

Theme One: Role of religion and spirituality in the lives of Afghan immigrants

Sub-Theme: Religion and spirituality as a source of distress

Code Category: Intolerance within religion as a source of distress

Description: This code category delves into participant experiences and perspectives on intolerance within religious contexts and its consequential impact as a source of distress. The code within this category scrutinizes instances where differing beliefs or interpretations within a religious framework led to conflict, discrimination, and exclusion.

Codes:

- Islam and its sects as a source of challenge
- Intolerance and discrimination inside Islam
- Religious discussions in therapy expected to be an argument over right vs. wrong
- Religious interpretations as a source of stress for clients
- Religious intolerance and misperceptions about religion
- Religious intolerance and misperceptions about religion
- Religious intolerance
- Seeking religious support
- Religious intolerance
- Religious tolerance and acceptance
- Religious tolerance and humanity
- Clients feel weak and powerless when it comes to the religious aspect of their lives - especially women
- Clinical issues presented were related to closely held fundamental religious beliefs
- Culture mixed with religion can be used to justify gender-based differential treatment
- A collaborative approach as a means to counteract religious power assertion and bypass
- Cultural norms justified as religion are at the core of many issues for clients
- Extreme views can lead to using religion as a power assertion mechanism
- Gender-differentiated rules of religious practices and oppressiveness of those rules for women
- Clinical interventions: no God as punishment useful
- Religious interpretations as a source of stress for clients
- Religious practices and culture to justify abusive behavior
- Religious practices as limiting for women - e.g., divorce

- Extreme views can lead to using religion as a power assertion mechanism
- Gender-differentiated rules of religious practices and oppressiveness of those rules for women
- Religion used as justification for abuse by loved ones - parents, husband
- Religion used for rules and not a daily practice in life
- Cases of domestic violence and violence in general
- Culture mixed with religion can be used to justify gender-based differential treatment
- Religious interpretations as a source of stress for clients

Theme One: Role of religion and spirituality in the lives of Afghan immigrants

Sub-Theme: Religion and spirituality as a source of distress

Code Category: Association of traumatic experiences and discrimination with religion

Description: This code category investigates the intricate association between traumatic experiences, discrimination, and religion. It focuses on understanding how individuals or communities may endure traumatic events linked to their religious identity and how discrimination based on religion can exacerbate these traumas.

Codes:

- Clients who equate religion in any way, shape, or form with their abuses and want to stay away from them.
- Cultural norms justified as religion are at the core of many issues for clients.
- Religion can also be used to justify abuse.
- Religious practices and culture to justify abusive behavior.
- Religious practices as limiting for women - divorce, for example.
- Clients may leave religion as a result of negative experiences.
- Intergenerational issues as a main concern in therapy for Afghan clients.
- Clients report being pressured to adopt mainstream culture and clothing styles.
- Clients report being directed to change clothing as a way to free themselves.
- Mainstream organizations' preconceived notions of client religiosity.
- Religion and cultural values as a source of stress as they resettle, and children start taking on new values.
- Clients are expected to assimilate.

