Islamophobia and Psychiatry

Recognition, Prevention, and Treatment

H. Steven Moffic
John Peteet
Ahmed Zakaria Hankir
Rania Awaad
Editors

Springer

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Introductory Image: Ignorance is This

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About the Editors

H. Steven Moffic, M.D. Inspired by Rusti, his wife and muse of 50 years, H. Steven Moffic, M.D., has been an award-winning psychiatrist over his 45-year career for his academic, administrative, clinical, community, educational, and cultural endeavors. In recognition of his cultural psychiatry work, he was awarded the one-time designation as a Hero of Public Psychiatry by the Assembly of the American Psychiatric Association. Educationally, his focus on educating psychiatric residents and medical students on cultural psychiatry produced the first model curricula on the subject in 1979. He later went on to write or edit several books on various topics, as well as wrote hundreds of articles and gave countless presentations. Administratively, he was Medical Director of the first community mental health center to be highlighted in Community Mental Health Center Spotlight in 1979, and in 2016 received the intermittently given Administrative Psychiatry Award by the American Psychiatric Association and the American Association of Psychiatrist Administrators. He was a Founding Board Member of the American Association of Community Psychiatrists, where he was known as "da man in ethics." Clinically, he was honored by both the local and national NAMIs. Academically, he received both Wisconsin state and federal grants for the mental healthcare of refugees in the 1990s, including Muslims from various countries, and now believes that Islamophobia and Muslim mental healthcare are the major cultural challenges in psychiatry and many societies.

John Peteet, M.D. After receiving his M.D. at Columbia University, he completed a medical internship at UNC in Chapel Hill, a residency in psychiatry at the Massachusetts Mental Health Center, and a fellowship at the Peter Bent Brigham Hospital, in Boston. For over 40 years, he has been a psychiatrist at Brigham and Women's Hospital and Dana-Farber Cancer Institute, where he is an Associate Professor of Psychiatry at Harvard Medical School. A Distinguished Life Fellow of the American Psychiatric Association, he has received several teaching awards and published numerous papers in the areas of psychosocial oncology, addiction, and the clinical interface between spirituality/religion and psychiatry. He has authored or co-edited six books, including *Doing the Right Thing: An Approach to Moral Issues in Mental Health Treatment*, *Depression and the Soul*, and *The Soul of Medicine: Spiritual Perspectives and Clinical Practice*. He serves as president of the American Psychiatric Association's Caucus on Religion, Spirituality, and Psychiatry.

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Rania Awaad, M.D. is a Clinical Assistant Professor of Psychiatry at the Stanford University School of Medicine where she is the Director of the Muslim Mental Health Lab and Wellness Program and Co-Director of the Diversity Clinic. She pursued her psychiatric residency training at Stanford where she also completed a postdoctoral clinical research fellowship with the National Institute of Mental Health (NIMH). Her research and clinical work are focused on the mental health needs of Muslims. Her courses at Stanford range from instructing medical students and residents on implicit bias and integrating culture and religion into medical care to teaching undergraduate and graduate students the psychology of xenophobia. Her most recent academic publications include works on Islamic Psychology, Islamophobia, and the historical roots of mental health from the Islamic Golden Era. Through her outreach work at Stanford, she is also the Clinical Director of the San Francisco Bay Area branches of the Khalil Center, a spiritual wellness center pioneering the application of traditional Islamic spiritual healing methods to modern clinical psychology. She has been the recipient of several awards and grants for her work. Prior to studying medicine, she pursued classical Islamic studies in Damascus, Syria, and holds certifications (*ijaza*) in Qur'an, Islamic Law, and other branches of the Islamic Sciences. Dr. Awaad is also a Professor of Islamic Law at Zaytuna College, a Muslim liberal arts college in Berkeley, CA, where she teaches courses on *Shafi'i Fiqh,* Women's *Fiqh*, and Islamic Psychology. In addition, she serves as the Director of the Rahmah Foundation, a non-profit organization dedicated to educating Muslim women and girls. At Rahmah, she oversees the *Murbiyyah* spiritual mentoring program for girls. Dr. Awaad is a nationally recognized speaker, award-winning teacher, researcher, and author in both the Islamic and medical sciences.

Editors' Introduction

Since the beginning of the new millennium, there have been many important societal changes. The escalation of Islamophobia is one of them.

Islamophobia has been extensively covered in the popular media, and its politics have been addressed in many publications and books. However, despite the inclusion of a psychological term like phobia, attention to Islamophobia within psychiatry is just emerging. Indeed, as many of our authors learned in carefully researching their topics, relevant literature is minimal.

To help address this deficiency, we embarked in June 2017 on a comprehensive edited text, inspired by a Symposium given at the annual meeting of the American Psychiatric Association in May 2017. Led by Roomana Sheikh, M.D., "Islamophobia: Social, Religious and Clinical Perspectives" was well attended, and led to considerable discussion. Following this session, Dr. Moffic was contacted by a representative from Springer about the possibility of an edited book on the topic. Dr. Moffic, in addition to editing other psychiatric books, had focused on cultural psychiatry over his 45-year career, including establishing the first model curriculum on this subject for psychiatric residents in training. Following that, another of the symposium's participants, John Peteet, M.D., who has had a major interest in the importance of religion and spirituality in the practice of psychiatry showed interest, and both then decided to test the feasibility of the project through collegial contacts.

Fortunately, not only did there seem to be enough potential chapter authors, but serendipity and contacts soon led to two other well-known psychiatrists, co-editors Ahmed Zakaria Hankir, M.D., and Rania Awaad, M.D., each a major spokesperson on Islamophobia and Psychiatry in their respective countries, Great Britain and the United States. That left us with four co-editors representing a spectrum of age, experience, religion, gender, and countries of professional work, united in a passionate concern for the psychological and societal harm of Islamophobia.

Though represented mostly by Muslim psychiatrists, the same multicultural spectrum of psychiatrists, and more, is now reflected in the chapter authors, itself a reflection of the importance for a multicultural endeavor. Diversity is represented not only by the varied perspectives on Islamophobia of Muslim psychiatrists, but psychiatrists of other religions. Most authors come from the United States, but there are also psychiatrists associated with other countries, including the United Kingdom, Saudi Arabia, Canada, and Pakistan.

Moreover, the chapter authors included prominent scholars, everyday clinicians, and a combination of both. Some as residents in training to be psychiatrists already recognize the importance of this topic for their education and that of all mental healthcare clinicians. Selected psychologists and psychiatric social workers added their expertise. All suggested that the time had come for what seemed to be the first book on this topic.

In addition to the Introductory and Concluding material, the chapters of this book are divided into four main sections, which convey the main psychiatric and psychological implications of Islamophobia and Psychiatry along the lines of recognition, prevention, and treatment: General Issues, Psychiatric Implications of Islamophobia, Specific Clinical Challenges, and Social Psychiatric Implications. Chapters are meant to both stand alone, as well as to connect with other chapters in this book. Because of this book's new and comprehensive approach to this area, some overlap and lack of consensus are inevitably present. For instance, specific definitions of Islamophobia can vary from chapter to chapter. General principles for culturally competent care are also presented from different perspectives in several chapters. It is as if the rainstorm of Islamophobia has produced a rainbow of different insights.

This book contains much information that is likely to be new to many readers. Examples include the role of Islam in establishing the first psychiatric hospitals, and the contributions of Muslim physicians to precursors of Freudian theory. Other chapters present updated perspectives of Jungian and psychoanalytic thinking on Islamophobia.

Controversial topics such as homosexuality and Islam generated among us extensive debate and discussion, but were included in the end.

In addition to covering the basics, we also included topics rarely covered topics that seemed relevant to Islamophobia. Examples included the Rohingya refugees and African-American Muslims, and the contributions of neurobiology and social psychology to intergroup conflict. Muslim women and children receive special attention. Patient care is a primary focus, but "treatment" of both civilian and military communities is also considered. When proposed chapters could not be accepted, their subject matter was covered elsewhere in this book.

Since a long scholarly book can seem dry and even well-crafted words often cannot convey all necessary meaning, we have infused this book with visual art, and devoted an entire chapter to the relevance of art. We hope that this volume is a model for the bio-psycho-social-spiritual approach of psychiatry to important human problems having broad cross-cultural implications, and that its ripple effects among readers will reduce Islamophobia and improve Muslim mental healthcare.

