J Contemp Psychother (2017) 47:105–117
DOI 10.1007/s10879-016-9347-2

ORIGINAL PAPER

Psychotherapy in Saudi Arabia: Its History and Cultural Context

Haifa Algahtani[1] · **Yasmine Buraik**[2] · **Yasser Ad-Dab'bagh**[3,4]

Published online: 15 November 2016

Abstract The introduction of modern mental healthcare standards and services in the Kingdom of Saudi Arabia (KSA), has resulted in a gradual shift towards a more positive perspective on mental health issues and related services, and has increased the demand for qualified mental health professionals and psychological interventions (WHO 2016). Despite recent advances in mental healthcare services, psychopharmacology remains the main treatment modality for the majority of mental health issues in KSA. Psychotherapy has had a rather slow developmental trajectory in KSA, and its provision requires an understanding of many specific aspects of Saudi culture (Dubovsky 1983). This paper will shed light on the historical development and current challenges of psychiatric and psychological services and the availability of psychotherapy in KSA. By offering an explication of a selection of local social phenomena, this paper will attempt to explain how unique Saudi cultural constructs and social contexts influence the training, perception, and practice of psychotherapy in the country, outlining existing challenges as well as some expected future directions.

✉ Haifa Algahtani
haifamsg@agu.edu.bh

Yasmine Buraik
yasmineburaik@yahoo.com

Yasser Ad-Dab'bagh
yasser.dabbagh@kfsh.med.sa

[1] Arabian Gulf University, Manama, Bahrain

[2] Saudi Aramco Health Organization, Dhahran 31311, Saudi Arabia

[3] Department of Mental Health, Neuroscience Center, King Fahad Specialist Hospital-Dammam, Dammam, Saudi Arabia

[4] Department of Psychiatry, University of Ottawa, Ottawa, ON, Canada

Keywords Culture · Saudi Arabia · KSA · Psychotherapy · Mental health

Saudi Arabia: An Introduction

The Kingdom of Saudi Arabia (KSA) has a land area of approximately 2,150,000 km^2 (830,000 sq. mi), making it the fifth-largest state in Asia, the second largest Arab state, and the largest and most populous country in the Gulf Coalition Counsel (GCC). According to the Saudi General Authority for Statistics (GSA), KSA's population is estimated to be over 31 million as of 2015. 67 % of the populations are Saudis, 33 % are non-Saudi expatriates. The population is relatively young, with 47.1 % of Saudi nationals and 41 % of the total population falling in the 0–24 age range, while only 3 % of the total population is in the 65+ age group. At least 78.8 % of the population resides in urban centers (Stats.gov.sa 2016).

KSA is the birthplace of the religion Islam, which is one of the largest religions in the world. The country is referred to as "The Land of the Two Holy Mosques" and it's government and population are adherent to an orthodox interpretation of this religion. The majority of Saudis belong to the Sunni sect (Ezzi et al. 2014).

Mental Healthcare Services: A Historical Background

The World Health Organization (WHO) estimates the burden of mental disorders in KSA to be 2917 Disability-adjusted life years (DALYS) per 100,000 population with a suicide rate of 0.4 (age-standardized per 100,000 population) (Who.int 2016). The traditional view of mental illness

among Saudis largely resembles views on mental illness in traditional cultures prior to the era of modern psychiatry. The stigma associated with seeking psychiatric or psychological services in KSA is such that doing so is often equated with "being crazy" and archaic notions of madness. Arguably, this may in part be attributed to the longstanding perception of the poor quality of treatment received by the mentally ill, who were often deprived of their basic rights, including being locked up and treated against their will (Al-Habeeb et al. 2016).

The first mental health hospital, the Taif Mental Health Hospital, commonly known as "Shehar", was established in 1952 in the Western region of KSA. Mentally ill patients were often committed for lengthy periods of time (Koenig et al. 2014; Al-Habeeb et al. 2016), and Shehar was the only institution for the confinement of the criminally insane until recently. Shehar has been associated in popular culture with stigmatized notions of mental illness. Even in current colloquial expressions people are still considered to "belong in Shehar" if they act inappropriately, with an implied stigma not much different from that associated with the expression "nafsi" (Arabic for 'mental').

From the outset, psychiatric services were largely available only within a handful of psychiatric institutions that were isolated from other health services. In the 3–4 decades that followed the establishment of Shehar, psychiatric hospitals have undergone a more state-of-the-art revision and evolved to include inpatient and outpatient services as well as some addictions-related services. More recently, psychiatric services are gradually being integrated into many general hospitals.

Improved training opportunities for psychiatrists and psychologists in Western, Arab, and local universities have created alternatives to institutionalization and pharmacological treatments. Globalization and advances in media and communication have resulted in increased awareness and better understanding of mental health issues by the public similar to what other countries with comparable demographics and culture have experienced (Ezzi et al. 2014).

The Ministry of Health (MoH) remains the key provider for inpatient and outpatient psychiatric as well as psychological services in the country. Additionally, psychiatric and psychotherapy services are provided to specific segments of the population at university hospitals and hospitals affiliated with the military, National Guard, and security forces sectors (Qureshi et al. 2013). These public sectors do not charge patients for services, and provide more than 80 % of outpatient and almost all inpatient psychiatric services in the country. Private sector, where costs are paid out-of-pocket or through employer-purchased insurance coverage, psychiatric and psychotherapy services are available mainly on an outpatient basis, and may be attached to general hospitals or offered at independent private clinics.

Comparable to global trends, psychiatric and psychotherapy services remain largely hospital based, physician oriented and medication dependent (MoH report, 2014; McHugh 2016). However, and unlike the situation in developed countries, this was primarily a result of the nearly complete absence of psychotherapeutic services until the 90s of the twentieth century.

The number of mental health professionals in KSA has been progressively increasing but does not meet the complicated mental healthcare demands of a young and rapidly growing population. According to the latest mental healthcare atlas (Al-Habeeb et al. 2016) the number of mental health professionals per 100,000 population is, 11.3 nurses, 1.43 psychologists, 2.43 psychiatrists, and 2.2 social workers. The situation is significantly more dire for highly specialized services. For an example, the authors estimate that there are only about 0.08 child and adolescent psychiatrists per 100,000 population.

Mental health services in primary care settings remain limited to prescribing a restricted list of antidepressants, in part due to national policy-based restrictions on the scope of practice of primary care providers. The referral system is similar to that in Mexico (Rhem 2007) whereby primary health care physicians based in the community or at general hospitals will refer patients with mental health issues that they cannot manage to hospital based psychiatrists who will perform a symptomatic assessments, start medication in most cases, and may then refer patients to psychologists (MoH report, 2014). Rarely do primary care physicians or psychiatrists consider referring a patient to a psychologist for psychotherapy. When psychologists are consulted, the referrals most frequently request IQ testing of children with special needs or other psychometric evaluations. Primary care physicians and psychiatrists often demonstrate poor knowledge of the scope of practice of various psychology and social worker subspecialties and their specific roles in mental healthcare teams. In addition, the relative paucity of trained psychotherapists reduces the likelihood of considering psychotherapy as an option for which referrals could be made.