Theme One: Role of religion and spirituality in the lives of Afghan immigrants

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| Sub-Theme: Religion and spirituality as a source of distress |
| <p>Code Category: Misuse of religion as a justification for maladaptive psychological mechanisms</p> <p>Description: This code category delves into the critical exploration of the misuse of religion as a justification for maladaptive psychological mechanisms. It focuses on understanding instances where religious beliefs or doctrines are manipulated or distorted to rationalize harmful behaviors, attitudes, or coping mechanisms.</p> |
| Codes: |
| <ul style="list-style-type: none"> • Countering religious bypass • Ineffectiveness of religious bypass and culturally driven religious practices • Religious bypass as ineffective and harmful • Clinicians find it important to address spiritual bypass by challenging it • Extreme views can also impact therapeutic relationship as client seeks religious validation • Religion and God's punishment as a justification for previous mistakes (religious wrongdoings) • Therapists differentiating culture and religion in dealing with mental health stigma • Clinicians addressing issues keeping religious beliefs intact or unchallenged - even if they are close to spiritual bypass • Clinical issues presented were related to fundamental religious beliefs being closely held |
| Theme One: Role of religion and spirituality in the lives of Afghan immigrants |
| Sub-Theme: Religion and spirituality as a source of distress |
| <p>Code Category: Acculturation and religious identities of children growing up in Canada</p> <p>Description: This code category delves into the intricate interplay between acculturation and the development of religious identities among children growing up in Canada. It focuses on understanding how the process of acculturation, where individuals adopt aspects of a new culture while retaining elements of their heritage, influences the formation and evolution of religious beliefs and affiliations.</p> |
| Codes: |
| <ul style="list-style-type: none"> • Unsupportive community • Compromises for resettlement • Coping challenges • Culturally diverse clients being judged severely • Disconnect from religious community due to disconnect from Afghan community • Discrimination based on religion and views of religion • Discrimination shows up in sessions regularly • Forced migration • Having a constant sense of loss as an immigrant despite the benefits |

- Immigration process hardships
- Lack of acceptance in the community because of religious beliefs
- Loss of educational achievements and career
- Losses as immigrants as a source of doubts and discrimination as an add-on to that process
- Discrimination and prejudice
- Hardship in immigration and resettlement challenges
- Religious beliefs or lack of them as a challenge to connect to the community
- Mental health issues because of being an immigrant and away from home
- Perceived discrimination because of religious identity
- Being judged due to being a Muslim
- Religious exclusion from own community in CA
- Clients being proud of their identities despite the negative emotions of others around them
- Clients dealing with discrimination and judgment constantly
- Religious categorization based on specific stereotypes
- Difference of perspective between children and parents. Children more questioning.
- Older first-gen immigrants use religion as a means to make sense of events.
- Parents of clients being angry or upset if the client left religion
- Younger first-gen immigrants more questioning compared to older first-gen immigrants
- Younger generations struggle with getting a good understanding of the place of religion in their lives
- Youth wanting to figure out their place in relation to religion and culture
- Clients with CAS tend to lose culture because of distance from religion and culture.
- Intergenerational issues as core issues within families

Theme One: Role of religion and spirituality in the lives of Afghan immigrants

Sub-Theme: Religion and spirituality as a source of support

Code Category: Religion and spirituality as a coping mechanism

Description: This code category delves into the role of religion and spirituality as coping mechanisms in the face of life's challenges and adversities. It focuses on understanding how individuals turn to their faith, belief systems, and spiritual practices to navigate and make sense of difficult circumstances.

Codes:

- Clients using religious practices as coping mechanisms
- Religion and science - mental health go hand in hand and support each other
- Religion as a uniting factor

- Religion has never been a source of distress
- God as a witness, supporter, and helper
- Helped clients stay grounded after becoming religious
- Prayers used as therapeutic tools
- Religion perceived as a higher power, a place of wisdom and grounding
- Religion as a helpful aid to mental health
- Religion as a source of support and helpfulness to deal with hardships
- Religion in therapy is positive
- Religion in therapy process - self-directed
- Religious support from an Imam
- Value system
- Groundedness
- Peace and comfort
- Sense of satisfaction because of a change in perspective on religiousness
- Clients use religion as a tool
- Clients use religion as a way of life
- Religion and the religious community as sources of support in resettlement and community support
- Religion as an important aspect of clients' lives
- Religion as a source of support and distress for Afghan clients
- Religious beliefs considered by clients as the solution to issues
- Religion and religious practices as sources of mental health support
- Religion as a source of support in immigration
- Religion as a helpful resource
- Religion as part of life
- Therapeutic relevance
- Religious identity as a support system in the immigration journey
- Emotional empowerment and connection with God
- Praying as a way to connect with God
- Source of connections
- Clients appreciated support with religion even in the absence of therapy
- Clients find religiousness or the lack of religiousness as sources of their issues
- Reading the Quran as a tool for therapeutic means

- Religion as a common ground for connection with other Muslims from all around the world
- Religion as a source of support, resiliency, and oppression

Theme One: Role of religion and spirituality in the lives of Afghan immigrants

Sub-Theme: Religion and spirituality as a source of support

Code Category: Religious and spiritual community as a source of support

Description: This code category delves into the significance of religious and spiritual communities as sources of support, camaraderie, and belonging. It focuses on understanding how individuals find a sense of connection, purpose, and shared values within these communities.

