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Cultural and Religious Influences on Muslim Clients' Mental Health Support Experiences: A Systematic Review and Narrative Synthesis

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ABSTRACT

Aims: This systematic review aimed to synthesise qualitative empirical evidence exploring Muslim clients' experiences of seeking and receiving psychological support. The study sought to illuminate the complexity, differences and shared patterns in Muslim clients' therapeutic encounters to inform culturally responsive and inclusive mental health care practices.

Methods: A systematic review and narrative synthesis of qualitative studies was conducted using the SPIDER framework. Searches of APA PsycArticles and PsycINFO covered peer-reviewed articles from January 2020 to February 2025. Study quality was appraised with the Critical Appraisal Skills Programme (CASP) tool. Data synthesis followed Popay et al.'s four-stage narrative approach, addressing three research questions on help-seeking, therapeutic experiences and cultural-religious influences.

Findings: Ten studies met inclusion criteria. This narrative synthesis explored Muslim clients' mental health support experiences via three guiding questions. Key findings: (1) Islamic faith both supports and delays help-seeking through spiritual comfort and beliefs in jinn, black magic, or the evil eye; (2) stigma, emotional suppression and family honour concerns hinder open discussion and therapy engagement; (3) therapeutic relationships based on empathy and cultural humility outweigh shared religious identity, especially when aligned with Islamic values; and (4) cultural, relational and religious factors influence engagement.

Conclusions: This systematic review highlights how Islamic beliefs, cultural norms and relational contexts shape Muslim clients' mental health experiences. Faith can both support and hinder formal care access, while stigma and family honour concerns complicate help-seeking. Findings underscore the need for culturally responsive therapies that integrate Islamic values and acknowledge supernatural beliefs.

1 | Introduction

Mental health support encompasses psychological and therapeutic approaches that promote well-being and alleviate distress (van Agteren et al. 2021). However, access and experiences vary significantly across communities (Torres Sanchez et al. 2022). For Muslim clients, who make up over 1.8 billion people globally, engagement with mental health services is shaped by cultural, religious and social factors that influence how distress

is understood and how care is experienced (Cinnirella and Loewenthal 1999; Graham et al. 2009; Rassool 2015).

Understanding this complexity begins with recognising that Muslim communities encompass diverse ethnicities, national backgrounds, languages, migration stories and theological interpretations (Kozaric 2023; Nasir et al. 2024). Many Muslims may conceptualise emotional distress through spiritual or religious frameworks rather than the biomedical models that dominate

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Implications

- Implications for practice
 - Implications for practice pertain to how mental health practitioners can better support Muslim clients who understand their distress using their faith. Making concerted efforts to understand and explore lived experiences and beliefs may support clients to feel validated and respected. When using evidence-based therapies, such as CBT or ACT, small adjustments to include Islamic values, like patience and trust in God, could be useful. Practitioners could work towards this by engaging in ongoing reflection, seeking out meaningful training and connecting with Muslim communities and organisations.
- Implications for policy
 - Implications for policy relate to how mental health services can be set up to work better for Muslim clients. Services need to see religion as part of who people are culturally. This means giving staff proper guidance and training and creating ways to work together with faith communities. All of this makes mental health support feel more welcoming and easier to access.

Western mental health services (Haque et al. 2016). Distress may be attributed to causes such as the evil eye, *jinn* (supernatural beings in Islamic theology), or spiritual imbalance, with healing sought through prayer, Qur'anic recitation, or religious guidance instead of therapy or medication (Dein et al. 2008). These interpretations represent internally coherent worldviews grounded in Islamic tradition (Fernando 2012).

Religious beliefs can both support and complicate help-seeking. For some, distress is seen as *ibtālā'* (a divine test), punishment for sins, or evidence of weakened *īmān* (faith in Allah) (Abu-Ras and Abu-Bader 2008; Brunstein Klomek et al. 2016). From this perspective, increased worship, rather than therapy, is viewed as the appropriate response, which can lead to feelings of guilt or spiritual inadequacy when seeking professional help (alHarbi et al. 2023). Faith may therefore function as both a resource for resilience and a barrier to accessing care (Pargament and Lomax 2013).

These spiritual interpretations are embedded within broader communal and relational contexts. In many Muslim communities, help is first sought within extended family networks, where elders offer advice informed by religious teachings (Jabeen and Snowden 2022; Rothman 2021). Religious leaders, such as Imams or Islamic scholars, may also act as counsellors, providing guidance rooted in Qur'anic interpretation rather than psychological theory (Tanhan and Young 2022). This communal orientation contrasts with the individualistic focus typical of Western therapeutic paradigms (Saherwala et al. 2021). However, concerns around privacy, family honour and mental health stigma may inhibit open discussion of emotional struggles (Malik 2023).