Based on the current referral system in most hospitals in KSA, self-referral to psychotherapy is not feasible except at private hospitals or clinics with very few exceptions. This restriction on the possibility of self-referral hinders access to care, prolongs the suffering of patients and results in complications to the individual, family and society. This is especially problematic in light of the observation by many practicing psychologists that many patients view psychological services, including psychotherapy, as less stigmatizing and more favorable to psychiatric and psychopharmacological treatment.

Psychology, Psychiatry and Psychotherapy Training

Psychology has been taught at Saudi universities since the 1970s. Bachelor of Arts (BA) degrees in Psychology are comprised of 4-year programs providing theoretical foundation courses with limited or no exposure to psychotherapy training (El-Naggar 2012).

There are numerous masters and doctoral degree programs in various universities in KSA. They offer specializations in areas such as Counseling Psychology, Clinical Psychology, Abnormal Psychology, Developmental Psychology, Social and Industrial Psychology, Psychometrics, and Forensic Psychology. Masters students in these programs are required to finish two full semesters of practical training in their area of specialty. The quality of training in these degrees is disputed among professionals in the field in KSA, especially Western university graduates from the United States, Canada, Australia, and the United Kingdom. This has resulted in much polarization in the field amongst faculty and students of these programs. While this polarization and the resulting ongoing debate on the quality of psychology training programs have helped raise the standards in these programs, they have also added to the challenges faced in establishing local professional associations for psychologists.

The Saudi Commission for Health Specialties (SCFHS) is the governing body for registering (licensing) and classifying all health professionals; it sets the general rules and procedures for professional evaluation and classification (SCFHS 2016a). Although it has made great strides in certification and licensing, degree requirements, and job scope for mental health professionals, its authority does not extend to on-the-job practice. SCFHS also oversees the development and execution of medical residency and fellowship programs, as well as arranging for standardized certification/qualification examinations at the end of these programs. Psychiatry residency training programs have commenced in 1997 under the rubric of SCFHS (Gaffas et al. 2012). Prior to that most doctors wishing to specialize in psychiatry had to seek specialization outside KSA to complete their training (Al-Sabaie 1989). Most of these psychiatrists studied in the United States, Canada, and the United Kingdom. Within the SCFHS residency programs, some training in psychotherapy became mandatory in 2012 whereby residents were required to complete two cases in psychotherapy during their four years of training without specifying a specific number of treatment or supervision hours. More recently, this has been amended to an objective of demonstrating working knowledge in at least one of the following: interpersonal psychotherapy (IPT), cognitive behavioral therapy (CBT), psychodynamic therapy, family therapy, group therapy, and/or supportive therapy (SCFHS 2016a, b). A plan to require residents to have at least one case in long-term psychotherapy is also underway. There are no reliable mechanisms yet to ensure the execution of these requirements in the different training centers. In addition, the number of qualified psychotherapy supervisors is scarce. When supervision is possible, the therapy modality most likely to be available for supervision is CBT. As a result of these practical training challenges, psychotherapy skills among Saudi Board-certified psychiatrists remain inadequate in most cases.

As an evidence-based modality of psychotherapy with proven efficacy in treating a wide range of psychological and emotional problems (McManus et al. 2010), CBT has attracted great attention by mental health professionals in KSA in recent years. This is partially due to the perceived suitability of CBT for relatively short training modules needed to increase the qualifications of many young psychotherapists in the country.

Despite the strong evidence for its effectiveness, CBT remains underutilized in clinical settings internationally due to the limited availability of comprehensive training programs and qualified CBT mental health professionals (Myhr and Payne 2016). Recognizing this deficiency, there was an effort by a core group of Western-trained Saudi psychiatrists and psychologists qualified in CBT to conduct workshops for professionals on the basics of CBT and on illness specific CBT techniques. With CBT's gain in popularity and the increased demand for it, a 'market' for CBT has evolved, resulting in a plethora of brief workshops often conducted by persons improperly qualified in CBT and offering non-standard CBT training formats. Many of the attendees of CBT workshops are professionals interested in adding a new certificate to their resume, accumulating continuous medical education (CME) hours and/or qualifying for a job promotion.

In comparison to providing brief CBT workshops, the literature has shown that providing extensive CBT training has been associated with improved therapist skills and confidence. Furthermore, there is evidence that therapist competence can affect patient outcome (Westbrook et al. 2008). These insights led to additional efforts by the same core group of CBT qualified professionals to develop two CBT diploma programs in Riyadh and Jeddah (Alsaedi and AlHadi 2015). As of now, these diploma programs have yet to be accredited by the SCFHS, and they are currently recognized only at the level of the institutions conducting them.

Another worthy development in psychotherapy in recent years was the translation of several psychotherapy resources—particularly CBT-related resources—to Arabic. Most notably, in collaboration with the Academy of Cognitive Therapy, the Cognitive Therapy Scale was translated to

Arabic to be utilized in future CBT training in KSA (Algahtani and Alhadi 2013).

Psychodynamic and psychoanalytic modalities of psychotherapy are very rarely available in KSA. As a major modality of psychotherapy worldwide, with a growing body of literature supporting its efficacy (Kivlighan et al. 2015); and with an important pioneering role in the history of psychotherapy, Saudi trainees often express substantial interest in learning about this group of therapies. Training programs, especially psychiatric residency programs, often require a working knowledge of basic theoretical concepts derived from psychoanalytic theory. They will often rely on literature that may be difficult to access to learn material that is difficult to comprehend without the support of therapists capable of explicating these concepts for them or demonstrating their use in clinical practice, let alone offering supervision.

The situation psychoanalytic and psychodynamic modalities of therapy face in KSA has resulted from a fairly unique set of circumstances specific to the country. Up until the end of the 20th century, literature on psychoanalysis and psychoanalytic theory were banned in KSA, due to the influence of religious scholars from the early decades of the century who declared much of Freud's contributions to be heretical based on a very poor and superficial understanding of some of his ideas. Exposure to psychodynamic concepts was limited to what was available in psychiatry textbooks and a few Arabic psychology textbooks. Since then, and largely the result of access to training in the West, this situation has softened and the resistance to this modality of therapy has declined substantially. Presently, there is only one member of the International Psychoanalytical Association (IPA) that is Saudi, a psychiatrist, and one Saudi psychologist that is trained as a non-IPA psychoanalyst. Three more Saudis are expected to become psychoanalysts soon. Several Western-trained psychiatrists and a few psychologists and counselors have had some training in psychodynamic psychotherapy and attempt to provide it or integrate it in their work.

There are scattered efforts throughout some academic and mental health institutions to promote other psychotherapy modalities other than CBT, particularly Family Systems Therapy, Reality Therapy and Clinical Supervision models. These efforts are being considered because psychotherapists have observed the need for these approaches in therapy sessions. These efforts are still in the infancy stage of development in KSA.