Codes:

- Balancing life during resettlement
- Community support
- Supportive community
- Family and relationships with family
- Family connection as a resource
- Positive role of religion in resettlement
- Hardship in immigration
- Importance of community and belonging
- Importance of companionship and sharing
- Importance of family and connections for mental health
- Speaking to family as a way to address stress
- Religious constraints in Canada
- Resettlement hardship
- Traumatic experiences of immigration
- Companionship and marriage as a way to address loneliness
- Speaking to family as a way to address stress
- Clients being proud of their identities despite the negative emotions of others around them
- Religion and religious community as a source of support in resettlement and community support
- Religion as a common ground for connection with other Muslims from all around the world
- Clients who have spent more time in Canada may be more open to therapy
- Mainstream perspectives that practitioners stereotype Muslims for their way of life
- Clients using religious practices as coping mechanisms
- Religion and science - mental health go hand in hand and support each other

- Religion as a uniting factor
- Religion has never been a source of distress
- Has not been a source of distress
- A resource
- God as a witness, supporter, and helper
- Helped clients to stay grounded after becoming religious
- Prayers used as therapeutic tools
- Religion perceived as a higher power, a place of wisdom and grounding
- Religion as a helpful aid to mental health
- Religion as a source of support and helpfulness to deal with hardships
- Religion in therapy is positive
- Religion in the therapy process - self-directed
- Religious support from an Imam
- Religion as an important aspect of clients' lives
- Religion as a source of support and distress for Afghan clients
- Religious beliefs considered by clients as the solution to issues
- Religion and religious practices as a source of mental health support
- Religion as a source of support in immigration

Theme One: Role of religion and spirituality in the lives of Afghan immigrants

Sub-Theme: Religion and spirituality as a source of support

Code Category: Religion and spirituality as a meaning-making mechanism

Description: This code category delves into the profound role of religion and spirituality as mechanisms for creating and seeking meaning in life. It focuses on understanding how individuals turn to their faith, beliefs, and spiritual practices to find purpose, coherence, and significance in their experiences.

Codes:

- Although clients question how God takes care of them, they also use religion to justify it.
- Clients asking questions about religion and culture.
- Clients being skeptical about the religion parents want them to follow.
- Clients connect challenges to religion.
- Clients connect to a higher being.
- Clients connect challenges and their abilities to God and religion.
- Clients question religion because of being judged for it.

- Clients questioning belief in God and questioning God's role.
- Discomfort with gender differences in religion and expectations from two genders as sources of struggle.
- For many clients, religion is part of their identity and influences how they see and operate in the world.
- For many, it is what they were taught through generations and less about identity.
- Major issues of Afghan clients are conceptualized as God's plan.
- A practical way of life.
- Religion and religious practices as sources of mental health support.
- Religion as a source of support in immigration.
- Religion as a way of life.
- Religion as being personal and positive.
- Religion as a helpful resource.
- Religion as part of identity.
- Religion as part of life.
- Religion being identity versus a way of life for clients.
- Religion creates a sense of community.
- Religion is a major mechanism of meaning-making for many clients.
- Religious affiliation.
- Religious identity as a support system in the immigration journey.
- The role of religion in clients' lives.
- Praying as a way to connect with God.
- Source of connections.
- A sense of fear induced by the obligatory nature of religious practices as a source of stress.
- A sense of satisfaction because of a change in perspective on religiousness.
- Clients appreciated support with religion even in the absence of therapy.
- Clients use religion as a way of life.
- The majority of clients identify as Muslims.
- Religion was also a superficial aspect - attire but not practicing.
- Change of perspective from a God that is against me to a God that can help me.
- Religion as a justifying mechanism - punishment from God.
- Emotional empowerment and connection with God.
- Some clients hide it out of fear of being judged for their religious identity.