When Muslims do access professional services, their experiences vary widely. Some report feeling affirmed when therapists acknowledge and integrate their spiritual values (Weatherhead and Daiches 2010), while others encounter cultural misattunement, including therapists who overlook, dismiss, or pathologise religious beliefs (Shah et al. 2021; Abrar and Hargreaves 2023). Therapeutic models that emphasise individual autonomy may conflict with Islamic values such as submission to Allah's will and the prioritisation of family or community over the self (Pilkington et al. 2011). Core spiritual practices, daily prayers (*ṣalāh*), supplication (*du'ā'*), fasting and Qur'anic reflection often play a central role in emotional regulation and meaning-making (Rafique et al. 2019). When these practices are excluded from therapeutic conversations, clients may feel unseen or that essential aspects of their identity are unacknowledged (Naz et al. 2019).

Help-seeking among Muslim clients is shaped by a dynamic interplay of spiritual beliefs, cultural norms, family expectations and broader social forces, such as racism, discrimination and Islamophobia (Amri and Bemak 2012; Ciftci et al. 2013). Understandings of mental distress may differ significantly from dominant Western paradigms, and some clients report feeling pressured to compromise their beliefs in therapy or misunderstood by practitioners unfamiliar with Islamic worldviews (Abu-Ras and Abu-Bader 2008; Amer and Bagasra 2013; Mitha 2020).

Despite these complex realities, no systematic exploration has yet been conducted on how Muslim clients engage with therapy once they are in the room. Existing studies tend to focus on barriers to access, are methodologically diverse, and rarely examine in-session dynamics (Pilkington et al. 2011). This fragmentation limits the development of culturally competent practice and relevant practitioner training that reflects Muslim clients' lived realities.

To address this, the present review systematically collates qualitative studies on Muslim clients' experiences of psychological support, tracing both shared and divergent themes to inform culturally responsive care. By moving beyond generalised notions of diversity, this approach seeks a more nuanced understanding of how Islamic worldviews shape therapeutic engagement (Uddin et al. 2022). A narrative synthesis was selected to explore complexity and variation without reducing findings to overly broad generalisations. The following research questions were posed:

1. How do Muslim clients perceive mental health help seeking?
2. What are the experiences of Muslim clients receiving mental health care?
3. What role do cultural, relational and religious factors play in Muslim clients' experiences of mental health care?

2 | Methods

A systematic review and narrative synthesis of qualitative literature were undertaken to explore the experiences and adaptations of mental health support for Muslim clients across different cultural contexts.

TABLE 1 | SPIDER criteria applied to the current study.

SPIDER criterion	Inclusion criteria	Exclusion criteria
Sample (S)	Muslim clients aged 18 to 65 years seeking mental health support in Western and Muslim-majority countries	Studies involving non-adult (< 18) samples or non-Muslim communities
Phenomenon of interest (PI)	Experiences and adaptations of mental health support across cultural contexts, including religious and spiritual integration, cultural adaptation, stigma and accessibility	Studies not related to help-seeking or mental health, or those focusing solely on interventions without exploring client experiences
Design (D)	Primary qualitative studies (e.g., interviews, focus groups, ethnography, case studies, theoretical analyses with qualitative evidence)	Quantitative studies or mixed-methods studies
Evaluation (E)	Client perspectives on mental health support, treatment adaptation, cultural and religious integration, accessibility, engagement and barriers	Studies that do not explore Muslim clients' own views, focus only on professionals or carers and overlook cultural or religious aspects
Research type (R)	Primary peer-reviewed qualitative studies	Non-empirical research, including reviews, meta-analyses and grey literature

2.1 | Eligibility Criteria

The research question and eligibility criteria were defined using the SPIDER tool (Cooke et al. 2012), which examines Sample, Phenomenon of Interest, Design, Evaluation and Research type (details in Table 1).

2.2 | Search Strategy and Terms

A comprehensive literature search was carried out using two electronic databases: APA PsycArticles and PsycINFO. The search was limited to full-text, peer-reviewed journal articles published in English between 1 January 2020 and 20 February 2025. Non-English publications were excluded due to the language capacities of the researcher, rather than relevance, and this limitation is acknowledged in interpreting the findings. The 2020 start date was chosen to align with the release of recent guidance on culturally adapted psychological interventions, ensuring the review reflects contemporary practices and understandings.

The search terms were developed around four core concepts (see Table 2). These terms were combined using Boolean operators (AND, OR) to construct comprehensive search strings (full search strategy is provided in Appendix A).

2.3 | Study Screening

The initial yield of 1,324 studies was imported into RefWorks, with duplicates manually removed. Title/abstract screening preceded full-text review against eligibility criteria. The lead investigator (YM) and a peer (AC) screened all entries independently. Disagreements were resolved through discussion, with

TABLE 2 | Core concepts and example search terms used in the literature search.