Current Status of Psychotherapy Practice in KSA

Historically, psychotherapy was provided by Western psychologists and psychiatrists who required translators to facilitate the therapeutic exchange (West 1987). There is no documentation in the literature of the therapeutic modalities that were used or found effective (Koenig et al. 2014). Research on psychotherapy practice in the GCC is rare. In a recent survey of 63 mental health professionals from different regions of KSA (Algahtani 2010), the most common intervention used in clinical practice was pharmacotherapy (71 %), followed by supportive therapy (40 %), cognitive therapy (23 %), combined approach (17 %), psychodynamic and family therapies(8 %), and group therapy (6 %). These results are not different from global trends in which psychopharmacology is the standard treatment for most mental health problems even among vulnerable populations such as children and adolescents (Baldessarini 2014; Gaudiano and Miller 2013; Overholser 2013). The above-mentioned results are based on self-reporting and do not reflect on the adherence of the psychotherapist to the standards of these therapeutic approaches or the quality of the actual psychotherapy process. Our experience suggests that CBT tends to be the most common modality in KSA among trained therapists who adhere to the therapeutic modalities they were trained to provide, and remains the most likely modality to have well-trained therapists providing it.

Based on the experience the authors of this paper in teaching and conducting psychotherapy over a period of 10–16 years, mental health professionals working in the field in KSA often employ loose and fluid definitions of psychotherapy practices and then describe their work in technical psychotherapeutic terms. Examples of this may include providing psychoeducation to a group of people then claiming the process constituted group therapy, or conducting meetings with families to discuss issues related to patients then claiming the process constituted family therapy. Such understanding has its own implications on practice and research. The looseness with which therapeutic processes and techniques are defined may also allow liberties to be taken with such techniques, often by therapists ill-equipped to make such modifications. This should not be confused with the legitimate use of what is referred to as 'eclectic' psychotherapy (Patterson 1989). We contend, based on anecdotal evidence, that such integrative approaches are used by a small number of therapists in KSA, but it is by no means a common phenomenon.

Psychotherapy in KSA is provided mostly by psychologists, psychiatrists and social workers. Psychologists and social workers practicing at university hospitals tend to have higher education and more experience in providing a variety of psychological interventions (Al-Habeeb et al. 2016), compared to psychologists working within MoH or private sectors, most of whom have no postgraduate training and limited clinical experience. Due to a mandate of acquiring competency in several modalities of psychotherapy during their training, a few psychiatrists who

completed their residency training in North American centers will provide psychotherapy but they do so mostly in their private practices.

Over the past two decades, KSA has witnessed an influx of 'quack' or non-evidence based modalities that purport to treat various mental health issues among other claims. Modalities such as neurolinguistics programming (NLP), energy healing, emotional freedom technique (EFT), tapping, and many others have gained popularity and are seen by segments of the lay public as alternatives to psychotherapy. Many of the proponents of these modalities market concepts that are tied in with culturally valued religious and spiritual concepts. Training in many of these modalities is provided in very short training courses, which has also added to their appeal. Many people were attracted to these modalities as self-help approaches and a way of seeking nonprofessional help in a manner that allows them to avoid the stigma of mental illness. Public interest in these approaches may also reflect the substantial shortage of, and difficulty in gaining access to professional mental health practitioners. These practices are generally shunned by the majority of Saudi academics and mental health professionals in KSA. This stance is especially important in the absence of a regulatory body that oversees the credentials of practitioners of these modalities claiming to treat mental health issues. While the courses, workshops and training programs appear to be popular, there is no evidence yet that the public finds these intervention modalities helpful. Just as was the fate of many other pseudo-treatments, the excitement about these practices is expected to die off gradually (Overholser 2013).

Influence of Saudi Culture on Mental Illness and Therapy

While a majority of Saudis are well-adjusted with no significant negative impact of KSA's unique religious and cultural context, many struggle to adjust with aspects of this culture while others manifest its impact through culturally-specific idiomatic expressions of distress and/or mental illness. When working within the Saudi culture or with Saudi clients or families, therapists need to understand these aspects of Saudi culture as they likely play an influential role in the everyday life of their clients.

KSA follows a strict interpretation of Islam. The holy book of Islam, the 'Qur'ãn', and 'Hadith' (sayings of the prophet Mohammad) are sourced to detail the daily life, laws, knowledge and the spiritual experiences of every Saudi as is the case for most observing Muslims around the globe (Roysircar 2003).

Additionally, large segments of Saudi society are deeply rooted in tribal and regionally specific traditions, a factor that imposes another set of complicated and strict social rules that members of the tribe are expected to honor and adhere to. This 'honor' is a collective honor whereby one's own shame affects the whole tribe; conversely the individual expects the tribe's support when facing challenges and difficulties. Issues like homosexuality, promiscuity, religious and political affiliations, are perceived as shameful and thus affect the reputation of the extended family and the whole tribe. Thus, the individual is viewed as an extension of his/her immediate and extended family that in turn are members of a bigger tribe (Al-Krenawi and Graham 2000). There are significant segments of Saudi society that do not have deep tribal affiliations, and this fact adds a need for therapists to be familiar with the significant regional and subcultural variations within Saudi society.

As this is the main objective of the paper, we have listed some key cultural factors with potential implications on the therapeutic process:

Role of the Family

The extended family is a powerful social unit in Saudi culture, and individuals attending therapy can seldom be viewed in isolation of this social structure. It is common, relative to other societies, for adult children to continue living with their family or to live in close proximity to their family even after marriage. Single young adults seeking to live independently without good justification are sometimes scorned. Adult offspring are often expected to contribute financially to family expenses when needed even if they have their own families and/or live independently. This is especially true when a family member is getting married, is building a house, buying a car, or getting an education. Siblings are expected to be supportive of each other. As a result, an individual turns to the family first when facing problems that are unlikely to stigmatize the family. Marital problems may be reported to the couple's extended families who may get involved for reconciliation or arbitration. KSA's family law is based on Islamic law, which is called "Shari'a", but with substantial contributions from specific, uniquely Saudi additions. Thus, this law gives guardianship to the father or men in the family over children and women regardless of age. It also governs duties of the offspring towards parents and vice versa.

Although protective and reassuring at one level, it is evident that this structure has the potential of becoming stifling and overpowering. In psychotherapy it is frequently the source of internal and external conflict for individuals seeking increased autonomy and individuality. This is especially true for women and young adults, but can be applicable to any family member. To add to this, many issues related to mental health or personality development

may have a stigmatizing effect on the family. This may dramatically change the dynamic of help seeking and/or the supportive stance provided by the family.

A recurrent example seen in psychotherapy is that of young adults who experience family conflict because they are neglecting to pray, adopting non-conservative dress and hairstyles, expressing liberal ideas and attitudes such as listening to music, watching movies, or using social media, or sometimes reading "wrong" books and magazines. When presenting for psychotherapy, these young adults are usually angry or feel helpless and express a sense of alienation from their family and social systems. Saudi youth are facing challenges integrating societal norms, economic pressures and self-fulfillment needs in a global world. Frequently, their issues may be perceived by professionals as idiomatic expressions or precursors of mental illness. The following are a few excerpts of actual therapy sessions with these clients.