- Some clients are strong in the face of discrimination and continue to practice.
- Sports as an alternative to deal with stress in the absence of spirituality.
- Views on religion as being part of everyone's life.
- Youth wanting to figure out their place in relation to religion and culture.
- Religious tolerance and humanity.
- Clients being proud of their identities despite the negative emotions of others around them.
- Religion perceived as a higher power, a place of wisdom and grounding

Theme One: Role of religion and spirituality in the lives of Afghan immigrants

Sub-Theme: Religion and spirituality as a source of support

Code Category: Religion and spirituality as a key contributor to resiliency

Description: This code category delves into the significant role of religion and spirituality as key contributors to resilience in the face of adversity and challenges.

Codes:

- Resilience
- Clients use religion as a tool
- Religion as a part of identity and a source of resilience
- Religion as a source of support, resiliency, and source of oppression

Theme One: Role of religion and spirituality in the lives of Afghan immigrants

Sub-Theme: Changing attitudes of participants towards religion and spirituality

Code Category: Increase in religious and spiritual practices in the post-migration phase

Description: This code category examines the notable increase in religious and spiritual practices that often occur during the post-migration phase. It focuses on understanding how individuals and communities, after relocating to a new country or culture, often intensify their engagement with religious and spiritual activities.

Codes:

- Change in attitude towards religion
- Empowering
- More practicing
- Despite being non-religious, at times go back to reading the Quran
- Religious beliefs and views
- Change in religious experience after immigration
- Change in religious practice after migration
- Change of perspective from a God that is against me to a God that can help me

- Influence of a change of belief system on others - encouraging openness of others
- Issues with the practice of religion
- View on religion changing to be more present
- Change of religious view to more practicing after coming to Canada
- Openness to discuss religion as we grow up and have more solid perspectives
- Positive religious experiences in Canada
- Relief from a sense of guilt induced by religion as calming
- Religious practices as empowering
- Religious practices being just duties
- Religious practices when young
- Religion as a justifying mechanism - punishment from God
- Role of religion different in Canada vs home culture
- A source of support that was less used in home culture
- Emotional empowerment and connection with God
- Views on religion as being part of everyone's life
- Change of perspective on religion as a challenging issue for the family to adjust to
- Religion as a way of life but not accepted
- Mental health is stigmatized with clients
- Religion as an integral part of the process that defines positive, negative, or neutral

Theme One: Role of religion and spirituality in the lives of Afghan immigrants

Sub-Theme: Changing attitudes of participants towards religion and spirituality

Code Category: Decrease in religious and spiritual practices in post-migration phase

Description: This code category explores the decrease in religious and spiritual practices that sometimes occur during the post-migration phase. It focuses on understanding how individuals and communities, after relocating to a new country or culture, may experience a reduction in their engagement with religious and spiritual activities.

Codes:

- Moving away from religion
- Clients do not come back to religion down the road of therapy
- Conservatism of the community as a key factor in staying away from religion
- Conversion from Islam
- Difficulty identifying how religion can be useful
- Distance from religion due to religious superiority

- Freedoms in Canada
- Moving away from religious beliefs because of how culture shapes them
- Moving away from religion by choice
- Negative experiences and expectations from religious guidance
- Not having a religious identity
- Lack of connection to religion due to a lack of connection to Afghans
- Religion does not solely define who you are.
- Religious practices - induced sense of guilt for missing them
- Religious practices as being ineffective
- Religious skepticism
- Religious skepticism and questioning religious practices
- Does not follow
- Client's move to religiosity impacts relationships and adjustment
- Clients suffering consequences due to their belief system
- Clients may leave religion as a result of negative experiences
- Some clients go from one end to the other - not being religious to being religious

Theme One: Role of religion and spirituality in the lives of Afghan immigrants

Sub-Theme: Changing attitudes of participants towards religion and spirituality

Code Category: Change of belief system in the post-migration phase

Description: This code category examines the phenomenon of belief system change that can occur during the post-migration phase. It focuses on understanding how individuals, after relocating to a new country or culture, may undergo shifts in their fundamental beliefs, values, and worldviews.