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Part I

General Issues

1 Mental Health in the Islamic Golden Era: The Historical Roots of Modern Psychiatry

Rania Awaad, Alaa Mohammad, Khalid Elzamzamy, Soraya Fereydooni, and Maryam Gamar

Significance of Mental Health in Islam

In Islam, human beings are viewed as socially and religiously responsible in the sight of God. An individual is expected to fulfill many duties toward oneself, one's family, one's society, and toward God. One of the central Islamic legal maxims states, "Anything that is required to fulfill a mandatory duty is, itself, mandatory" [1]. Therefore, it is not surprising that physical and mental well-being have long been revered by Muslim scholars as they are considered prerequisites to fulfilling one's mandatory duties. A quick glance at the Islamic legal texts would reveal the considerable attention placed on sanity and the significance of mental capacity, being listed in almost every chapter as a prerequisite for fulfilling religious and social duties including rituals, financial transactions, marital contracts, and others.

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Additionally, "preservation of intellect/mental capacity" is regarded as one of the five major objectives of Islamic legislation in general (the other four are preservation of religion/faith, life, family, and wealth) [2]. Anything that was believed to negatively impact one's intellectual faculties, such as intoxication, was discouraged or forbidden. Muslim scholars have even viewed strong emotional states such as severe anger as barriers to sound cognitive judgments, e.g., a judge is not to make judgments while in a state of anger [3]. The Quran and Hadith laid the foundations for such understanding.

This emphasis on mental and general health and well-being has many roots in the (revealed) Islamic tradition, i.e., the Quran and Hadith. The Quran and Hadith address general concepts related to illness and health, offering guidance for advancing knowledge on the subject. Hadith has opened the doors for people to look for cures for all illnesses. It emphasized that for every illness created by God, a cure was equally created [4]. Consequently, Muslims as early as the first converts following Prophet Muhammad in the 600s CE invested deeply in matters concerning healing and medicine. The way in which classical Muslim philosophers and scholars viewed health is similar to the definition suggested by the World Health Organization (WHO) which describes health as "a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity" [5]. Among many examples is that of the famous al-Balkhi from the ninth century who advocated for a balanced approach to well-being that takes into consideration both psychological and physical aspects of health [6].

A Comprehensive Outlook: Relationship of the Mind and Body

Recently, integrating behavioral and physical health has gained increasing attention and support through the establishment of programs that address both the mind and the body [7]. Many studies have documented the significance of the "mind-body" connection. For example, emotional states have been shown to impact the immune system's response to infections [8]. Other studies have shown that psychological factors can influence cardiac conditions and promote adverse cardiac events [9]. Positive emotions have also been linked to less likelihood of developing physical illness including hypertension, diabetes, and respiratory infections [10]. While this remarkable acknowledgement of the mind-body connection has opened ways for advanced studies, it has fluctuated in its social acceptance among medical professionals.

In his 1997 book, *Timeless Healing*, contemporary pioneer of mind-body research and founding president of the Mind/Body Medical Institute at Harvard, Herbert Benson, strongly criticized Western science for disregarding the physical effects of beliefs and emotions. Describing these psychological processes as the work of the soul, he put forward the argument that a balanced approach for well-being must consider humans as emotional, spiritual, and intellectual beings [11]. This criticism is no different from that of Abu Zayd al-Balkhi's nearly identical claim eleventh centuries

earlier. In his work titled "Sustenance of the Body and Soul," al-Balkhi urged medical practitioners who were restricting health and treatment to physical characteristics to stop neglecting an ineluctable interaction of the body and the mind. Al-Balkhi's assertion that the human being is composed of body and soul established the foundation for a psychophysiological approach to well-being in Medieval Islam [12]. Much of the medical work of Muslim scholars and philosophers is built upon this concept of sustaining both body and soul equally in order to attain balance and stamina for protecting against illnesses and preserving health.

Introducing the Concept of the Soul

Al-Balkhi's explanations of the disturbances of both the body and the soul are instrumental for understanding the mind-body connection in an Islamic context. While the body experiences physical illness such as fever, headaches, and other pains that affect the organs, the soul experiences illnesses such as anger, sorrow, anxiety, fear, panic, and other similar psychological afflictions. When the body undergoes illness, it impacts the mental capacities of the soul, and when the soul is afflicted, it prevents the body from experiencing joy and may also manifest as physical illness in the body [12]. To al-Balkhi and the majority of Muslim scholars, the soul is synonymous with the psyche or mind with the addition of a spiritual component and is responsible for faculties such as thought, imagination, judgment, and memory. Abu Hamid Al-Ghazali (1058–1111 CE), one of the greatest philosophers in Islamic history, described the soul as made of four constituents: the heart, the spirit, the self, and the intellect [13]. Muslims are encouraged to engage in purifying the soul and its constituents in obedience to the Quran, which strongly suggests such purification is the means to true success (Quran 91:7–11, Oxford World's Classics edition). The majority of Muslim philosophers and scholars attribute seeking purpose and meaning of life to the soul, considering the soul as one's compass directing one toward attaining knowledge of God and ultimate happiness and success.

Religious and Philosophical Influences

In the pre-Islamic Middle East, illnesses of the soul or spirit were seen by the ancient Hebrew society as either a punishment for disobedience to God or as a divine gift. This is important because it sets the tone for primitive religious interpretations of mental illness. Renowned stories from the Old Testament, like that of Saul and David who were afflicted by madness, brought attention to mental disturbances, making them recognizable and to some degree socially acceptable. At the same time, warnings in the Old Testament such as "if you do not obey the Lord your God by diligently observing all his commandments and statutes which I lay upon you this day...The Lord strike you with madness, blindness, and bewilderment" (Book

of Deuteronomy 28:15, 28, New International Version) shaped the concept of madness in the Medieval Middle East.

Psychopathological behaviors were explained and understood by what was believed to be their causes: disease, sin, or demons. Healing was dependent on God and those who can heal were considered to have a gift from God. For example, Jesus of Nazareth earned the reputation as "a charismatic teacher, healer and exorcist" [14]. Exorcism became a common practice in the early Judeo-Christian tradition. When Islam was introduced in Mecca, the Quran and guidance of Prophet Muhammad reformed many practices and conceptualizations of God. For instance, instead of viewing illnesses as a punishment from God, Islam taught that people may be tested with their health and wealth and will be rewarded for their patience (Quran 2:155, Oxford World's Classics edition) and that with disease, pain, or illness comes expiation of sins [15]. However, while the Quran does not point to miraculous healing, demon possession, or exorcism like in the Old and New Testaments, it does acknowledge the existence of elusive, omnipresent spirits or jinn, leaving room for the imagination of later Muslims.

The concept of saints did not exist in the Islamic tradition until the century following Prophet Muhammad's death when the Islamic empire stretched to include cultures from southern Spain to northern India. The synthesis of beliefs and practices of many different people, including supernatural beliefs and magical arts, influenced and altered some customs such that sainthood, miraculous healing, and exorcism eventually emerged among the Muslim people. Accounts of miraculous healing especially among elite Arabs led some Muslims in the early Islamic period to resort to Christian saints for healing [14]. However, it was the East Christian doctors trained by Galenic teachings who were appointed positions in the court and government to teach and translate the Greek texts as the Muslims of ruling classes ardently sought to acquire the ancient knowledge. By the eighth century, princes, khalifs, and emirs not only pursued culture with profound interest but especially indulged in the treasures and delights of the intellectual culture. They were eager to translate the Greek medical texts that they received as gifts and acquired during expeditions. Syriac translations were one of the first sources for translations of Galenic texts into Arabic which marked the beginning of one of the greatest translation movements [16]. The House of Wisdom in Baghdad is where the majority of the translations of all the world's classical knowledge into Arabic took place through the eighth to the tenth century.