Client #1 Female. Age 22. Education: College student. Cultural view: Undecided (self-described)

> I have decided I will run away from my parents' house until I can leave the country. I can't do anything. I went to volunteer the other day; like learn to paint houses and fix things, real volunteer work: helping people help themselves, my dad saw a girl go out with an Abaya [a traditional black robe-like garb covering a female's body] but no head cover, he started shouting "these are the people you want to hang out with". Hello!!! I am fully covered. I want to go to Toastmasters; I want to learn things… "NO! NO! NO! It is mixed [i.e. no gender segregation] and you can't go". He even told me I couldn't go out of the house without my 13-year-old brother because he has to learn to be a man! I said 'you want him to be a man at my expense?' He said "With this attitude no man will marry you!

Client #2 Female. Age: 20. Education: College student. Cultural view: Religious (self-described)

> I am active and like to participate in events at my college. You know mixed [i.e. co-ed] colleges here is a new thing, people are not used to it. Sometimes I have to work with the male students. I act very appropriately, like talk a little or joke a little. The others talk about me badly, that I have no shame. Several guys from my hometown came up to me and told me they want to protect me because I am a girl from their town. I feel now everyone is looking at me all the time and gossiping about me. I will keep doing what I do because I am not doing anything wrong. I just want to do useful things, I have ambitions.

Client #3 Male. Age: 20. Education: College student. Cultural view: Open-minded (self-described)

> Sometimes I can't take it anymore; the way people think. I had to change my isle seat because I was sitting next to a woman. Biggest sin to sit next to a woman!!! My cousin, who is my best friend, can't go out to a restaurant with me anymore because I am a guy and she is a girl. My friends in the US are very happy; they live a normal life. There is no place for us in society. I just have to leave. I can't live here. I can't be what I want to be.

Client #4 Male. Age 33. Education: Bachelor's. Cultural view: Conservative

> I am the youngest male child in my family, so usually I had to serve the coffee to male guests in social gatherings… My father and older brothers would throw me glances and sometimes come and whisper directions to me if I was not doing it right. I used to be very anxious about making a mistake, which would embarrass me and bring shame to my family… Until today I avoid social gatherings… There are so many rituals and I worry about making any mistakes.

Thus, in the above case notes, "cultural views" were indicated, which were needed to understand the clients' self-described position and how the individual related to the social paradigms in Saudi society. In all cases the client needs to be validated while simultaneously encouraged to weigh pros and cons of their choices, including legal and social ramifications for him/her. The therapist may help the client explore options for self-actualization and encourage finding alternatives that promote acceptance of self and others. Family members may be involved in the therapy if appropriate and with the patient's consent. Often conflict resolution techniques are used. Parents may be provided with psychoeducation on developmental stages and encouraged to consider more positive and lenient approaches to help alleviate their own distress as well as the client's distress.

The social construct of the family plays an important role in marriages in KSA. Most marriages are arranged by matriarchs in the groom's family. Consanguineous marriages between 1st cousins are legal and frequent and are usually the first choice of the family. Young people have to present a socially acceptable narrative if they were involved in a romantic relationship, and in most cases they

would opt to deny romantic involvement as it would be considered shameful. Since marriage is arranged by the family and extended families and tribes are central to the cultural make up, family members often continue to be a big part of the subsequent life of the couple. The following is a case that demonstrates the family's role in the married couple's life.

> A young couple has a 2-year-old child who has recently been diagnosed with autism spectrum disorder (ASD). They had a recent episode in which the husband was physically abusive for the first time, upon which his wife packed her belongings and went to her parents' house. The husband demanded that his wife should return home on her accord because she left the house on her own accord which does not mandate him socially to pick her up from her father's home. On the other end, the wife and her sisters demanded that the husband must come to pick the wife up since her father wants to talk to him. Eventually, her father-in-law called her father and apologized for his son's ill behavior and promised it will not happen again or it will be "in his face" [i.e. he would lose face and the resulting shame will be his]. In an unrelated gesture her brother called her mother and offered his total financial assistance of the special education needs for his nephew. The current crisis was resolved when it was agreed that the husband could pick up his wife and child from her parents' house without having to talk to them. When conceptualizing this case of marital discord, the couple was considered fortunate to have the family support they did have given the diagnosis and special needs of their child, which may have added significant strain on the relationship. Most local therapists would have recommended couples counseling. The domestic abuse issue would be addressed first by explaining the legal consequences to the abuser; secondly the current conflict would require further exploration, as would the couple's marital history. Anger management and assertiveness skills may also be explored. However, it is unclear that any of these interventions would have improved the outcome and there are possible negative repercussions to these interventions that may not be worth the risk. Nonetheless, a nuanced and watchful stance with particular attention to prevention of future domestic abuse is warranted.

In short, the strict application of Western therapeutic interventions that focus on occidental perspectives of individuality, autonomy and the self without considering the family may not be practical in Saudi culture (Kirmayer 2007).

Gender Differences

Traditionally the man is considered the breadwinner and guardian of the family. Females in general have fewer privileges compared to males in society even if they hold degrees or are employed. For example, many families will not allow women to go out without an escort even to university or hospital visits. Working in a gender 'mixed' or non-segregated environment is shameful in the perspective of many families even for a physician. Most marriages are arranged and pre-marital romance or courting is not socially accepted. The groom bears a substantial proportion of the expenses of marriage, and has to pay a dowry, fund a lavish wedding, and rent and furnish a home. While pre-marital sexual relationships are strictly forbidden, society is more forgiving towards indiscrete men, while a woman's indiscretion is often severely punished or results in ostracism. Although men have more privileges and are supposed to carry more social responsibilities than women, especially in public settings, this is often not the case within Saudi households today. Saudi women have experienced a radical change in their education and as a result are more aware of their worth and more demanding of their rights. Many middle aged and young women are rebelling against social norms that they perceive as cultural and not religious and deem them to be unfair to their acquired educational and occupational status. Laws against abuse have recently been introduced in the country, but there is still a long way to go in terms of social awareness, reporting, providing shelters, and training employees of various agenesis involved in dealing with domestic violence issues. A women's rights movement in Saudi society has been advocating for the reduction or elimination of many or all of these restrictions, and has enjoyed a gradually increasing support in society and in government, but not without loud opposition and often contentious, hostile debates in regular as well as in social media.

This background has resulted in a significant amount of heterogeneity in the social profiles of Saudi women in contemporary KSA. There is no 'one' Saudi woman, but rather a mosaic of Saudi women with differences in education, employment and aspirations, all of whom live under a guardianship system that is buttressed by a legal system that is a stronghold of male ultraconservatism. All this is taking place in a society that is discovering that its members fall on a continuum between the extremes of social conservatism and liberalism: While this is true of most societies, Saudi society has for decades encouraged conformity to a particular promoted image of the norm, and its realization of polarization and diversity within it was a relatively recent development. This is important for therapists providing psychotherapy to Saudi women to understand; therapists need to spend time on assessing an

individual woman's views and relationships to her culture, assess her psychological strengths, assertiveness skills, as well as her mental health issues. Saudi women often have deep emotional reservoirs and flexible coping resources that they continuously try to apply to the situational challenges they regularly encounter.