Codes:

- Belief in a superpower as opposed to religion
- Found more calmness from spiritual actions rather than religious practices
- Humanity as superior to religiousness
- Move from strict religious practice to open views in adulthood
- Other spiritual practices preferable to religious practices for mental health support
- No religious belief followed
- Open attitude towards religion
- Spiritual belief system as a way of life
- Spiritual person who believes in a superpower

- Spiritual side
- Sports as an alternative to deal with stress in the absence of spirituality
- Religious practices when young

Theme Two: Psychotherapeutic process of Afghan immigrants

Subtheme: Attitudes of Afghan immigrants toward mental health

Code Category: Attitudes of Afghan immigrants toward mental health

Description: This subtheme and associated codes delves into the attitudes of Afghan immigrants toward mental health, aiming to understand their perceptions, beliefs, and behaviors regarding psychological well-being in their new cultural context. Codes in the subtheme are closely related and does not require separate code categories

Codes:

- Afghan clients differ in their perception of religion and its role in their therapy.
- Anti-Western sentiments in Afghan society.
- Dealing with stress through sports.
- Solution-oriented mindset - looking for relevant solutions.
- Experience with psychotherapy.
- Importance of family and connections for mental health.
- Mental health help-seeking.
- Resettlement and transition as a key issue for therapy for Afghan clients.
- Seeking counseling as a useful approach to verbalize.
- Seeking mental health support.
- Afghan clients report mental health in somatic forms.
- Cases of domestic violence and violence in general.
- Clients expect clinicians to give them direction.
- Clients expect out-of-the-ordinary approaches in the first session.
- Clients expect Muslim therapists to be accommodating of their beliefs.
- Clients report not understanding the Western-style therapy that does not include religion.
- Doctors refer clients.
- Clients do not know what to expect.
- Clients expect their therapist to be more involved in directing the process.
- Clients are expected to assimilate.
- Female clients appreciated having a Muslim counselor.
- Letting clients know the nature of counseling is a good starting point.

- Once clients come, if therapy is addressing their needs and culture, they stay.
- Seeking therapy as a referral process
- Seeking therapy is often not the client's first choice.
- Significant histories of trauma.
- Clients at times may need empowerment.
- Clients believe clinicians will not understand them and their suffering.
- Clients sometimes lack the ability to distinguish between religion and their interpretations as a source of stress.
- Clients who have spent more time in Canada may be more open to therapy.
- Knowing the client's historical context of religion is very important.
- Clients may test clinicians for their religious tolerance before they open up about negative experiences.
- Clients receive answers for their questions on religion and therapy, and sometimes related ones in relationships.

Theme Two: Psychotherapeutic process of Afghan immigrants

Subtheme: Role of religion and spirituality in the therapeutic process – client perspective

Code Category: Inclusion of religion and spirituality in the therapeutic process

Description: This code category delves into client perspective on meaningful inclusion of religion and spirituality in their therapeutic processes, exploring how these aspects of their experience can contribute to their healing and well-being. The code category also explores client expectations from their practitioners in relation to integration of religion and spirituality in therapeutic processes

Codes:

- Approach to religiosity combined with therapy
- Exploring religion as a valuable topic to explore in therapy
- Faith as a grounding source and support mechanism to deal with challenges
- Discussion of culture and religion as important, even if it is for sharing only
- Religion as a helpful aid to mental health
- Religion as a source of support and helpfulness to deal with hardships
- Religion in therapy is positive
- Religion in the therapy process - self-directed
- Religious practice as beneficial
- Exploring the role of religion in clients' lives as a key factor
- Religion at the core of conflict and issues for therapy
- Religious beliefs considered by clients as the solution to issues