The efforts to preserve Greek medicine promoted Greek philosophy throughout the ninth and tenth centuries, enabling Muslim scholars to integrate Greek scientific knowledge into their medical education. The teachings of Galen which emphasized the physiological causes of illness and its physical treatments were maintained at the basis of the Islamic curriculum. However, unlike the Greek tradition, which is mainly known for its observations and theories, the Muslims built upon their interest to test the ancient theories along with their own, thus establishing the first scientific method of experimentation [17]. By the ninth century, when the compilation and authentication of the Hadith culminated in Baghdad, medicine was approached

by Muslim scholars through consideration of Greek philosophical and scientific tradition combined with the theological principle that God is the ultimate creator of all things. This accommodated the Islamic interpretation of divine cause and effect and restricted methods of research and treatment to those which upheld physical laws while also in accordance to Islamic law [14].

It was through the adherence to Islamic law that early Muslims heartily invested in the expansion of all scientific knowledge, flourishing into the renaissance of Islam, also known as the Islamic Golden Era. From 622 to 1492 A.D., this golden time period in a vast empire that stretched across Arabia, Iraq, Syria, Lebanon, Palestine, Egypt, and much of North Africa, Central Asia, Spain, and the fringes of China and India was inextricably linked to religion. The interest to combine faith and reason through the use of *independent reasoning*, a legal concept known as *ijtihad*, opened channels of tolerance for scientific enquiry. Schools were attached to every mosque and education became institutionalized teaching medicine, pharmacology, botany, geology, geography, sociology, chemistry, physics, mathematics, astronomy, literature, and philosophy. In this Islamic empire, individuals of learning took precedence over all others irrespective of race, religion, or nationality [17, 18]. Learning seemed to have become the chief business of life for the ruling classes: they were statesmen, philosophers, jurists, authors, scientists, and scholars [18]. The major cities of the Islamic empire were recognized as international centers for culture, learning, and enterprise, becoming centers for dissemination of knowledge and advancement of civilization. Muslims, Christians, and Jews from all parts of the world came to these centers with the same rights to learn civilization and science, mastering the Arabic language to do so [17–19]. Arabic was the official language of science for five centuries hence the coined concept of Arabic Science despite the numerous contributions made by renowned non-Arab scientists and scholars.

Classification and Conceptualization of Mental and Psychological Illnesses

Overview of Major Scholars and Treatises

In 2008, the International Institute of Islamic Thought (IIIT) undertook a major project, the largest of its kind, in which more than 200 psychological manuscripts, written by Muslim scholars, spanning the second to the fourteenth centuries A.H. (110–1350 A.H./8–20th A.D.), were surveyed and annotated, yielding a three-volume publication titled “Psychological Sciences in the Islamic Heritage” [20]. This work highlighted the great interest that Muslim intellectuals took in understanding normal and abnormal psychological functioning and in promoting well-being. The treatises examined in this work could be classified into three domains: a philosophical domain, a medical domain, and a domain that addresses moral, spiritual, and ethical matters.

In the philosophical domain, a large number of treatises addressed an array of psychological topics such as the nature of the soul, conceptualization of the mind and its mental and cognitive faculties, interpretations of dreams, and defining concepts such as happiness, among many others. Authors cited in this domain include scholars like Ibn Rushd (Averroes), ibn Sina (Avicenna), al-Farabi, al-Kindi, Miskawayh, and others, all of whom have drawn upon Greek philosophy as well as contributed their own ideas and views. Within the medical domain existed treatises that profoundly impacted medical education in Europe for many centuries. These include ibn Sina's "The Canon of Medicine" and al-Razi's "The Comprehensive Book of Medicine." These two main medical encyclopedias contained chapters that provided detailed accounts of mental illnesses as they were recognized at their times. Symptoms and etiologies for such illnesses as well as treatments and various types of interventions were listed and described.

Finally, considering the *heart*, *soul*, and *spirit* combined as a major component of human existence, many Muslim scholars dedicated volumes and treatises to topics in the third domain relating to morality, spirituality, and ethics. Al-Ghazali, Al-Muhasibi, Al-Balkhi, and Ibn Hazm among others were especially renowned for their work in this domain that not only defined and described the various spiritual, moral, and emotional diseases but also prescribed treatments and preventative antidotes for them. Examples of such topics within these treatises are training one's desires and resisting temptations, managing anger, processing grief, and overcoming anxiety, to name a few. These are familiar topics that are comparable to much of what is published today in psychological literature, as they are considered significant from contemporary psychological perspectives as well.

There are many other remarkable books and treatises that, despite not receiving as much attention, were written by renowned scholars and elaborated greatly on mental health and illness which contributed to these three domains. In an effort to illustrate the vast work and array of topics addressed by the early Muslim scholars, the authors have composed a humble list of scholars along with their relevant books and treatises and a brief overview of some of their mental health contributions (Table 1.1).

Categories of Mental and Psychological Illnesses

It is very well understood that classification and reclassification of mental disorders is an ongoing process. For example, the Diagnostic and Statistical Manual of Mental Disorders (DSM), which is the most popular diagnostic system for mental disorders in the USA, underwent numerous text revisions in the course of over 60 years and is currently in its fifth edition. These revisions and editions paralleled the changes that were taking place in the WHO's International Classification of Diseases (ICD), which is currently undergoing its 11th revision to be published in 2018. While revisions continue to take place, these successive editions witness the regrouping of existing illnesses into modified categories, the addition of new illnesses, and in some cases the elimination of certain illness upon reevaluation [21]. It was with this

Table 1.1 Contributions of major scholars and treatises

	Scholar	Alternate Name	Date (AD)	Relevant Books/Treatises	Contribution
1	Ya'qub Ibn Ishaq al-Kindi		(801–870)	On Sleep and Dreams; On Dispelling Sadness; Discourse on the Soul	Major translation efforts
					Major treatise on understanding and combating sorrow
					Dream psychology
2	Ali Ibn Sahl Rabban al-Tabari		(838–870)	*Firdous al-Hikma* (*Paradise of Wisdom*)	One of the first and oldest encyclopedias of medicine
					A chapter on "diseases of the head and the brain"
					Mind-body connection
					Doctor-patient relationship
					Perceptions and emotions
					Child development
3	Abu Bakr Muhammad ibn Zakariyya al-Razi (Rhazes)	Rhazes	(865–932)	*Al-Hawi fi al-Tibb* (*The Comprehensive Book of Medicine*); Al-Mujarrabat; Al-Tibb al-Mansuri; Al-Tibb al-Ruhani	The largest medical encyclopedia written by a Muslim
					A chapter on "diseases of the head" including neurological and psychiatric illnesses
					Mind-body connection
					Practical experiences of treating patients
					Psychological, moral, and emotional illnesses and their treatments
					Music therapy for mental illnesses
4	Abu Zayd al-Balkhi		(850–934)	*Masalih al-Abdan wa al-Anfus* (*Sustenance of the Body and Soul*)	Distinction between mild and severe mental illness
					Detailed account of four mental disorders: anger, sadness, fears/phobias, and obsessional disorders
					A pioneer of cognitive therapeutic approaches
					Mind-body connection
5	Abu Nasr Muhammad ibn al-Farabi	Al-Farabi	(870–950)	*Al-Madina al-Fadila* (*The Virtuous City*)	Psychological and mental faculties
					Philosophy of happiness
					Dream psychology
					Social psychology

(continued)

Table 1.1 (continued)

	Scholar	Alternate Name	Date (AD)	Relevant Books/Treatises	Contribution
6	Abu Bakr Rabee Ibn Ahmad Al-Akhawyni Bokhari		(Unknown – 983)	*Hidayat al-Muta'allimin Fi al-Tibb* (*A Guide to Medical Learners*)	Significant interest in mental disorders (was called "the doctor of the insane")
					A variety of brain diseases and mental illness among other types of illnesses
7	'Ali ibn 'Abbas Al-Majusi (Haly Abbas)	Haly Abbas	(930–994)	*Kamil al-Sina'a al-Tibbiya* (*The Complete Book of the Medical Art*)	A systematic and practical medical book
					A wide range of neurological and psychiatric disorders
					Mind-body connection
					Doctor-patient relationship
					Medical ethics
8	Ahmad Miskawayh	Miskawayh	(930–1030)	*Tahdhib al-Akhlaq (The Refinement of Character); Al-Fawzal-Asghar* (*The Diminutive Triumph*)	Pioneer of moral philosophy and ethics
					Emphasis on psychological well-being
					Psycho-spiritual treatments for anxiety and depression
					Epistemology
9	Abu Ali al-Husayn ibn Sina (Avicenna)	Avicenna	(980–1037)	*Al-Shifa* (*Healing*); *Al-Qanun fi al-Tibb* (*The Canon of Medicine*); *Risala fi al-Nafs* (*Treatise on the Soul*)	A pioneer of Islamic philosophy
					One of the most comprehensive accounts written by a Muslim scholar on the nature and faculties of the "self"
					A canonical medical encyclopedia
					Mind-body relationship
					Diseases of the brain
					Perceptions
					Emotions
					Dreams
					Conditioning
					Individual differences