Needless to say, this imbalance of power and social privilege in favor of men is often material for psychotherapy sessions. Due to limitations on the length of this paper, only a brief excerpt from a therapy session will have to suffice as a clinical vignette:

> *Client* Female, 24, Education: 9th grade. Cultural views: conservative
>
> I have now severed all contacts with my family inside the house, I have built myself a room on the roof and furnished it with my money, and I buy my own food or eat at work. My family call me a maid and a whore because I work as a janitor and use taxis to go to work… I don't care… Would you believe that the only place I ever felt respected was at work? People say 'good morning' and 'thank you' to me!!! One of the secretaries is teaching me how to open an email account… My family can't do anything to me now because they are afraid I will run away again… My mother curses me and says "I wish you dead"… I tell her "I wish you dead too"…I will not have children because I don't want her to be their grandmother… She thinks I am a shame to the family… She threatens to have my brother beat me up… I tell her "I will file a complaint against your favorite son to the police"… I will do it!!… She worries it will affect his employment future if he has offenses on his record"

In this case example it is evident that the therapeutic approach must be guided by the client herself, while supporting the client in weighing pros and cons of her behavior, exploring consequences and the safest alternatives available to her. Although women demonstrate different levels of resilience and have varying levels of social support in dealing with gender related issues, it is our opinion that it is vital to guard against the eagerness of the psychotherapist to steer the client in any specific direction. Therapists need to practice restraint when it comes to the empowerment of women beyond their intrinsic limits and capabilities.

The Role of Religion

The importance of taking religion into account in therapy has drawn mental health professionals' attention in recent years (Post and Wade 2009; Winton 2013). This shift was supported by the positive effect of religion on health and wellbeing (Al-Yousefi 2012; Koenig 2012) and the emergence of culturally sensitive counseling (Post and Wade 2009) that respects and addresses religious issues pertinent to specific culture (Sabry and Vohra 2013). It can be argued that adopting a psychologically-minded understanding of the basic tenets of Islamic theology might be helpful in working with Muslim clients (Ad-Dab'bagh 2001).

As discussed previously religion determines a Saudi individual's worldview, including his/her view of illness in general, and mental illness in particular. Saudis generally perceive medical illness as a test from God ("Allah"). Illness is perceived to teach them patience and purify them of sin (Adib 2004; Al-Mutair et al. 2013). As in other religious denominations, additional religion-supported supernatural concepts are applied to explain mental illness such as magic, contemptuous envy, the eye (also known as the evil eye), or possession by "Jinn" (WhyIslam 2016). Ascribing illness to these factors is the main motive for patients to seek treatment from traditional faith healers (clergymen using faith based techniques for healing), and this is frequently prioritized ahead of seeking psychiatric or psychological help. These supernatural forces are seen as more acceptable explanations for psychological and psychiatric symptoms than having a mental illness such as depression or schizophrenia. This interpretation also alleviates the notion of any personal defect or responsibility since these supernatural forces can affect people randomly and equally through no fault of their own. While they are associated with some stigma, they may not affect the reputation of the family as much as mental illness could. The latter may have implications and consequences on marriage and the individual's and the family's image in society, while the former is often thought to be potentially fully reversible with the right kind of faith healing. Denying the role of the traditional healer in treatment is often counterproductive, and their involvement should be guided by the client's preference, as long as they do not interfere with the provision of care by mental health professionals. Some government hospitals have recognized faith healers as part of their staff, and their supervised and regulated involvement is now recognized as one of the patients' rights.

In a survey of cultural beliefs in mental health (Algahtani 2008), participants were asked to order factors contributing to mental illness from the most to the least important. Men assigned the following order to factors affecting mental health: (1) stress, (2) chemical imbalance, (3) fate and (4) genetics; whereas women ranked these factors in different order: (1) chemical imbalance, (2) stress (3) genetics and, (4) fate. More men compared to women considered magic and possession by Jinn as contributing factors, however, both agreed that "weakness of faith" was

as an important causative factor. This false notion, which is not actually supported by the religion (Ad-Dab'bagh 2001), is especially torturous for patients with mental illness in a deeply religious society.

Beliefs about mental illness and its cause will affect the choices of treatment, and unfamiliarity with the client's religious beliefs can affect a professional's clinical judgment (Post and Wade 2009). It is therefore imperative that psychotherapists practicing in KSA or with Saudi clients and patients are well informed and familiar with these notions to avoid confusing them with delusions, and that they familiarize themselves with client-specific perspectives on such notions to accurately assess their impact on the process of psychotherapy.

An example of a common mental illness affected by religious beliefs is obsessive–compulsive disorder (OCD). Hoarding and checking are more prevalent in Western patients with OCD as compared to Arab Muslims who experience obsessions with more religious themes and compulsions involving religious rituals (Williams and Steever 2015). Prayer in Islam is repeated five times daily at specific times with specific requirements. It requires the individual to cleanse her/himself through the practice of ablution prior to every prayer. Ablution in turn is done in a very ritualistic manner. Muslims usually manage the ablution and prayer sequence effortlessly, but for many OCD patients it becomes a problem (Williams and Steever 2015). Common themes of obsessions are related to guilt of not being a good Muslim and/or fear of punishment, and may occasionally include blasphemous or ideologically objectionable ideas. The compulsions to overcome the distressing feelings often include repeating the ablution and prayer sequence "until it feels right" or engaging in specific supplication rituals. It is extremely difficult to treat OCD in KSA without reference to religious concepts. It is often a first step in therapy to require patients to consult with a clergyman (Shaikh) about these compulsions. Many clergymen are familiar with these symptoms and commonly accept that they are attributed to OCD. They have a religious rule about ignoring the doubts. While the advice and reassurance from a clergyman may lead to a modest decrease in ritual repetition, our experience is that their prior advice is often necessary for any psychotherapeutic intervention to be successful.

Interaction between medical practitioners and traditional faith healers is limited in the majority of Arab countries (Salem et al. 2009). However, seeking treatment for an illness is mandatory in Islam. One hadith says: "To each ailment there is a treatment…" (Albukhari 2016) and the Qur'ãn "And we send down of the Qur'ãn that which is healing and mercy for the believers" (Suart AlIsra, Ayat 82). These concepts are useful to reinforce the biopsychosocial model in therapy (Sabry and Vohra 2013) and to encourage medication and psychotherapeutic compliance. It is often useful to tell patients "seeing faith healers is one way to improve, but since Allah is the ultimate healer who has created medications and placed you in the path of qualified professionals, they deserve a try" (Adib 2004; Al-Mutair et al. 2013)

A noteworthy addition to this section is the preference of some clients or patients for a Muslim psychotherapist. Clients with liberal views may prefer to see an expatriate psychotherapist. The reason cited by both groups in our clinical experience is that they believe or anticipate they would be "better understood", have "greater freedom to express themselves" and/or have a "lower likelihood of being judged". In addition to the therapist's religion, his or her gender matters for reasons that have to do with gender segregation. For example, in many sections of the health care system female therapists can only see female clients and male therapists can only see male clients or female clients in the presence of a chaperon.

Polygamy

Polygamy is a sanctioned practice in Islam and in Saudi Society. Polygamy has become more prevalent in Saudi and other Muslim cultures in recent years (Salhi 2010). A man is allowed to have up to four wives simultaneously without any of the previous wives' permission in the local interpretation of this religious sanction. From both religious and social perspectives a man is required to be fair and just to his wives and treat them all equally: financially, emotionally, socially and sexually. While this requirement is felt to be nearly impossible to meet by most, it is not abided by or perceived to be facilely achievable by enough men for the practice to be a significant social phenomenon.