Concept	Search terms
Muslim identity	“Muslim”, “Islamic”, “Muslim client*”, “Muslim communit*”, “Islamic communit*”
Mental health support	“mental health support”, “psychological support”, “therapy”, “counsel”, “psychotherapy”
Qualitative methodology	“qualitative research”, “ethnograph*”, “phenomenolog*”, “thematic analysis”, “interview*”
Geographic context	“UK”, “United Kingdom”, “Asia”, “Middle East”

Note: Terms were selected to capture studies exploring Muslim identity, experiences of mental health support, qualitative approaches and relevant geographic regions. Asterisks (*) indicate truncation to capture multiple word endings.

supervisor arbitration available. Exclusions followed PRISMA guidelines (Page et al. 2021) and study quality was assessed using CASP criteria (Critical Appraisal Skills Programme 2024). The full process appears in Figure 1.

2.4 | Data Extraction

Key study characteristics, including author details, country of study, aims, sample size, participant demographics, data collection and analysis methods, and primary themes, were extracted and organised using Microsoft Excel for Mac by YM.

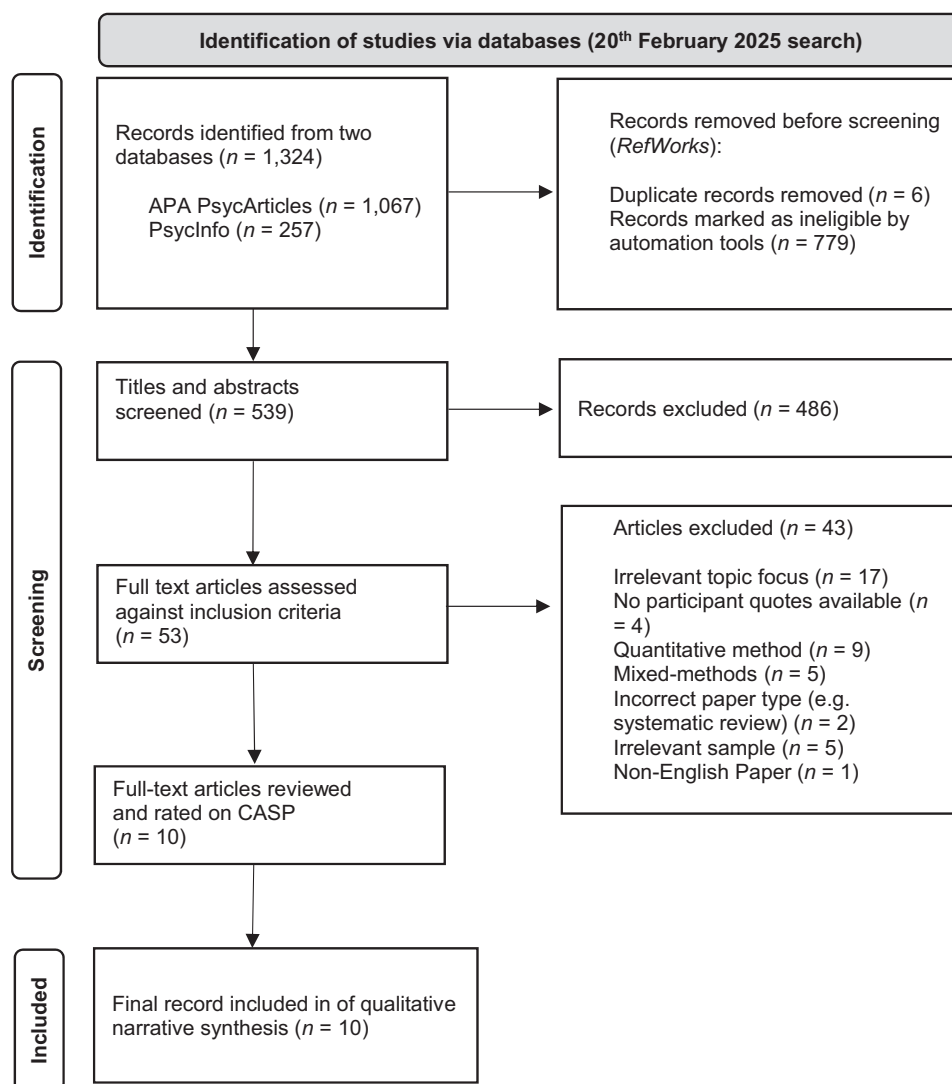


FIGURE 1 | PRISMA flow diagram summarising the stages in eligibility screening from the database searches.

2.5 | Quality Assessment

The quality of the included studies was assessed using the Critical Appraisal Skills Programme (2024) tool, which evaluates validity, results and applicability across 10 items. The lead investigator (YM) and a peer (AC) independently rated each paper and their scores were compared to ensure consistency, with both agreeing on the ratings. Even though the studies varied in quality, all were included due to the limited number of relevant papers available, allowing for a wider range of insights (Thomas and Harden 2008). The details and CASP ratings are available in Appendix B.