10	Abu Hamid Al-Ghazali (Algazel)	Algazel	(1056–1111)	*Ma'arij al-Quds fi Madarij Ma'rifat al-Nafs* (*The Ascent to the Divine Through the Path of Self-Knowledge*); *Ihya' 'Ulum al-Din* (*The Revival of Religious Sciences*); *Kimya's al-Sa'ada* (*The Alchemy of Happiness*)	A pioneer of religious ethics and Islamic philosophy Comprehensive approaches to behavior modification and self-discipline Philosophy of happiness The nature and faculties of the "self"
11	Zayn al-Din al-Jurjani		(1040–1136)	*Zakhireye-i Kharazmshahi* (*The Treasure of Khwarazm Shah*)	Sleep psychology and physiology Psychology of emotions, e.g., anger, shame, laughing and crying, sadness and happiness, etc. A wide range of neurological and psychiatric illnesses, as well as therapeutic techniques, e.g., music, psychotherapy, occupation therapy, and environmental modifications Biochemical view of mental illnesses
12	Ibn Al-Ayn Zarbi		(Unknown – 1153)	*Al-Kafi fi al-Tibb* (*The Sufficient Book of Medicine*)	Physical and mental illnesses and their treatments Biological basis of mental disorders
13	Fakhr al-Din Muhammad 'Umar al-Razi	Al-Razi	(1150–1210)	*Kitab al-Nafs Wa al-Ruh wa Sharh Quwahuma* (*Book on the Soul and the Spirit and their Faculties*); *Al-Matalib al-'Aliya* (*The Higher Aims*)	Psychology of pain and pleasure; Physiognomy; Cognitive and behavioral treatment for moral illnesses Individual differences

same diligence that early Muslim scholars, philosophers, and physicians defined and categorized psychological and mental disorders.

In the early classifications that emerged in the twentieth century, mental disorders were conceptualized as either binary forms or sometimes as a continuum of psychoses or neuroses [21–23]. Exploring the classical Islamic literature with these two broad categories in mind (neurosis and psychosis), psychotic illnesses were frequently found in the medical domain under brain disorders, while neurotic illnesses were mainly covered within the moral, spiritual, and ethical domain. Discussions of each category of illnesses in its respective domain indicate how Muslim scholars conceptualized and further treated mental illnesses. Illnesses in medical treatises were thought to have organic causes, i.e., body humors, temperament changes, etc., and they were usually prescribed *somatic treatments* such as medicines, herbs, syrups, physical interventions, etc. [24]. Whereas neurotic illnesses, such as sadness, anxiety, phobias, and obsessions, were considered part of the ethical and spiritual domain, and were prescribed cognitive and behavioral-like treatments [6]. The following section will briefly elaborate on early establishments and methods used for providing treatment and care to individuals undergoing mental illnesses.

Providing Treatment and Care

Hospital Care

Historically, there have been many institutions for the mentally ill, two of which are insane asylums and psychiatric hospitals. The former has ceased to exist in mainstream medicine as its main function was to keep mentally ill citizens away from society. The latter method of institutionalizing mental illness, perpetuated in the modern day, was begun by Muslim physicians in the eighth century.

The early Islamic society was efficient in providing care for individuals with mental illnesses. Hospitals were supported by the community with an endowment known as a *waqf*. The first psychiatric ward in the world was established in 705 CE in Baghdad as part of the Islamic hospital system and soon became a mainstay of most Islamic hospitals from that time onward. Through its continual assertions of scientific competence, the Islamic hospital furnished an intellectual base for an independent field of studying insanity, a specialty known to no other institution. Islamic hospitals became hubs for research, offering apprenticeships for students and disseminating the “true science” of cerebral illnesses. Subsidized by the Islamic government, Islamic hospitals were not only advancing medicine through scientific research but also serving the mentally ill and the poor as obliged by Islamic law, “And do not give the weak-minded your property, which Allah has made a means of sustenance for you, but provide for them with it and clothe them and speak to them words of appropriate kindness” (Quran 4:5, Sahih International edition). This commandment and others like it in the Quran were at the base of

formulating the general attitude toward mental illness and treatment of individuals with mental illnesses.

The creation of psychiatric wards in the Muslim world then inspired the creation of stand-alone psychiatric institutions, the first of which referred to as Bimaristan was established in Baghdad in the ninth century by the Abbasid Caliph Harun Al-Rashid [14, 25]. These Islamic psychiatric institutions became famous for their humane and "moral" treatment of patients – particularly their emphasis on inclusion and not isolation. The Islamic psychiatric institution was also famous for introducing the concept of the psychiatric milieu: providing patients with clean clothes, daily bathing, purposeful activities, and a healthy diet [26]. These institutions are also credited with the introduction of novel treatments like music therapy and massage therapy in addition to treatment by medication and talk therapy during daily visits by physicians. Also unique was the interdisciplinary nature of the treatment team, which, in addition to the physician, often included members to whom we would today refer as nurses, social workers, chaplains, and pharmacists – treating the whole patient, and not just their illness.

It is noteworthy that the Islamic hospital was a secular establishment where mental illness was attributed to organic pathology [25]. The mentally ill were housed in these hospitals during this era, whereas the neighboring Christian empire would house the mentally ill in monasteries [27]. It is important to note that these institutions were purposefully often located in the heart of town in order to facilitate visitation by family, in keeping with their emphasis on inclusion within the society. Great care was taken to make sure that the psychiatric hospital was decorated with lavish gardens and flowing fountains in order to bring a sense of calm to the ill. All of these services were fully paid for by the Islamic government for any of its mentally ill residents for the duration of their illness, even if it spanned a lifetime. The funding for these institutions was derived from the obligatory yearly alms (zakat) paid by Muslims.

Throughout the Golden Age of Islam, reputable hospitals were found in all the major cities across the Muslim world such as in Damascus, Alexandria, and Cairo [28]. One of the most famous was the Qalawun Hospital in Cairo, Egypt. It was established in the 1280s and was part of a larger complex including a *madrasa* (school), a hospital, and a mausoleum [29]. The families of patients were often involved in the care of their afflicted relatives, whether this was at home with a medical assistant or in the hospitals as supporting visitors [28]. The inclusion of the mental health ward in a general hospital rather than in separate asylums normalized mental illness, making it merely another affliction that needed treatment. People were less inclined to demonize those with mental illnesses or feel the need to cast them out because there were available facilities to care for them.

Many hospitals were concerned with providing support that would grant their patients some aspects of normalcy. Human interaction was found to be an effective treatment, and therefore individuals were assigned companions known as *Murafiqeen*, to help patients with hygiene, eating, and emotional support. The word *murafiqeen* roughly translates to "escorts" or "companions," which

clarifies the fact that their role was to care for the patients and not to act as a handler. Additionally, entertainers such as storytellers and musicians were employed by hospitals for the benefit of the patients. They delivered services that were therapeutic in nature and created a soothing environment. These were early versions of music and talk therapy, which have proven to be successful in modern times.

Somatic Therapies

Believing that mental derangements are physical or organic in nature, Muslim physicians tended to prescribe somatic treatments upon analyzing the symptoms presented by their patients. The literature reveals numerous case studies and clinical interactions from which physicians based much of their treatment practices. Detailed chronicles were recorded to describe physiological and pathological information regarding individual cases and their management. Such clinical experiences were often passed on between physicians and teachers, adding to a bank of medical knowledge and references. Medical treatises strongly suggested that each physician was well aware of the practices used by others in their field.