In popular culture the "betrayed" wife is the latest wife prior to her husband's new marriage. So the first wife will be considered betrayed by the husband when he takes a second wife, and the second wife will be considered betrayed if he takes a third wife while the first wife is expected to be less affected and concerned when the latter takes place.

The potential for a husband to take on another wife is a constant worry for many married Saudi women. Although the initial reactions of most married women to their husbands' polygamy is similar to that to infidelity, the severity and duration of the reaction might be influenced by the woman's age, educational level, employment status, the nature of the marital relationship, the duration of the marriage, whether the couple have children, and the existence of polygamy within her family of origin. This is a time when the family of origin will rally around the couple to help them process this development in a manner that is hoped to keep the marriage intact. Initial threats of divorce

may be dissuaded by other females in the family, but occasionally goaded by them. The polygamous man may also receive support from his family and other men helping him to reconcile with the first wife and managing the situation successfully. However, some find a more hostile reception within their social circles and may be, at least temporarily shunned.

Polygamy has psychological, financial and social impacts. In a study comparing polygamous and monogamous Syrian families, women from polygamous families reported lower satisfaction in marital life, low self-esteem and decreased satisfaction with life in general. In comparison to second or third wives, first wives were more prone to experience somatization, anxiety and depression (Al-Krenawi 2013). Our clinical observations suggest that most women experience polygamy to be a form of "sanctioned infidelity". Not unlike what is often appropriate in therapy provided in the West, we believe the psychotherapeutic focus should initially be on validating the woman's feelings, providing support and allowing the woman to process her feelings about the event. Just as it may be appropriate for Western clients, it may be appropriate for the therapist treating Saudi clients to encourage problem solving using therapeutic approaches that are suited to the need of the client such as cognitive-behavioral, psychodynamic, reality, solution-focused, interpersonal and/or acceptance therapy. As always the choice of therapy or techniques should be guided by the therapist's assessment of the client's needs during various stages of therapy.

Regardless of the therapist's personal feelings about polygamy, it is imperative to avoid making decisions on the client's behalf, or to dissuade her from ending the marriage if she so wishes. It may be useful to negotiate a time frame, such as a period of six months or so, to consider the options and their repercussions before the decision to end that marriage is made. This may allow her to better reflect on or plan her situation after divorce, especially if she is unemployed, does not have a supportive family, or has children whose custody she may lose. The effects of polygamy are chronic for women from what we have observed in clinical work. Many women will turn to therapy, often for years to deal with various issues that result from polygamy such as intense jealousy, poor self-esteem issues, interpersonal conflicts with in-laws or the new wife, sibling rivalry issues and/or financial problems.

Multicultural Counseling and Psychotherapy in KSA

The Psychology Dictionary defines multicultural counseling as "simply counseling patients but taking into consideration their cultural beliefs and the effect that they can have on their treatment." (Psychology Dictionary 2016).

The Association for Multicultural Counseling and Development (AMCD) has issued a document outlining core competencies in April 1991 that has become the gold standard for multicultural counseling (Sue et al. 1992; Multicultural Competencies 1991). Some important aspects of multicultural competencies include understanding and addressing issues in multicultural counseling with clients directly, self-reflection by therapists, and ongoing education and skill development.

According to Bernal et al. (2009), cultural adaptation in the treatment context includes modification of certain protocols to become culturally compatible with the clients' meanings and values. Understanding the cultural context and influences when applying psychotherapy is likely to lead to better outcomes (Gaytandjieva and Bontcheva 2013). There exist numerous models for cultural adaptation, a fact that reflects the importance and complexity of such adaptation processes (Domenech Rodríguez et al. 2010). One of the models of cultural adaptation is the Ecological Validity Model, which will increase the congruency between the client's cultural experience and the properties of the therapy delivered (Bernal et al. 2009).

Considering CBT in KSA as a case example; it may be culturally compatible with the Ecological Validity Model for the following considerations: basic CBT concepts are in alignment with Islamic beliefs, such as the notion that changing behavior is a prerequisite for a positive outcome; and the short goal directed format and the promotion of positive thinking and optimism seem to fit social expectations from therapy (Alhadi et al. 2012). Additionally, CBT is suitable for the conservative cultural constructs of the populations, where patients initially attend therapy with an apprehension of divulging 'private family issues', 'discussing sensitive subjects', or 'being weak and emotional'. The CBT format in therapy allows many therapists to be more confident, and allows the patients a more concrete approach to their 'presenting complaint' whilst building rapport in a more 'structured way'.

This congruency was supported in a qualitative study of professionals, clients and their families about the suitability of CBT in Saudi culture (Algahtani 2015). Respondents were in agreement that CBT is a culturally appropriate therapy in KSA but requires a more appropriate translation of materials, and cultural modifications to accommodate pervasive religious beliefs that affect client views and interpretations of mental health issues.

Experiential psychology approaches such as mind–body therapies and mindfulness have been found by Saudi psychotherapists to be accepted by clients from both genders. In an unpublished research study, 'mind–body medicine groups' were found to possibly have a positive impact on

mental health issues on Saudi clients regardless of age and gender. A probable negative correlation was found with women physicians. The sample size was too small to make any conclusive inferences (Buraik 2009). The acceptance of these therapies may be explained by the relative ease with which the main concepts and practices in these approaches can be linked by psychotherapists and clients alike to common cultural and religious beliefs. In addition, it is common for Saudi clients to express their psychological distress through somatic presentations (Racy 1980; Becker et al. 2002), which is another reason for receiving these modalities openly. Psychotherapists using these modalities are recommended to keep the focus on approaches and techniques that are supported by the scientific evidence and avoid an excessive emphasis on religious aspects. In our view, the link to cultural and religious concepts is best made by the client and not suggested by the psychotherapist.

Person-centered therapy is a psychotherapy orientation used in KSA, mainly within what Saudi therapists refer to as "supportive therapy", which was ranked as the second most commonly used treatment modality (Algahtani 2010). With its emphasis on unconditional positive regard, congruence and a non-directive approach it well fits into a multicultural counseling system in KSA. However, the non-directive nature of this therapy requires special attention when used with Saudi clients, who often attend psychotherapy sessions with a view of "seeking the counsel of the wise". This is especially important in rapport building where therapists have to choose their open questions wisely. A therapist must avoid the danger of becoming the "wise person" in the client's life, and discourage dependency without losing the therapeutic alliance by appearing to be unhelpful or useless by the client. The following brief excerpts highlight this issue:

Pure approach:
Client: What do you think I should do?
Therapist: I can't tell you what to do; you are the expert on your own life. You have to decide what to do.
Client: If I knew what to do, I wouldn't be sitting in front of you. You are the therapist; you have to tell me what to do. Why else did I come to you? It is your job!
Culturally modified approach
Client: What do you think I should do?
Therapist: What have you tried to do before?
Client: What can I do? it is hopeless!
Therapist: What do your mother, sisters, or friends suggest you do?
Client: [provides examples]

We have observed that when Western, or Western-trained psychotherapists working with Saudi clients attempt to utilize language based on direct empowerment, explicit transparency or intellectualization, they may have difficulties establishing a sufficient therapeutic alliance. With clients accustomed to consulting the elders or professionals for "advice", therapists need to carefully balance building and sustaining a therapeutic alliance and client empowerment, while simultaneously staying congruent to the principles of making the client the best authority on her/his own experience. Strict adherence to non-directive therapy formats without cultural modifications seems to lead to a higher rate of attrition in our experience than when therapy is practiced with cultural modifications to the non-directive approach. This may be somewhat of a variable phenomenon that depends on the degree of individuation achieved by the client or the degree to which the client holds liberal cultural values or has exposure to Western cultures.