2.6 | Data Synthesis

A narrative synthesis, guided by Popay et al. (2006), was used to interpret qualitative findings across diverse studies, chosen for its suitability in addressing the conceptual and contextual heterogeneity of the literature. This approach prioritised the narrative meaning of each study, preserving the cultural, relational

and religious contexts of Muslim clients' experiences. The synthesis progressed through four iterative stages: summarising key findings, identifying patterns and divergences, examining inter-study relationships and engaging in reflexive interpretation to construct a coherent account that addressed the review's research questions while respecting the complexity of the data.

3 | Results

A systematic database search conducted on 20 February 2025 identified 1,324 records across APA PsycArticles ($n = 1,067$) and PsycINFO ($n = 257$). After removing six duplicate entries using RefWorks, additional automated filters (e.g., by publication type, language and peer-reviewed status) were applied at the database level, resulting in 539 records for manual screening by title and abstract. A further 53 full-text papers were reviewed, of which 10 met the inclusion criteria and were included in the synthesis. A summary of the selection process is presented in the PRISMA flow diagram (Figure 1). Key study characteristics are summarised in Table 3.

TABLE 3 | Key features of the articles included in the review ($n = 10$).

Study	Country of study	Title	Number of participants	Participant age	Data collection method	Data analysis approach	Main themes	Findings
Ali et al. (2022)	USA	Role of mosque communities in supporting Muslims with mental illness	$n = 37$	18 to 55 years (Gender-segregated groups)	Focus groups	Content analysis (Thematic approach)	Community support, stigma, religious coping	Mosque communities play a crucial role in mental health support, but stigma remains a barrier. Participants valued religious coping strategies
Alnaji et al. (2023)	Lebanon	Syrian refugee women's maternal mental health perceptions, coping strategies and help-seeking practices in Lebanon	$n = 8$	Postpartum mothers—19 to 37 years	Semi-structured interviews	Phenomenological analysis (Colaizzi's method)	Refugee health, maternal mental health, coping strategies	Refugee women faced barriers to mental health support due to stigma, financial constraints and limited services
Alqasir and Ohtsuka (2024)	Saudi Arabia	The impact of religious cultural beliefs and superstitions in shaping the understanding of mental disorders and mental health treatment among Arab Muslims	$n = 12$	18 to 60 years (6 men; 6 women)	Semi-structured interviews	Thematic analysis (Braun & Clarke)	Cultural beliefs, superstition, mental health awareness	Religious and cultural beliefs influence mental health perceptions; some view mental illness as supernatural, leading to delays in seeking professional help
Bahattab and AlHadi (2021)	Saudi Arabia	Acceptance and Commitment Therapy (ACT) for Saudi Muslim women with depression and anxiety	$n = 8$	Eight women aged between 21 and 46 years old	Focus groups & semi-structured interviews	Thematic analysis (Braun & Clarke)	ACT experiences, cultural adaptation, emotional regulation	ACT was effective but required cultural modifications to align with religious beliefs

(Continues)

TABLE 3 | (Continued)

Study	Country of study	Title	Number of participants	Participant age	Data collection method	Data analysis approach	Main themes	Findings
Callender et al. (2022)	USA	Prayer and mindfulness in relation to mental health among first-generation immigrant and refugee Muslim women	$n = 9$	Nine women aged between 20 and 50 years old	Focus groups & semi-structured interviews	Thematic analysis (Braun & Clarke)	Religious coping, community support, intentional awareness	Participants used prayer and mindfulness to manage stress, though some faced community stigma
Harrison et al. (2025)	UK	'You've gotta be a man and be strong': Pakistani fathers' experiences of perinatal loss	$n = 5$	25 to 50 years	Semi-structured interviews	Interpretative phenomenological analysis	Masculinity, grief, stigma in Muslim communities	Fathers struggled with grief due to cultural expectations of masculinity, leading to suppressed emotions and isolation
Khawaja et al. (2022)	Australia	Tree of Life therapy for culturally diverse older Muslim women	$n = 9$	Nine women aged between 59 and 65 years old	Focus groups & facilitator observations—Case study approach	Thematic analysis	Therapeutic benefits, feasibility, cultural adaptation	Tree of Life therapy was beneficial in promoting self-expression and community bonding but required cultural modifications
Mahmoodi et al. (2023)	Iran	Integration of Islamic spirituality in the treatment of grief for pregnancy loss	$n = 3$	3 Case studies Females aged 31, 32, 32 years	Case studies	Narrative synthesis	Islamic spirituality, grief management, coping strategies	Islamic spiritual practices provided emotional relief, facilitating grief processing and acceptance
McBryde-Redzovic et al. (2025)	USA	The family's role in mental health care: Perceptions of Bay Area Muslims	$n = 37$	18+ years (Community-based sampling) The young adults were 18–25 years old, and the older participants were 26 years old and above.	3 Focus groups, men ($n = 10$), women ($n = 17$) and young adults ($n = 10$).	Thematic analysis (Braun & Clarke)	Family involvement, mental health barriers, community perceptions	Family plays a dual role—supportive but sometimes a barrier due to stigma and lack of awareness