For each illness described in the texts, there were records of prescribed treatments along with the dosage recommendations, duration, and a list of medicinal ingredients. Medicine was made available in a variety of forms such as creams, herbal mixtures, solid pills, and liquids. Along with the herbal and organic medicaments, other somatic therapies that were commonly recommended included exercise routines, relaxing environments (i.e., established through music and garden walks), and activities such as storytelling and singing.

Records also indicate that it was common to prescribe a combination of therapies for a balanced and comprehensive treatment. For instance, ibn Sina gives detailed instructions for conducting phlebotomy to treat melancholia while at the same time instructs his patients to take baths or use hot oils and furthermore engage in practices that strengthen the heart. References to such a combination of somatic therapy with other therapies (e.g., behavioral and psychotherapeutic practices) indicate just how comprehensively physicians approached treating their patients with mental illnesses.

Psychotherapy

Ibn Hazm asserts that the universal goal of “being free from anxiety” is what drives people to take action in life [30]. Al-Balkhi also highlighted that even “normal people” are plagued with psychological symptoms, such as anxiety, anger, and sadness, most of which are learned behaviors and are related to how different people react to emotional stress. His detailed discussions on changing one’s faulty thinking and

irrational beliefs, which are responsible for their emotional states, were at the core of his development of cognitive therapy eleventh centuries ago [12]. Numerous texts by Muslim scholars described cognitive components of depression and sadness, anxiety and fear, obsessions, and anger in detail and suggested a variety of therapies and treatments.

Al-Balkhi's groundwork in developing cognitive therapy included a number of features that are recognized in today's modern therapy. For instance, his preventative approach which encouraged individuals to keep healthy cognitions handy for use during times of distress is compared with today's "rational cognitive therapy" [12]. In addition, he and other prominent early Muslim scholars such as Al-Ghazali, al-Kindi, Ibn Hazm, and Ibn Taymiyyah demonstrated practices of reciprocal inhibition in their treatments which is fundamental for today's behavioral therapy. Miskawayh, one of the first Muslim ethicists from the tenth century CE, established a theory describing the changeability of human behavior to promote using discipline. This was foundational for many later works that focused on changing behaviors, attitudes, and manners through processes of learning, training, and gradual steps of behavior shaping [30–34].

Moral development was a significant branch of Islamic psychotherapy. Many scholars dedicated monographs to address behavioral and ethical development. These included detailed descriptions of ethics and methods for acquiring higher morality as well as moral illnesses, such as self-centeredness, lust, avarice, etc., and methods for treating them [30, 32, 35]. Scholars like Al-Ghazali defined moral development as a means not of suppressing all forms of desires and needs but rather of practicing balance and self-discipline [32]. Religious beliefs were also known to have a very strong impact in shaping a person's emotions and behaviors [30].

Described along with self-discipline were concepts of reinforcement, reward, and punishment. For example, al-Razi distinguished between the experiences of internal positive reinforcement and external positive reinforcement when learning new behaviors and manners [36]. Understanding and utilizing reinforcers are essential to the Western theories of behaviorism, which was only developed in the late nineteenth century. Works of Miskawayh and Ghazali, for example, describe a strategy similar to what is now known as "response cost" to eliminate undesired behaviors, such as punishing/purifying oneself through psychological, physical, or spiritual means like paying money to the poor, fasting, etc. [32, 35]. While it was not uncommon to incorporate such religious rituals into therapeutic treatments as they are directly in adherence to the Quran, some Muslim scholars, philosophers, and physicians integrated many of their inherited Greek doctrines, despite some religious controversy. For instance, the Greek medico-musical tradition influenced Muslim philosophers like al-Kindi, to make music a part of the allopathic system of treatment, despite it being disliked by a number of interpreters of the Islamic law [14]. These examples are only a few that illustrate the genesis of theories and practices of psychotherapy adopted by intellectuals of this time with the infusion of diverse traditions.

Conclusion

Despite the appearance of a European renaissance independent of outside influence, Islamic sciences played an integral role in the Renaissance. Early generations of intellectual historians coined the concept of "ancient science" as distinguished from the "Islamic sciences," emphasizing a rich development of scientific activities in the early Islamic civilization. A fair look into the written works of early Muslim scholars reveals a plethora of remarkable scientific, medical, philosophical, and psychological contributions to the field of mental health transcending geographical, cultural, language, and religious boundaries. While this chapter brought to light a number of pioneering scholars and canonical treatises that explored and defined psychological illnesses, foundational theories such as that of the mind-body connection, and treatment approaches to well-being from an Islamic lens, it only tapped into the vast bank of knowledge surrounding mental health from the Islamic Golden Era. The magnificent contributions of this time period are understudied and underutilized. They reflect a holistic, culturally adaptive, scientific approach that would undoubtedly enlighten the contemporary interdisciplinary field of psychiatry and enhance its practice.

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2 Islamophobia: An Introduction to the Academic Field, Methods, and Approaches

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Introduction

Academic fields, even those with established records of examining marginalized communities, are still early in the process of examining "othering" of Islam and Muslims and the racialization of its followers. Moreover, in a broadly secular society and in secular universities in areas such as the USA and Europe, Islam and its adherents are not considered participants or partners in the affairs of "civil society," thus relegating the subject to a single field of religious studies or possibly Middle/Near Eastern Studies. This has resulted in a structural marginalization of the study of Islamophobia at the university.

How should we approach Islamophobia and can we think of it within the field of postcolonial studies, ethnic studies, sociology, or area studies? What is the relationship between present-day Islamophobia and well-documented race and gender discourses? Should Islamophobia be studied as the new manifestation of old patterns of racial and gender formation or can we think of alternative models due to the specificity of the subject matter and the added religious dimension? Furthermore, how should we examine Islamophobia as the new otherness while critiquing Muslim internal and external discourses?

Another set of questions must contend with the postcolonial theory and decolonization. What would be the impact of moving from a postcolonial approach to a decolonial theoretical framework? How does examining and deconstructing Islamophobia impact this area and contribute to the development of a new paradigm? What new or

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modified theoretical frameworks should be employed? Are the existing academic fields and their current methodologies able to deconstruct Islamophobia, or do we need adjustments and, if so, where and how?

All the above questions and others bearing on the field and many areas remain unresolved or unaddressed altogether. Yet on a broader level, the "war on terror" single focus on the Muslim subject and Islam created a global context for the deployment of Islamophobic discourses to rationalize pernicious and highly discriminatory policies across the world. It also brought the field into an early and speedy level of maturity, giving researchers accelerated engagement with power, racism, militarism, and scholarly production and an accelerated level of scholarly production. The Islamophobia Studies field is a budding enterprise, and this volume and its unique contributions in the intersectionality of healthcare, mental health, and anti-Muslim discourses are an illustration of this precise point.

Tracing the Origins of the Term

At the start, let us agree that Islamophobia is an imperfect term. Debating the validity or accuracy of the term Islamophobia is a healthy and worthwhile academic exercise. Almost predictably, every conference in the past 12 years on Islamophobia has raised the question of the term's validity and whether an alternative one might be more useful. Here, I am not only entertaining the rejection of the term altogether by individuals and groups that belong to the Islamophobia industry but also its rejection by those who not only assert that there is no such problem called Islamophobia but rather go further to assert that it is a made-up term to silence any criticism of Islam and the protection of Western civilization from being infiltrated and over run by Muslims. Debate around the validity of the term is no longer a central concern of the Islamophobia Studies field and is only a tangential undertaking without any bearing on the increasing scope of scholarly production. On the contrary, the term has already been extensively adopted into public policy discourses both domestically in the USA and across the globe. Consequently, the United Nations, European Union, and Organization of Islamic Cooperation have all adopted the term at one level or another, and reporting and investigation agencies often use it in publications.

Tracing the emergence of the term is an important aspect of Islamophobia Studies field, which began in the early part of the twentieth century. The term Islamophobia first appears in the French language in relation to the discriminatory treatment directed at Muslims in North Africa by French colonial administrators. *Islamophobie* was the French term used by Alphonse Etienne Dinet in a book written in 1916 and published around 1918 [1]. In the English translation of the book, the word was rendered for meaning purposes "feelings inimical to Islam," but not yet codified into the term Islamophobia [1].