In psychoanalytic psychotherapy, one might have expected that its purely non-directive format could pose significant challenges to the therapeutic process. While this modality of therapy is rarely available, in the experience of one of the authors (Y.A.), similar degrees of acceptance of, comfort with and/or resistance to the basic techniques used are encountered in Saudi and Western clients. This may be due the substantial departure experienced by clients in this modality from common doctor-patient or therapist-client forms of interactions that they may have had or have grown to expect. The novel nature of the experience may allow many clients to forego such pre-existing expectations, which enables them to tolerate or benefit from this deliberately non-directive approach. Further, this therapeutic modality values the development of tolerance for ambiguity and uncertainty, capacities that are also valued religiously but are uncommon in contemporary Saudi society. Therefore, it may be relatively easy for clients to incorporate the development of these capacities in their objectives for undergoing psychoanalytic psychotherapy. However, it is difficult to be certain about the generalizability of these observations given the scarcity of therapists practicing this modality of psychotherapy in KSA.

Conclusions

This paper has attempted to provide an experiential and anecdotal account of the reality and challenges facing psychotherapy practice in KSA. In principle, providing psychotherapy in KSA is not unlike providing psychotherapy for any ethnic or culturally distinct population in any other country. The main psychotherapy approaches are used with various degrees of training. Psychotherapy research has shown that therapeutic alliance and the therapeutic relationship are the most effective factors in

therapy regardless of which type of therapy is applied (Allen 2013). It is for the successful development and maintenance of this therapeutic relationship that we believe that a culturally informed approach is necessary. Psychotherapists working with Saudi clients have to demonstrate an understanding of collective cultural as well as unique individual contributions to the personality of their clients (Dwairy 2006). As such it is imperative for non-Saudi practitioners in KSA to be trained in the core competencies of multicultural psychotherapy. It is also important for local therapists to realize, address and handle cultural issues that may interfere with the specific principles and techniques of the different therapeutic modalities. Saudi and expatriate psychotherapists need to achieve a balanced and informed stance that, on the one hand helps them consciously guard against the risk that their own opinions on Saudi cultural constructs may overshadow their therapeutic judgment and intellectual neutrality, and on the other does not lead to avoidance of honest and non-judgmental discussion of cultural issues that may be interfering with the therapeutic alliance.

In our opinion Saudis are experiencing a substantial gap between their perceived need for psychotherapy and available therapeutic services. KSA is, therefore, ripe for a major expansion in the availability of training programs and its population is likely to welcome any and all forms of psychotherapy. This places the additional responsibility on those who introduce therapeutic modalities and plan training programs to not exploit public hunger for psychotherapy and to promote well-established and evidence-based modalities.

References

Ad-Dab'bagh, Y. (2001). The median: Islamic faith and mental health. In S. Akhtar & H. Parens (Eds.), *Does god help? Developmental and clinical aspects of religious belief* (1st ed., pp. 254–289). Northvale: Jason Aronson Inc.

Adib, S. (2004). From the biomedical model to the Islamic alternative: a brief overview of medical practices in the contemporary Arab world. *Social Science and Medicine, 58*(4), 697–702.

Albukhari M (2016). *Book of Medicine—Sahih al-Bukhari—Sunnah.com—Sayings and Teachings of Prophet Muhammad (صلى الله عليه و سلم)*. http://sunnah.com/bukhari/76. Accessed on Aug 25, 2016

Al-Habeeb, A., Helmi, B., & Qureshi, N. (2016). Mental and Social Health Atlas: An update, Ministry of Health, Saudi Arabia, 2015. *International Neuropsychiatric Disease Journal, 6*(3), 1–20.

Alhadi, A., Algahtani, H., & Salem, M. (2012). Cognitive behaviour therapy in middle east: 1. In F. Naeem & D. Kingdon (Eds.), *Cognitive behaviour therapy in non western cultures* (1st ed., pp. 93–101). New York: Nova Science Publisher Inc.

Al-Krenawi, A. (2013). Mental health and polygamy: The Syrian case. *World Journal of Psychiatry, 3*(1), 1.

Al-Krenawi, A., & Graham, J. (2000). Culturally sensitive social work practice with Arab clients in mental health settings. *Health and Social Work, 25*(1), 9–22.

Allen, J. (2013). Psychotherapy is an ethical endeavor: Balancing science and humanism in clinical practice. *Bulletin of the Menninger Clinic, 77*(2), 103–131.

Al-Mutair, A., Plummer, V., Clerehan, R., & O'Brien, A. (2013). Needs and experiences of intensive care patients' families: A Saudi qualitative study. *Nursing in Critical Care, 19*(3), 135–144.

Al-Sabaie, A. (1989). Psychiatry in Saudi Arabia: Cultural perspectives. *Transcultural Psychiatry, 26*(4), 245–262.

Al-Yousefi, N. (2012). Observations of Muslim physicians regarding the influence of religion on health and their clinical approach. *Journal of Religion and Health, 51*(2), 269–280.

Baldessarini, R. (2014). The impact of psychopharmacology on contemporary psychatry. *The Canadian Journal of Psychiatry, 59*(8), 401–405.

Becker, S., Zaid, K., & Faris, E. (2002). Screening for somatization and depression in Saudi Arabia: A validation study of the Phq in Primary Care. *The International Journal of Psychiatry in Medicine*, *32*(3), 271–283. http://ijp.sagepub.com/content/32/3/271, Accessed on Aug 26, 2016.

Bernal, G., Jiménez-Chafey, M., & Domenech Rodríguez, M. (2009). Cultural adaptation of treatments: A resource for considering culture in evidence-based practice. *Professional Psychology: Research and Practice, 40*(4), 361–368.

Domenech Rodríguez, M., Baumann, A., & Schwartz, A. (2010). Cultural adaptation of an evidence based intervention: From theory to practice in a Latino/a community context. *American Journal of Community Psychology, 47*(1–2), 170–186.

Dubovsky, S. (1983). Psychiatry in KSA. *American Journal of Psychiatry, 140*(11), 1455–1459.

Dwairy, M. (2006). Counseling and psychotherapy with Arabs and Muslims: A culturally sensitive approach. ArabPsychnet ejournal. http://arabpsynet.com/Books/Dwairy.B1.pdf, Accessed Aug 26, 2016.