- Religious practice as a cleansing by the client
- Religious practices as coping mechanisms
- Positive role of religion in resettlement
- Clients using religious practices as coping mechanisms
- Religion and science - mental health go hand in hand and support each other
- Religion and religious practices as sources of mental health support
- Religion as a source of support in immigration
- Religion as a helpful resource
- Religion as part of life
- Therapeutically relevant religion and spirituality
- Helped clients to stay grounded after becoming religious
- Religion perceived as a higher power, a place of wisdom and grounding
- Religious inquiries as part of the intake process
- Clients use religion as a tool

Theme Two: Psychotherapeutic process of Afghan immigrants

Subtheme: Role of religion and spirituality in the therapeutic process – client perspective

Code Category: Clinician openness to inclusion of religion and spirituality in therapy

Description: This code category explores client's perspectives on the willingness and receptiveness of clinicians to incorporate client's religion and spirituality into the therapeutic process. It focuses on client experiences and perceptions on how clinician's approach and navigate the inclusion of these aspects of clients' lives in therapy.

Codes:

- With an open space, clients will take the therapist to places that are important for them in a religious sense.
- Wrong religious practices can be more harmful.
- Challenging for clinicians to work with client belief systems.
- Clients expect clinicians to give them direction.
- Clients expect out-of-the-ordinary approaches in the first session.
- Clients expect Muslim therapists to be accommodating of their beliefs.
- Clients report not understanding the Western-style therapy that does not include religion.
- Extreme views can also impact the therapeutic relationship as the client seeks religious validation.
- Supportive professionals also support clients by finding ways to address religious questions.
- Once clients come, if therapy is addressing their needs and culture, they stay.

- Clients need collaborative work with the therapist to distinguish religion from culture.
- Clinician being aware of and considering client spirituality and religious beliefs is an important part of therapy.
- Positive impact of therapist inclusivity of religious beliefs.
- Positive impact expected from a religiously accommodating therapist.
- Abusive cultural practices justified as religious or cultural.
- Clinicians' openness to religious aspects plays a role in clients feeling open to discuss.
- Therapy is expected to fit in their religious lifestyle.
- Doctors refer clients.
- Clients do not know what to expect.
- Clients expect their therapist to be more involved in directing the process.
- Clients are expected to assimilate.
- Clients may test clinicians for their religious tolerance before they open up about negative experiences.
- Client's move to religiosity impacts relationships and adjustment.
- Clients receive answers for their questions on religion and therapy, and sometimes related ones in relationships.
- Clinical issues presented were related to fundamental religious beliefs being closely held.
- Clinicians use religious practices within the frame of secular therapy techniques, like wudu or mindfulness.
- Clinicians using a narrative approach to address questions of God and reliance on God.
- Clinicians do not mention religion unless asked by clients.
- Clinicians' interventions – "no God as punishment" – are useful.
- Female clients appreciated having a Muslim counselor.
- Letting clients know the nature of counseling is a good starting point.
- Once clients come, if therapy is addressing their needs and culture, they stay.
- Seeking therapy as a referral process.
- Seeking therapy often is not the client's first choice.
- Significant histories of trauma.
- Clients expect clinicians to give them direction.
- Clients expect out-of-the-ordinary approaches in the first session.
- Clients expecting Muslim therapists to be accommodating of their beliefs.
- Clients report not understanding the Western-style therapy that does not include religion.
- Clients report being pressured to adopt mainstream culture and clothing style.
- Clients at times may need empowerment.

- Clients believe clinicians will not understand them and their suffering.
- Clients who have spent more time in Canada may be more open to therapy.
- Clinicians see distance from religion as a red flag and an area of interest.
- Knowing the client's historical context of religion is very important.

Theme Two: Psychotherapeutic process of Afghan immigrants

Sub theme: Role of religion and spirituality in the therapeutic process – clinician perspective

Code Category: Clinician ambivalence towards religion and spirituality

Description: This code category explores the complex phenomenon of clinician ambivalence towards religion and spirituality in the context of therapy.