On April 29, 2018, at the 9th Annual UC Berkeley Islamophobia Conference, Seyda Karaoglu presented an original paper, Islamophobia à la Française: A Definition in Étienne Dinet's Hajj Travelogue, based on her master's thesis, which is

a translation "and a study of The Pilgrimage to the Sacred House of Allah (1930), a hajj travelogue by French orientalist painter Étienne Nasreddine Dinet, also believed by many to have coined the term "*islamophobie*." [2] The first attempt to define the term, according to Karaoglu, can be attributed to Étienne Dinet and Sliman Ben Ibrahim [2]. In their work, Karaoglu maintains that "Dinet and Ben Ibrahim defined Islamophobia as the "persistence of Europe's more or less disguised hostility against Islam." Significantly, Karaoglu was impressive in identifying Dinet's and Ben Ibrahim's framing "three elements that are essential to understanding the phenomenon," pointing out that for Dinet, "Islamophobia was first and foremost inscribed in a history that goes back to the Crusades. It was then understood as 'an ideology of conquest' against colonial forces." [2] Finally, Karaoglu maintains that Dinet suggested a typology of Islamophobia, distinguishing between "pseudoscientific Islamophobia" and "clerical Islamophobia." [2] Most importantly, however, Karaoglu argues that Dinet depicts Islamophobia as a networked political ideology developed in bad faith, rather than a simple matter of ignorance about the Muslim faith at the individual level [2].

What Dinet and Ben Ibrahim referred to as Europe's hostility toward Islam was embedded into the European colonial project. Certainly, the French, British, and Dutch colonial programs were racist and posited the inferiority of the colonized population, Muslims included, which involved a process that made possible a whole host of policies to "civilize" the native populations across the globe. Dinet and Ben Ibrahim's use of the term Islamophobia was not in connection to specific colonial policies; rather, it was generally used to describe the ill-treatment directed at the colonized Muslim subject.

Another engagement with the phenomenon of Islamophobia without the actual use of the term itself is easily ascertainable in the work of Franz Fannon, a West Indian psychoanalyst and social philosopher, who wrote a number of important works focused on the Muslim colonial subject. Fanon's work includes *Peau noire, masques blancs* (1952; Black Skin, White Masks) which provided "a multidisciplinary analysis of the effect of colonialism on racial consciousness," using his work under French colonial administration [3]. Fanon's most widely known book and published before his death is *Les Damnés de la terre* (1961, The Wretched of the Earth), a work that served as a foundational text for decolonial studies and arguably examined the impacts of Islamophobia without naming it as such. Fanon's experience and theoretical contribution in the field of colonial studies formed in Algeria, the Global South, may be considered as the precursor to the emergence of the term Islamophobia and the treatment of Muslims and Islam in the Global North. As an enterprise, the colonial project was constructed around Islamophobia and sought to negate and dehumanize the Muslim subject him/herself, so as to rationalize and embark upon a program of civilization and domination.

Taking a decolonial and world history approach to the Islamophobia Studies field, Ramon Grosfoguel locates the emergence of Islamophobia in the critical events arising from 1492, the expulsion of Muslims and Jews from Spain and the "discovery" of the new world [4]. In a very widely used article in decolonial studies, "Epistemic Islamophobia and Colonial Social Sciences," Grosfoguel defines and

locates Islamophobia in the emergence of the modern world centered on a process of "genocides and epistemicides" committed against indigenous population including Muslims and Jews [4]. Here, Grosfoguel is arguing that Islamophobia is rooted in knowledge production of the West, which produces Eurocentric worldviews that are inherently founded upon racial demarcation at the level of the human. Ramon maintains that "Epistemic racism in the form of epistemic Islamophobia is a foundational and constitutive logic of the modern/colonial world and of its legitimate forms of knowledge production." [4] Ramon's field of Islamophobia Studies originates in 1492 and locates the problem in the formation of the modern Eurocentric world with all the erasures, genocides, and sub-humanness that gave birth to it.

Another article by Ramon Grosfoguel and Eric Mielants (2006), "The Long-Durée Entanglement Between Islamophobia and Racism in the Modern/Colonial Capitalist/Patriarchal World-System: An Introduction," provides a road map to Islamophobia Studies from a decolonial vintage point [5]. The article provides four different ways to think about and conceptualize the academic approach to Islamophobia: (1) Islamophobia as a form of racism in a world-historical perspective, (2) Islamophobia as a form of cultural racism, (3) Islamophobia as Orientalism, and (4) Islamophobia as epistemic racism [5]. Gorsfoguel and Mielants maintain "that Islamophobia as a form of racism against Muslim people is not only manifested in the labor market, education, public sphere, global war against terrorism, or the global economy, but also in the epistemological battleground about the definition of the priorities in the world today." [5] The essay is a very useful mapping of Islamophobia across different fields, connecting it to existing frames of academic research.

Coming closer to the more recent period are the late Edward Said's books, *Orientalism* and *Covering Islam*, which managed to reintroduce the term Islamophobia into scholarly circulation as a way to understand the intensification of hostilities toward Islam and Muslims in the aftermath of the Iranian revolution. Said's work provided both a historical lens to explore knowledge production relative to the Muslim subject in Western academia, and a theoretical framing by which to understand the process of otherization. Orientalism located the otherization of Muslims in Western discourse to Napoleon's invasion of Egypt in 1797 and the setting in motion of representations of the East [6]. Here, Said's work locates Islamophobia within the scope of modern European colonization, centering the field on the reproduction of distorted representations of the Arab and Muslim subject. In *Covering Islam*, Said traces the tropes and frames used by the media when talking about Islam and Muslims, which continue to be deployed on a regular basis despite the wealth of information and contacts with the Muslim world [7]. Said's Covering Islam was one of the early works on media representations of Islam and Muslims, which should be read next to Jack Shaheen's seminal work, *The Reel Bad Arabs: How Hollywood Vilifies a People*, which examined the persistent deployment of stereotypes in movies and TV production [8]. "Public enemy #1" was Jack Shaheen's framing of how Hollywood represents Arabs and post 9/11 Muslims in US media and based on his close examination of over 1000 movies and TV shows (2014: *The Reel Bad Arabs: How Hollywood Vilifies a People*) [8]. Up to the date of his passing

in 2017, Professor Jack Shaheen challenged Islamophobia directly before and post 9/11 and was a major critical voice in efforts to counter the pernicious deployment of discredited stereotypes; his contribution stands the test of time.

Islamophobia Entry into Public Policy

A critical moment in the Islamophobia Studies field was the publication of a report by The Runnymede Trust, an independent research and social policy agency which established the Commission on British Muslims and Islamophobia to examine the problem in the UK. The Commission's report, "Islamophobia: a challenge for us all," was the first such document to examine the problem with an eye toward public policy, using a multifaceted research to ground its findings and recommendations. Runnymede used the term Islamophobia to refer to "unfounded hostility toward Islam" which then provided eight different contrasting sets of what the Commission called closed views versus open views of Islam [9]. In the publication, the commission identified two goals for the report: "(a) to counter Islamophobic assumptions that Islam is a single monolithic system, without internal development, diversity and dialogue, and (b) to draw attention to the principal dangers which Islamophobia creates or exacerbates for Muslim communities, and therefore for the well-being of society as a whole." [9] It is interesting to note that the Runnymede Trust First Commission was set up in 1992 to address the issue of anti-Semitism in contemporary Britain and published a report on the subject in 1994. A reference to Runnymede Trust using the term as early as 1991/1992 is mentioned, but the issued report provides the most concrete entry of Islamophobia into public policy debates. Following the anti-Semitism report, the Commission shifted toward addressing the rising tide of Islamophobia. The report offered some 60 recommendations to various governmental bodies, schools, and civil society institutions to counter the problem. The entry of Islamophobia into public policy and the beginning of a sustained academic engagement in the subject are directly connected to this initial contribution in the UK influencing scholarship across the world.