(Continues)

TABLE 3 | (Continued)

Study	Country of study	Title	Number of participants	Participant age	Data collection method	Data analysis approach	Main themes	Findings
Tarabi et al. (2020)	UK	Guide or conversation? The experience of second-generation Pakistani Muslim men receiving CBT in the UK	$n = 6$	22 to 45 years	Semi-structured interviews	Interpretative phenomenological analysis	CBT experiences, cultural adaptation, language barriers	Participants felt CBT was helpful but lacked cultural sensitivity; language barriers hindered effectiveness

Note: All studies explore Muslim individuals' mental health experiences across diverse contexts. Sample sizes are small and qualitative methods are used, highlighting in-depth and contextual insights rather than generalisable findings.

Abbreviations: ACT = acceptance and commitment therapy, CBT = cognitive behavioural therapy, n = number of participants.

3.1 | Study Findings

This review employed a narrative synthesis to integrate qualitative findings on Muslim clients' experiences of psychological support. Findings are structured around three guiding research questions, with narrative accounts contextualising the data and, where available, supported by participant quotations from the original studies. The aim was to generate nuanced insights to inform culturally responsive and inclusive psychological practice, rather than to draw generalisable conclusions.

3.1.1 | How Do Muslim Clients Perceive Mental Health Help Seeking?

3.1.1.1 | Faith as Both Resource and Barrier. A recurring theme across the literature is the complex and sometimes contradictory role of Islamic faith in shaping attitudes towards seeking mental health support. Many Muslim clients described turning first to spiritual practices, such as prayer, reciting verses from the Qur'an (the Islamic holy text), and placing trust in Allah (God), as their main way of coping with emotional distress. This approach often brought comfort, as psychological distress was interpreted as a spiritual test or a divine challenge, which helped individuals make sense of their distress. As one participant expressed, 'I read the Quran and I do my prayers and I ask Allah to make things better. That is what helps me the most' (Callender et al. 2022, 9).

However, findings across several studies suggest that such spiritual interpretations also created barriers to accessing professional care. Emotional difficulties were, at times, attributed to supernatural causes, such as jinn possession or black magic. These beliefs often led individuals to seek religious rather than psychological remedies. As one participant noted, 'They told me someone had done black magic. So I went to the Imam, not a doctor' (Ali et al. 2022, 6).

3.1.1.2 | Stigma and Silence. Evidence from the reviewed studies highlights the pervasive impact of stigma within Muslim communities, where mental health struggles were often deemed taboo. Seeking therapy was frequently associated with weakness or familial dishonour. One participant observed, 'In our society, when you go to see a mental health specialist, people think you are crazy' (Alnaji et al. 2023, 275). These perceptions discouraged open discussions and delayed help-seeking.

A recurring theme identified was emotional suppression, especially among women, rooted in a lack of culturally sensitive mental health awareness. For example, one woman described the silence surrounding perinatal loss: 'You don't talk about baby loss... people feel awkward, they don't know what to say' (Harrison et al. 2025, 6), illustrating broader discomfort around acknowledging emotional distress.

3.1.1.3 | Supernatural Explanatory Models. Across multiple studies, participants interpreted mental distress through supernatural frameworks, including the evil eye, black magic and jinn. In Alqasir and Ohtsuka's (2024, 285) study, nearly all participants held such beliefs. One participant explained, 'Everyone believes that magic can cause physical and mental harm'.

These explanatory models shaped help-seeking pathways. Participants frequently described turning to religious healers or engaging in ruqyah before considering formal therapy. One woman attributed marital discord to the evil eye and felt better after using traditional remedies. Another stated, 'Before I even thought of a counsellor, I went to the mosque. That's just how we deal with things' (Alqasir and Ohtsuka 2024, 287).

3.1.2 | What Are the Experiences of Muslim Clients Receiving Mental Health Care?

3.1.2.1 | The Centrality of the Therapeutic Relationship. A consistent finding across the literature is that the quality of the therapeutic relationship is often more important to client outcomes than the specific techniques used. Empathy, cultural sensitivity and non-judgemental listening are repeatedly highlighted as key components of an effective therapeutic alliance, particularly when working with clients from minoritised or faith-based communities (Alqasir and Ohtsuka 2024). This insight illustrates how religion can be central to how clients understand, experience and manage their mental health. When therapists engage with such beliefs empathetically and without judgement, they help to build a therapeutic environment where clients feel seen, respected and safe. Failing to acknowledge these frameworks can, conversely, undermine the therapeutic bond.