Codes:

- Clinicians see distance from religion as a red flag and an area of interest.
- Therapists ask broad questions with the intention to understand clients' religious and spiritual beliefs.
- Therapists address resistance of the client to religion once the relationship is built.
- Therapists' awareness of religion as a key factor in client openness.
- Therapists to be aware of the risk of detachment if pushed too far.
- Clinicians can be reluctant to intervene on religious matters in a psychologically responsive manner.
- Clinicians need to be aware of their spiritualities and biases.
- Clinicians being open to exploring religious beliefs as useful in the therapeutic process.
- Clinicians encourage exploring religiously driven life goals with clients.
- Clinicians feel on the spot when it comes to religion in therapy and feel a lack of competence.
- Clinicians find it important to address spiritual bypass by challenging it.
- Clinicians find religion out of their scope of work.
- Clinicians need to know the culture-religion divide.
- Clinicians' openness to the religious aspect plays a role in clients feeling open to discuss.
- Clinicians trying to widen clients' narrative.
- Clinicians do not mention religion unless the client brings it up.
- Clinicians take a secular approach rather than mixing methods.
- Therapists let go of the idea of religion if clients do not show interest in the first attempt.
- Therapists do not force religion but consider it for their conceptualization.
- Therapists note they are not religious scholars.
- Therapists treat religion as any other topic that the client resists – discuss with caution.

- Unconsciously staying away from religion.
- Challenging for clinicians to work with client belief systems.
- Clinicians addressing issues keeping religious beliefs intact or unchallenged – even if they are close to spiritual bypass.
- Clinicians can be reluctant to intervene on religious matters in a psychologically responsive manner.
- Clinicians feel on the spot when it comes to religion in therapy and feel a lack of competence.
- Clinicians find religion out of their scope of work.
- Clinicians can be reluctant to provide direction to clients.
- Clinicians respond to questions rooted in religion the same way as other psychological dimensions.
- Clinicians use secular therapy techniques to address questions of religion.
- Clinicians do not mention religion unless asked by clients.
- Therapists pushing to accept the environment.
- Therapists rely on clients to bring religion into the process.
- Clients show openness to therapists who are non-judgmental about their religious identity.
- Religion as a source of comfort can be equated to other psychological phenomena like meditation.

Theme Two: Psychotherapeutic process of Afghan immigrants

Sub theme: Role of religion and spirituality in the therapeutic process – clinician perspective

Code Category: Cultural humility

Description: This code category centers around the concept of cultural humility, emphasizing an approach of openness, respect, and continuous learning proposed by clinicians who integrate client's religion and spirituality when engaging with diverse cultures and backgrounds.

Codes:

- Counselors need to familiarize themselves with religion and culture – cultural humility.
- Cultural humility as a principle for effective work.
- Cultural humility as a clinical practice.
- Cultural humility as a key element.
- Cultural humility as a key way to address client needs in religion.
- Listening to clients as a first step for clinicians to understand.
- The need for clinicians to listen and be humble.
- Therapists educating themselves about culture is essential.
- Therapists, even Muslim therapists, take a non-judgmental stance.
- Letting clients know the nature of counseling is a good starting point.

- Significant histories of trauma.
- Supportive professionals also support clients by finding ways to address religious questions.

Theme Two: Psychotherapeutic process of Afghan immigrants

Sub theme: Role of religion and spirituality in the therapeutic process – clinician perspective

Code Category: Safe and effective use of self

Description: This code category explores the safe and effective use of self in a spiritually integrative approach by clinicians.

Codes:

- Clinicians open to share their religion and spirituality in a sensitive and understanding way is helpful.
- Self-reflection and bias check are key factors in effective work with clients.
- Sharing religion and viewpoints as a foundational piece in trust building with clients.
- Clinicians' openness to religious aspects plays a role in clients feeling open to discuss.

Theme Two: Psychotherapeutic process of Afghan immigrants

Sub theme: Role of religion and spirituality in the therapeutic process – clinician perspective

Code Category: Inclusive therapeutic approaches

Description: This code category explores inclusive therapeutic approaches that prioritize the diverse needs, identities, and experiences of clients.