The emergence and intensification of Islamophobia in the British context followed the Salman Rushdie Affair, the publishing of the controversial novel *The Satanic Verses*, which was based or inspired by Prophet Muhammad's life. Massive protests in the UK and many parts of the Muslim world followed the publication of the novel. Then in 1989, the Ayatollah Ruhollah Khomeini, the leader of the 1979 Iranian Revolution, issued a fatwa (a religious opinion) calling for Muslims to punish Rushdie for committing blasphemy by attacking the character of Islam's Prophet. The demarcation lines between foreign and domestic were completely blurred and demonization of Britain's Muslim population for protesting the publication was the focus of the extensive Islamophobic campaign. Thus, the Runnymede Trust's report emerges out of and in response to the intensification of the otherization campaign directed at Muslims in Britain in the aftermath of the Rushdie Affair.

Consequently, the Runnymede report should serve as the actual birth date of the Islamophobia Studies field and the entry into the academic and public discourse of

researchers, journalists, and university professors undertaken to interrogate the phenomenon. The distinction I make between the earlier works on Muslims in Western imagination and policy versus the emergence of the Islamophobia Studies field is one of concrete focus on policies and regulations that impact Muslim subjects in specific Western contexts, which was for the first time quantified and legally challenged. Earlier conceptualizations, references, and engagement with the term and the phenomenon were undertaken broadly, referencing the colonial and postcolonial discourses effecting Muslim majority states. What the Runnymede report provided is a grounding of otherization of Muslims in Western society and a locating of it within the long and well-documented history of racism, anti-Semitism, and discrimination.

In 2017, the Runnymede Trust issued a 20th anniversary follow-up to the initial report entitled, *Islamophobia: Still a challenge for us all,* with the "aim… to improve the accuracy and quality of public and policy debate and action in response to Islamophobia." [10] The 20th anniversary report offered a longer and more complex definition to the term: "Islamophobia is any distinction, exclusion, or restriction towards, or preference against, Muslims (or those perceived to be Muslims) that has the purpose or effect of nullifying or impairing the recognition, enjoyment or exercise, on an equal footing, of human rights and fundamental freedoms in the political, economic, social, cultural or any other field of public life" [10].

Pedagogical Challenges Facing the Islamophobia Studies Field

The pedagogical challenge is how to study Islamophobia without constantly accepting the externalization of the subject matter, making sure that the approach is understood within the context of critical race theory and related fields including sociology, anthropology, American studies, decolonial and postcolonial studies, and labor and migration studies. Indeed, early scholarly engagement with the field was limited, and responses to Islamophobia were primarily focused on countering negative media and political representations of Islam and attacks on Muslim civil rights. While this work is important and was badly needed at the time, the long-term and structural approach to deconstructing Islamophobia was an urgently needed shift and the only way to undo the Eurocentric way of thinking that informs the media and shapes the political discourse. Here, the book, *What is Islamophobia? Racism, Social Movements and the State*, edited by Narzanin Massoumi, Tom Mills, and David Miller offers a unique contribution to the field. The editors provide a more critical way to approach the subject by offering the "five pillars of Islamophobia": (1) the institutions and machinery of the state; (2) the far right, incorporating the counter-jihad movement; (3) the neoconservative movement; (4) the transnational Zionist movement; (5) and assorted liberal groupings including the pro-war left and the new atheist movement [11]. The UK research group situates Islamophobia within existing power structures and examines the forces that consciously produce anti-Muslim discourses, the Islamophobia industry, within a broad political agenda.

One of the most engaged scholars with a focused Decolonial approach to Islamophobia is Professor Salman Sayyid, a professor of Social Theory and Decolonial Thought, Head of the School of Sociology and Social Policy at University of Leeds. In 2006 Professor Sayyid organized a workshop hosted by the Centre of Ethnicity and Racism Studies at the University of Leeds (Thinking Thru' Islamophobia) from which the collection of 28 essays co-edited with Abdoolkarim Vakil emerged (Thinking Through Islamophobia: Global Perspectives). This volume pioneered a radically novel typology of Islamophobia recognizing its global scope (including its occurrence in Muslim contexts) and a political perspective (rather than media and representational theorization of Islamophobia) which articulates local racist and global colonial hierarchies [12]. The approach outlined in that collection is one that Professor Sayyid has built upon. There are four main characteristics of this approach. Firstly, it sees Islamophobia as a historical phenomenon not a timeless one beginning with the Qur'iash or merely a response to 9/11 [12]. Secondly, the approach is characterized by the idea that Islamophobia is global rather than just national or local [12]. Therefore, you can see Islamophobes who are Muslims, and you can also have Islamophobes where there are no Muslims. Thirdly, Professor Sayyid conceptualizes Islamophobia not in relation to hostility or hatred of Muslims but rather as a form of racialized governmentality [12]. Islamophobia is about disciplining Muslims by reference to Westernizing horizons [12]. In other words, the point of Islamophobia is denied Muslim agency. This why Sayyid is convinced Islamophobia occurs only for Muslims as political subjects who have been subjugated. Fourthly, he understands the causes of Islamophobia not in psychological terms or in terms of media distortion but ultimately as political [12]. For Islamophobia is about how we transform relations between the ruled and rulers [12].

Professor Sayyid's approach to Islamophobia is an intersection between critical race theory, decolonial thought, and discourse theory which can be described as Critical Muslim Studies. Academic discussions of Islam and Muslims have tended to be dominated by Orientalism, whether framed within anthropological/ethnographic perspectives, or Islamic Studies, or international relations. In sociology and political theory, Muslims were not part of mainstream disciplinary debates and research. Critical Muslim Studies is a broad multi-fronted effort to develop a distinct research program as an approach to Islam and Muslims which is not bound by disciplinary constraints and is informed by dialogue with critical theory, poststructuralism, and postcolonial political theory. Sayyid's approach is to recognize that the analysis of Islamophobia often reproduces Orientalist tropes, and therefore it is critically important to develop methods and modes of research that go beyond them. Otherwise, the study of Islamophobia becomes part of the problem, not the solution, as it celebrates "moderate Muslims" [12]. Professor Sayyid observes: "My involvement in a project to produce a countering Islamophobia toolkit has reminded me how much of mainstream critique of Islamophobia studies is complicit with the prevailing racial order. The fundamental reason for the spread of Islamophobia is lack of political will to counter it" [12].

Currently, Professor Sayyid is working with Abdoolkarim Vakil on a project to develop a theory of Islamophobia. The difficulty, of course, is that this means taking Islamophobia Studies seriously as a field of study, rejecting the insularity, presentism, and lack of rigor of much of the work that is produced. It seems incredible to Sayyid that "so much research on Islamophobia appears without referencing the existing literature on the topic, without being aware of Islamophobia Studies journal. Books on Islamophobia often appear that are presented as novel contributions -where such evaluations are very often based on ignorance of the field" [12]. Decolonizing the study of Islamophobia is an essential prelude to understanding the phenomenon.

On the European front, Farid Hafez offers a major contribution to the academic field with both the Islamophobia Year Book and the annual European Islamophobia Report project. Farid's entry into the Islamophobia Studies field comes directly from his Ph.D. thesis, work which focused on legal restrictions on building mosques and minarets in two Austrian counties. Farid's first book, *Islamophobia in Austria*, co-authored with John Bunzl, won the prestigious Bruno-Kreisky-Anerkennungspreis of the Dr. Karl-Renner-Institut. Since Islamophobia has different modes of expression, Farid has been able to craft a niche in the Islamophobia Studies field in the German-speaking countries as a primary area of specialization as well as to create a scholarly infrastructure across Europe to produce the annual European report. The academic engagement and scholarly research on Islamophobia in German-speaking countries are linked theoretically to comparable anti-Semitism studies. Naturally, the history and experiences of Jews in Germany serve as a touchstone for examining structurally and epistemically the process of otherization directed at Muslims in the contemporary period.

Forging the Islamophobia Studies field is the current focus of the work at UC Berkeley's Islamophobia Research and Documentation Project (IRDP). This academic program applies a scholarly, systematic, and empirical approach to the study of Islamophobia and its impact on the Muslim communities and minorities in general [13]. What is unique at Berkeley is that the Project is situated within ethnic studies and locates Islamophobia in the long history of othering in the USA and Europe that is grounded in postcolonial theory. Up to this point, the Project has been able to set up an extensive global academic network of faculty, graduate students, and researchers engaged in work related to Islamophobia. The network is formed around a series of annual conferences, each dealing with critical and regionally focused issues.