In contrast, when therapy feels impersonal, overly technical, or disconnected from clients' lived values, engagement often falters. For example, in a UK study of second-generation Pakistani Muslim men who completed cognitive behavioural therapy (CBT), participants described frustrations with a rigidly structured approach: 'Sometimes it felt like it was just going through the motions... like ticking boxes. There was no space for me to talk about how my faith connected to what I was feeling' (Tarabi et al. 2020, 54).

Other participants echoed a sense of being constrained by inflexible methods that left little room for emotional depth or personal meaning. One client reflected:

You want to go a bit deeper about something, and I wasn't able to do that, so that was frustrating... the therapist would actively pull me back and say we are losing focus. I found that quite frustrating and sometimes it felt a bit incomplete

(Tarabi et al. 2020, 55).

3.1.2.2 | Culturally Responsive Therapeutic Approaches. An overarching theme identified is that clients appreciated therapy models that connected with their cultural and spiritual values. Across multiple studies, approaches like Acceptance and Commitment Therapy (ACT) were well received when they matched Islamic ideas, such as patience and acceptance. One participant said, 'Acceptance is a significant concept in Islam...ACT presented it in a different form' (Bahattab and AlHadi 2021, 89). Clients responded positively when therapists used familiar language and acknowledged their beliefs. Group therapy sessions also offered powerful

spaces where people could explore their identities and feel supported. One participant reflected, 'Hearing the members' values helped me clarify my values' (Bahattab and AlHadi 2021, 88).

3.1.3 | What Roles Do Cultural, Relational and Religious Factors Play in Muslim Clients' Experiences of Mental Health Care?

3.1.3.1 | Cultural and Religious Identity in the Therapeutic Alliance. A recurring theme identified is the influence of culture and religion on how clients see their therapists. Some felt more comfortable with therapists who shared their background, while others preferred someone outside their community to avoid judgement or gossip. One participant explained, 'Because she wasn't Muslim, I felt I could be more honest' (Tarabi et al. 2020, 60).

3.1.3.2 | Navigating Family Dynamics. A key theme emerging from the study is the tension between individual mental health needs and family or community expectations. Many participants described how relatives misunderstood therapy or actively discouraged it, often out of fear of stigma or concern for family reputation. One participant reflected on the emotional burden of seeking help: 'Again, it comes to the cultural issue where behavioural health or a psychiatrist appears to be such a taboo' and emphasised how only trusted family members might help someone access professional care, despite those taboos (McBryde-Redzovic et al. 2025, 4). Cultural narratives around strength, silence and preserving family honour were frequently cited as barriers to open engagement with therapy. In another discussion, participants described how parental pressure and expectations could increase distress, particularly when individual choices clashed with familial or cultural norms. This highlights how psychological support was not only stigmatised but also entangled in broader sociocultural dynamics that placed family image above individual well-being.

3.1.3.3 | Prayer and Religious Recitation as Coping Tools. Across multiple studies, participants described using prayer and verses from the Qur'an to manage emotional stress. These practices helped people feel calm and connected. For example, Syrian refugee women prayed during postpartum distress and found it emotionally grounding (Alnaji et al. 2023). Women in the U.S. also said certain verses helped them manage anxiety (Callender et al. 2022). These practices were often shared with others, such as praying with children, which helped build family strength and emotional connection.

3.1.3.4 | Islamic Teachings as Mental Health Resources. A recurring theme identified is the use of Islamic teachings to understand and cope with emotional distress. Participants often looked to the Qur'an or religious scholars for comfort and guidance. Teachings about patience, divine wisdom and life after death offered hope and meaning. For example, British Pakistani fathers found peace in the belief that they would be reunited with children lost during pregnancy (Harrison et al. 2025). These religious frameworks were sometimes brought into therapy, helping clients

make sense of their experiences in a way that felt spiritually supportive.

4 | Discussion

This review aimed to synthesise qualitative empirical evidence to explore the question: What are the experiences of Muslim clients seeking and receiving psychological support? Rather than drawing generalisable conclusions, the goal was to illuminate complexity, difference and shared patterns in Muslim clients' experiences to support more inclusive and responsive mental health care. The discussion below draws on the review findings while anchoring interpretations in conceptual frameworks and empirical insights from existing literature on Muslim mental health.

4.1 | How Do Muslim Clients Perceive Mental Health Help-Seeking?

One of the most prominent themes identified is the dual role of Islamic faith in the help-seeking process. For many clients, religious practices, such as prayer, Qur'anic recitation and trust in divine decree, served as the first line of emotional support. This supports earlier research emphasising the resilience and existential meaning derived from Islamic teachings during hardship (Saritoprak and Exline 2021). From this perspective, distress may be interpreted not as illness, but as *ibtīlā'*—a divine test or opportunity for spiritual growth (Abu-Ras and Abu-Bader 2008).