Codes:

- Therapists find a mixed clinical approach as effective.
- Religion, as a source of comfort, can be equated to other psychological phenomena like meditation.
- Clinicians should be mindful of finding like-minded professionals for collaborative work.
- Collaborative work requires professional role clarification and developing understanding.
- Collaborative work needs harmony between two professionals.
- Collaborative work reduces the burden on counselors.
- Collaborative work is very helpful in addressing client needs that are more religious.
- Collaborative work with religious scholars is helpful.
- A combined approach works well with clients.
- A combined spiritual and mental health approach is used to address issues.
- Collaborative approach is recommended when challenging religious situations arise.
- Collaborative work can have both sides - mental health on top and religious work on top with the other supporting.
- A mixed approach gives clients more autonomy.

- A mixed approach helps clients feel heard on both important fronts.
- A sense of responsibility as clinicians for the work of religious scholars or collaborators.
- Collaborative practice also addresses the stigma around mental health as religious counselors are also there.
- Islamic psychotherapy
- Therapeutic relevance of integrative method
- Religion was a topic of conversation in sessions in different ways.
- Religious support from an Imam.
- Therapists asking broad questions with the intention to understand clients' religious and spiritual beliefs.
- Therapists need to address the client's resistance to religion once a relationship is built.
- Therapists working collaboratively with clients to explore answers to religious questions.
- Therapists working collaboratively with clients to understand stigma and religion.
- Therapists ask questions relating to spirituality.
- Therapists' awareness of religion as a key factor in client openness.
- Therapists should be aware of the risk of detachment if pushed too far.
- Therapists can incorporate religion to address cultural issues too.
- Therapy more effective with inclusivity
- Using religious constructs to interpret events and situations.
- With an open space, clients will take the therapist to places that are important for them in a religious sense.
- Wrong religious practices are more harmful.
- Clinicians being open to exploring religious beliefs as useful in the process.
- Clinicians encourage exploring religiously driven life goals with clients.
- Clinicians try to widen the client's narrative.
- Clinicians using a narrative approach to address questions of God and reliance on God.
- Clinical interventions - no God as punishment - useful.
- Collaborative approach as a means to counteract religious power assertion and bypass.
- Integrating religion in conceptualization is an important element in the therapist's perspective.
- It is important to incorporate the idea of a creator and the client's religious beliefs in therapy.
- Knowing the client's historical context of religion is very important.
- A mixed approach gives clients more autonomy.
- A mixed approach helps clients feel heard on both important fronts.
- Religion can be used as a conceptualizing factor.

- Religious inquiries as part of the intake process.
- A sense of responsibility as clinicians for the work of religious scholars or collaborators.
- Supportive professionals also support clients by finding ways to address religious questions.
- Therapists find a mixed clinical approach as effective.
- Therapists use religious sources as tools in therapy.
- Therapists asking probing questions about religion and how it is operationalized in the client's life.
- Therapists discuss religion in the context of the learning process.
- Therapists explore how clients use religion as a source of support.
- Therapists explore the idea of parents and religion back and forth.
- Therapists explore how parents and other relations see it.
- Therapists inclusive of religious practice.
- Therapists not forcing religion but considering it for their conceptualization.
- Clinicians should be mindful of finding like-minded professionals for collaborative work.
- Clinicians see distance from religion as a red flag and an area of interest.
- Clinicians use secular therapy techniques to address questions of religion.
- Collaborative practice also addresses the stigma around mental health as religious counselors are also there.
- Nonjudgmental stance of therapists helps clients feel comfortable.
- Only validation can be helpful at times.
- Prayers used as therapeutic tools.
- Prioritizing the relationship of clients with religion.
- Reading the Quran as a tool for therapeutic means.
- Religion is an integral part of the process that defines positive, negative, or neutral.
- Therapist's openness to explore religion when it shows up is welcoming for clients.
- Using religion in therapy is a way to address mental health stigma for clients.
- Clinicians find it important to address spiritual bypass by challenging it.
- Clinicians use religious practices in the frame of secular therapy techniques like wudu or mindfulness.

---The End---