El-Naggar, A. (2012). Globalization influences on teaching psychology in Saudi Arabia. *Psychology Learning & Teaching, 11*(3), 396.

Ezzi, S., Teal, E., & Izzo, G. (2014). The influence of Islamic values on connected generation students in Saudi Arabia. *Journal of International Business and Cultural Studies*, *9*, 1–19. http://www.aabri.com/manuscripts/141939.pdf, Accessed on 2016.

Gaffas, E., Sequeira, R., AlNamla, R., & Al Harbi, K. (2012). Test blueprints for psychiatry residency in-training written examinations in Riyadh, Saudi Arabia. *AMEP, 3*, 31–46.

Gaudiano, B., & Miller, I. (2013). The evidence-based practice of psychotherapy: Facing the challenges that lie ahead. *Clinical Psychology Review, 33*(7), 813–824.

Gaytandjieva, A., & Bontcheva, I. (2013). Why do we fail to adapt to a different culture? A development of a therapeutic approach. *international journal of psychiatry*, *17*(3), 43–58. https://www.researchgate.net/publication/259620279_Why_do_we_fail_to_adapt_to_a_different_culture_A_development_of_a_therapeutic_approach, Accessed Jan 10, 2016.

Kirmayer, L. (2007). Psychotherapy and the cultural concept of the person. *Transcultural Psychiatry, 44*(2), 232–257.

Kivlighan, D., Goldberg, S., Abbas, M., Pace, B., Yulish, N., Thomas, J., et al. (2015). The enduring effects of psychodynamic treatments vis-à-vis alternative treatments: A multilevel longitudinal meta-analysis. *Clinical Psychology Review, 40*, 1–14.

Koenig, H. (2012). Religion, spirituality, and health: The research and clinical implications. *ISRN Psychiatry, 2012*, 1–33.

Koenig, H., Al Zaben, F., Sehlo, M., Khalifa, D., Al Ahwal, M., Qureshi, N., et al. (2014). Mental health care in Saudi Arabia:

Past, present and future. *Open Journal of Psychiatry, 04*(02), 113–130.

McHugh, R. K. (2016). Patient preference for psychological vs. pharmacologic treatment of psychiatric disorders: a meta-analytic review. http://www.ncbi.nlm.nih.gov/pubmed/23842011/, Accessed on Aug 25, 2016.

McManus, F., Westbrook, D., Vazquez-Montes, M., Fennell, M., & Kennerley, H. (2010). An evaluation of the effectiveness of Diploma-level training in cognitive behaviour therapy. *Behaviour Research and Therapy, 48*(11), 1123–1132.

Multicultural Competencies. (1991). The association for Multicultural Counseling and Development, 1st ed. [ebook] (pp. 1–3). http://www.counseling.org/Resources/Competencies/Multcultural_Competencies.pdf, Accessed on Aug 26, 2016.

Myhr, G., & Payne, K. (2016). Cost-effectiveness of cognitive-behavioral therapy for mental disorders: implications for public health care funding policy in Canada. *Canadian Journal of Psychiatry, 51*(10), 662–670.

Overholser, J. (2013). Chasing the latest fad: Confronting recent and historical innovations in mental illness. *Journal of Contemporary Psychotherapy, 44*(1), 53–61.

Patterson, C. (1989). Eclecticism in psychotherapy: Is integration possible? *Psychotherapy: Theory, Research, Practice, Training, 26*(2), 157–161.

Post, B., & Wade, N. (2009). Religion and spirituality in psychotherapy: A practice-friendly review of research. *Journal of Clinical Psychology, 65*(2), 131–146.

Psychology Dictionary. (2016). What is multicultural counseling? Definition of multicultural counseling (psychology dictionary). http://psychologydictionary.org/multicultural-counseling/, Accessed on Aug 25, 2016.

Qureshi, N., AlHabeeb, A., & Koenig, H. (2013). Mental health system in Saudi Arabia: An overview. *Neuropsychiatric Disease and Treatment*, *9*, 1121–1135.

Racy, J. (1980). Somatization in Saudi Women: A therapeutic challenge. http://www.ncbi.nlm.nih.gov/pubmed/7437655, Accessed Aug 26, 2016.

Rhem, L. (2007). Psychotherapy in Mexico: Practice, training and regulation. *Journal of Clinical Psychology, 63*(8), 765–771.

Roysircar, G. (2003). Religious differences: Psychological and sociopolitical aspects of counseling. *International Journal for the Advancement of Counselling, 25*(4), 255–267.

Sabry, W., & Vohra, A. (2013). Role of Islam in the management of Psychiatric disorders. *Indian Journal of Psychiatry, 55*(6), 205.

Salem, M., Saleh, B., Yousef, S., & Sabri, S. (2009). Help-seeking behaviour of patients attending the psychiatric service in a sample of United Arab Emirates population. *International Journal of Social Psychiatry, 55*(2), 141–148.

Salhi, Z. (2010). Polygamy and law in contemporary Saudi Arabia by Maha A. Z. Yamani. *Journal of Middle East Women's Studies, 6* (1), 134–137.

Saudi Council for Health Specialities (SCFHS). (2016a). *Guideline of professional classification and registration for health practitioners*. http://www.scfhs.org.sa/en/registration/ClassAndRegister/Reregister/Documents/Professional%20Classification%20manual%20for%20Health%20Practitioners.pdf, Accessed on Aug 25, 2016.

Saudi Council for Health Specialities (SCFHS). (2016b). *Saudi Board Psychiatry Curriculum 2015*. http://www.scfhs.org.sa/en/MESPS/TrainingProgs/TrainingProgsStatement/Psychiatry/Documents/Program%20Booklit.pdf, Accessed Aug 25, 2016.

Stats.gov.sa. (2016). *General authority for statistics*. http://www.stats.gov.sa/en/, Accessed on Aug 25, 2016.

Sue, D., Arredondo, P., & McDavis, R. (1992). Multicultural counseling competencies and standards: A call to the profession. *Journal of Multicultural Counseling and Development, 20*(2), 64–88.

West, J. (1987). Psychotherapy in the Eastern Province of Saudi Arabia. *Psychotherapy: Theory, Research, Practice, Training, 24* (1), 105–107.

Westbrook, D., Sedgwick-Taylor, A., Bennett-Levy, J., Butler, G., & McManus, F. (2008). A pilot evaluation of a brief CBT Training Course: Impact on trainees' satisfaction, clinical skills and patient outcomes. *Behavioural and Cognitive Psychotherapy, 36*(05), 569.

WhyIslam. (2016). *Jinn*. http://www.whyislam.org/on-faith/jinn/, Accessed on Aug 29, 2016.

WHO. (2016). *Integrated primary care for mental health in the Eastern Province*. http://www.who.int/mental_health/policy/services/SaudiArabia.pdf, Accessed on Aug 26, 2016.

Williams, M., Steever, A. (2015). Cultural manifestation of obsessive compulsive disorder. In: C. Lack, (ed.), *Obsessive-compulsive disorder: Etiology, phenomenology, and treatment*, 1st ed (pp. 63–84). Onus Books.

Winton, S. (2013). Religion in the consulting room. *British Journal of Psychotherapy, 29*(3), 346–357.