However, as found in this review and noted by scholars such as Rassool (2015) and Dein et al. (2008), these same faith-based explanatory models can deter engagement with psychological services. Mental health problems may be interpreted as evidence of weak *īmān* (faith or belief in Islam) or attributed to supernatural causes, such as *jinn* (supernatural beings in Islamic theology), the evil eye or black magic—frameworks that are coherent within Islamic cosmology but often misunderstood in clinical settings (Fernando 2012; Qamar 2013). This highlights a mismatch between clients' spiritual interpretations and the dominant biomedical models in Western services, as noted by Haque et al. (2016) and Kirmayer et al. (2003).

Additionally, the review affirmed that stigma, shame and concern for family honour continue to restrict open discussions about psychological distress. These findings align with previous studies showing that collectivist cultural values and community expectations often inhibit help-seeking, especially among women (Gunasinghe et al. 2019). Within many Muslim families, emotional difficulties are kept private to protect reputational integrity and professional support may be viewed as unnecessary or even shameful (Jabeen and Snowden 2022).

4.2 | What Are the Experiences of Muslim Clients Receiving Mental Health Care?

The quality of the therapeutic relationship emerged as central to clients' positive experiences. Cultural humility—defined as

an ongoing willingness to learn from clients about their cultural and religious worldviews—proved more important than shared religious identity. This supports Shah et al.'s (2021) findings, which challenge assumptions that cultural or religious matching automatically produces better therapeutic outcomes. Rather, as Abrar and Hargreaves (2023) argue, empathy and respectful engagement are key to establishing trust.

The review also highlighted the importance of culturally responsive interventions. Clients were more receptive to therapies that integrated Islamic values, rituals, or linguistic references—reinforcing calls from Kirmayer et al. (2003) and Fernando (2012) to move beyond generic multicultural competence towards therapeutic models rooted in clients' meaning-making systems. Furthermore, faith-based practices, such as prayer and Qur'anic recitation, were not merely coping strategies but spiritually grounded forms of healing. Prior research shows these rituals support emotional regulation and psychological resilience (Pramesona and Taneepanichskul 2018; Rafique et al. 2019), especially when practiced communally, reinforcing a sense of connection to both God and loved ones.

Group-based formats and value-driven interventions were also found to enhance engagement, reflecting Rothman's (2021) suggestion that Muslim clients often benefit from collective healing environments. Such approaches acknowledge the interdependence central to Islamic cultures, which contrast sharply with the individualistic ethos underlying many Western therapeutic frameworks (Summerfield 2008).

4.3 | What Roles Do Cultural, Relational and Religious Factors Play in the Therapeutic Experience?

This review revealed that cultural and religious identity exert complex influences on the therapeutic alliance. While some clients valued religious concordance with their therapist, others preferred religious or cultural distance to preserve confidentiality or avoid perceived judgement. These findings echo the nuanced picture drawn by Cinnirella and Loewenthal (1999), who argue that clients do not uniformly seek cultural matching but rather culturally attuned responsiveness.

Family dynamics were also central to the therapeutic process. Many participants faced tensions between the individualised nature of therapy and communal expectations prioritising family cohesion and privacy. This confirms Saherwala et al.'s (2021) findings that support is often sought within extended networks rather than from external professionals. Therapists unfamiliar with these dynamics may misinterpret resistance as denial, rather than recognising it as a reflection of competing loyalties.

Finally, the role of Islamic epistemologies in shaping mental health understanding was evident. Participants frequently turned to the Qur'an, Hadith and religious scholars, both online and offline, as primary sources of guidance, often before consulting psychological professionals. This supports Tanhan and Young's (2022) assertion that religious authorities hold epistemic authority in many Muslim communities and should be considered partners in care.

When therapists dismiss these sources, clients may feel alienated or misunderstood (Mahmud 2024).

4.4 | Implications for Practice

Practitioners should recognise the significance of religious and spiritual frameworks in shaping Muslim clients' understandings of mental distress. Beliefs such as jinn possession or divine testing can offer coherent, meaningful explanations and serve as important sources of resilience (Abu-Ras and Abu-Bader 2008). Providing a non-judgemental space where such beliefs are heard and explored respectfully can strengthen the therapeutic alliance and foster trust (Fernando 2012). Ignoring these perspectives risks alienating clients and undermining engagement.

Moreover, culturally responsive adaptation of therapeutic models is essential (Hodge 2005). Approaches such as CBT or ACT, often grounded in secular and individualist assumptions, may require modification to align with Islamic values, including patience (sabr), trust in God (tawakkul) and gratitude (shukr) (Haque et al. 2016; Kirmayer et al. 2003). Such adaptation demands more than superficial cultural references; it involves a commitment to deep, community-informed understanding of how faith shapes emotional experience and recovery goals. This work may require reflective practice, specialist training and consultation with communities or religious leaders. By adopting these practices, therapists can offer more equitable, effective and ethically attuned care that acknowledges clients' values while addressing barriers to engagement in mainstream services (Al-Krenawi and Graham 2000; Bhui et al. 2007).

4.5 | Strengths and Limitations

A key strength of this review lies in its emphasis on qualitative studies, which offer rich, first-hand insights into the ways Muslim clients experience mental health and therapy. By drawing on research conducted across a range of communities, the review captures both common themes and culturally specific nuances. It sheds light on how faith can function as both a source of support and a barrier to accessing care, depending on context.

Nonetheless, the reliance on small, qualitative samples limits the generalisability of the findings. The inclusion of mixed-methods studies or research involving larger and more diverse participant groups, spanning different ages, sects and diaspora experiences, could have strengthened the breadth and applicability of the conclusions. The stigma surrounding mental health in many Muslim communities may also have inhibited participants from sharing their full experiences. Future research would benefit from using culturally sensitive and anonymous data collection methods, such as peer-led or narrative-based approaches, to encourage more open disclosure.

5 | Conclusion

This review explored the experiences of Muslim clients in seeking and receiving psychological support. While not aiming

for generalisable conclusions, the findings suggest that help-seeking, therapeutic engagement and coping are significantly shaped by Islamic beliefs, cultural norms and relational contexts. Faith often functioned as both a source of strength and a barrier to accessing formal care, while stigma and concerns about family honour further complicated help-seeking. The review also highlights the importance of culturally responsive therapy, where interventions are adapted to align with clients' spiritual values and lived realities. It is recommended that future research build on this review by examining diverse Muslim populations across sects, diasporas and settings, and by including practitioner perspectives. By deepening understanding of the cultural and religious dimensions of mental health, services can be more ethically and effectively designed to support Muslim clients in ways that honour their identities and promote psychological well-being.

Funding

The authors have nothing to report.

Conflicts of Interest

The authors declare no conflicts of interest.

Data Availability Statement

The data that support the findings of this study are available from the corresponding author upon reasonable request.

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Appendix A

Full Search String

The following search string was used in both APA PsycArticles and PsycINFO databases:

("Muslim" OR "Islamic" OR "Muslim patient*" OR "Muslim client*" OR "Muslim communit*" OR "Islamic communit*")

AND

("mental health support" OR "mental health service" OR "psychological support" OR "therapy" OR "counsel" OR "psychotherapy" OR "mental health care" OR "mental health treatment" OR "psychological therapy")

AND

("qualitative research" OR "qualitative study" OR "ethnograph*" OR "37phenomenology*" OR "thematic analysis" OR "interpretative phenomenological analysis" OR "grounded theory" OR "narrative analysis" OR "focus group" OR "focus groups" OR "interview*")

AND

("UK" OR "United Kingdom" OR "Asia" OR "Middle East")

Appendix B

Quality Assessment of Included Studies Using the CASP Qualitative Checklist

The quality assessment of the included articles using the Critical Appraisal Skills Programme Qualitative Checklist (<i>n</i> = 10)										
	Q1. Was there a clear statement of the aims of the research?	Q2. Is a qualitative methodology appropriate?	Q3. Was the research design appropriate to address the aims of the research?	Q4. Was the recruitment strategy appropriate for the aims of the research?	Q5. Was the data collected in a way that addressed the research issue?	Q6. Has the relationship between the researcher and participants been adequately considered?	Q7. Have ethical issues been taken into consideration?	Q8. Was the data analysis significantly vigorous?	Q9. Is there a clear statement of findings?	Q10. How valuable is the research?
Study										
Ali et al. (2022)	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes, High
Alnajji et al. (2023)	Yes	Yes	Yes	Somewhat	Somewhat	No	Yes	Somewhat	Yes	Yes, Medium
Alqasir and Ohtsuka 2024	Yes	Yes	Yes	Somewhat	Yes	No	Yes	Yes	Yes	Yes, High
Bahattab and AlHadi (2021)	Yes	Yes	Yes	Somewhat	Yes	No	Yes	Yes	Yes	Yes, High
Callender et al. (2022)	Yes	Yes	Yes	Yes	Somewhat	No	Yes	Yes	Yes	Yes, High
Harrison et al. (2025)	Yes	Yes	Yes	Yes	Somewhat	No	Somewhat	Yes	Yes	Yes, High
Khawaja et al. (2022)	Yes	Yes	Yes	Somewhat	Yes	No	Yes	Yes	Yes	Yes, High
Mahmoodi et al. (2023)	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes, High