Approaching the subject in academia requires a fundamental shift in how we define Islamophobia and identify the areas of emphasis for research as we work to counter this pernicious phenomenon. At Berkeley's IRDP, which serves as a global hub for the field, Islamophobia is defined as "a structural organizing principle that is employed to rationalize and extend the dominant global power alignment, while attempting to silence the collective global other" [13]. Yes, the basic term, "Islamophobia," can be defined as "fear," "anxiety," or "phobia" of Muslims, but at the same time, it is a far more encompassing process impacting law, economy, media, and society [13]. At one level, its civil society ideologues attempt to classify

who belongs to the "civilized world," the criteria for membership, and who is the demonized and ostracized global other [13]. At a deeper level, Islamophobia is a renewed drive to rationalize existing domestic and global racial stratification, economic power hierarchies, and open-ended militarism [13]. Islamophobia reintroduces and reaffirms racial structures that are used to regulate resource distribution domestically and globally [13].

At the core, demonization of the Muslim subject has less to do with the subject himself/herself and more to do with the cunning forces that view the targeting of Muslims and Islam as the best strategy to rehabilitate their discredited agenda and image in society. Peddling and stoking fear is utilized as a substitute for offering sound economic and social policies and engaging in legitimate debates on how best to address the multitude of challenges facing society in general.

The strategy has been tried and tested many times in the past with devastating consequences. Claiming to defend and protect society from a "strange," "foreign," or "different" ethnic, religious, and racial grouping is not new and always ends in absolute disaster. A brief examination of America's history gives us many examples of such a strategy: targeting Native Americans; oppressing African-Americans during slavery, Jim Crow, and to the present; passing the Chinese Exclusionary Act; demonizing Catholics; encouraging anti-Semitism and targeting Eastern Jewish immigrants in the early period of the twentieth century; enforcing Japanese internment; and perpetuating the anti-Mexican discourse. Examining each these episodes in America's history, we can identify the political forces that used fear, bigotry, and demonization to gain power for themselves while claiming a defense of the country from enemies, which in each case led to undermining the constitutional, ethical, and moral foundation of society itself.

Critically, targeting Muslims in the USA serves as a convenient foil for right-wing political forces desiring to roll back civil rights legislation, voter and immigration rights, environmental protection, and equitable economic policies. Islamophobia makes it possible to reduce and narrow the scope of the debates and to frame national issues under the rubric of national security, through a manipulative appeal to patriotism. Here, the terms of debate are set by right-wing forces but also draw in the center, left, and segments of the progressives who respond to criticisms of religion and Islam, such as impassioned arguments to save Muslim women from Muslim men in faraway lands. We must be reminded that the debates are not about the nature of Islam as a religion but rather about the rights of Muslims as citizens and equals in American and Western society in general. Reducing the rights and citizenship of Muslims to a debate about the nature of Islam allows the right wing and Islamophobes to externalize and demonize Muslims, especially by magnifying cultural differences, a strategy which then is packaged into campaigns to save Western society from a possible takeover.

What is deployed first by the right wing eventually infuses all civil society, and the scope of the national debate begins to reflect bigotry at every turn. Let us be clear that the reactionary forces in America that opposed the passage of the Civil Rights, Voting Rights, and Immigration and Nationality Acts have set their sights on reversing the much-needed progress in the country and are utilizing Islamophobia

as the Trojan Horse to achieve this objective. "Take our country back" is shorthand for opposing equality, fairness, and dignity for all Americans, and Islamophobia is used to obfuscate the real targets.

Let us dispense with the notion that the problem of Islamophobia is driven by the media and the constant negative representation of Islam and Muslims. While I concur that media coverage intensifies the problem, the role of the press, as Noam Chomsky aptly argued, is to manufacture consent of the governed [14]. Right-wing economic and political forces identify society's supposed enemies, and the media then is off to the races with the needed distorted coverage. The corporate media is an economic enterprise owned by elites in the Global North, and the scope of coverage is shaped by those who own and operate media organizations. The media pursues the agenda that reflects the elite's priorities, and journalists are under a tight rein on who, what, or when is to be covered, with the final content subject to editorial control.

Targeting Muslims makes them an instrument to shape and reshape power disparities at a time when right-wing political and economic ideas in the West have failed. Right-wing ideas such as deregulation, privatization of education, reducing taxes while expanding military expenditure, shrinking government, and trickle-down economics have ended in failure. Islamophobia, then, emerges from right-wing elites in Western society who are fighting ideological battles among themselves, with Muslims construed as the enemy, making it possible for a proxy cultural, ideological, economic, and religious war to take shape. Fear of Muslims is used as a diversion from the real causes behind social and economic difficulties arising from massive global shifts and, indeed, failed right-wing policies.

In the imagination of civil society, Islam and Muslims are judged and approached as pre-constructed and never allowed to enter the discourse independently. Islam and Muslims become what is imagined and consumed in the confines of a closed-circuit internal reproduction system that always points back to the imagined.

Just as the Star Wars movies have created a rich discourse and tapestry about an imagined and unreal outer space, the Islamophobic imagination has succeeded in creating an unreal picture of Islam and Muslims. What people see and experience daily about the faith is akin to a well-arranged studio set with characters and props to fit into the Islamophobic narrative. Facts, data, and real narratives are irrelevant in the Islamophobic imagination because the constructed frame filters everything and reduces it to stereotypes centering around violence and terror. Unfortunately, many news organizations and political leaders end up reproducing an imaginary reality that links Islam to violent extremism. Furthermore, when for a moment or in complete error the narrative departs from the imagined violent norm, it is corrected by pointing out that these discrepancies represent mere exceptions.

Expansion of the Field

The emergence of the Islamophobia Studies field in the USA is directly linked first to the aftermath of 9/11, which witnessed a spike in attacks directed at Muslims and those are mistaken to be Muslims, as the case of the Sikh community

illustrates. The second significant impact on the emergence of the field resulted from the campaign and election of Barak Obama, the first African-American president accused of being a closet Muslim both during the Democratic primary and the general election. Attacking candidate Obama for his supposed Muslim background or being a closet Muslim was used as a signpost for anti-Blackness and served as fodder for conspiracy theorists as well as the conniving strategists who wanted to seize a wedge issue that could propel Hilary Clinton first as the candidate for the Democratic Party and then the Republicans into the White House after the Iraq War disaster. The Birther Movement, arising from this Islamophobic discourse, sought in 2008 to monetize it into votes at the ballot box. However, the strategy did not work in the 2008 presidential campaign: The US public, exhausted from the disastrous wars in Iraq and Afghanistan, was on an anti-war footing and sought to shift power to the Democratic Party.

The third and certainly most significant impact on the field was made by the 2010 midterm elections and the episode of the "Ground Zero Mosque" which thrust Islamophobia into normative mainstream discourses. Just as the Rushdie Affair provided the context for a spike in Islamophobia and the subsequent research and documentation in the UK, the "Ground Zero Mosque" controversy thrusts the issue to the forefront so that no one had the luxury of ignoring it. It is important to remember that the framing of the Cordoba Center into the "Ground Zero Mosque" was the work of Pamela Geller, a central figure in the Islamophobia Industry, which was used as tool to mobilize for Tea Party candidates and extreme right-wing Republicans in the 2010 midterm elections. Here, the election of 2008 served as a catalyst for setting up at UC Berkeley's Center for Race and Gender the Islamophobia Research and Documentation Project, a research program to examine the increasing hostility and demonization of Muslims in the USA. In the aftermath of the 2010 election, the Islamophobia Studies Journal began to serve as a hub for the increasing and varied scholarly engagement with the new academic field. In the same way that ethnic studies was born out of the complex set of events and responses to the civil rights movement and the anti-Vietnam mobilization, the Islamophobia Studies field emerged organically to interrogate and deconstruct the various strands that are at work to otherwise and demonize Muslims and Islam in the contemporary period.

At present, the academic landscape at universities presents a number of challenges for the growth and emergence of the Islamophobia Studies field. First, the challenge at the university level is the continued persistence of what I call latent Islamophobia, which impacts how the subject is addressed and whether academic programs begin to take on the subject matter without the entrenched discriminatory and orientalist attitudes brought to bear on incipient efforts. Second, existing ethnic studies, immigration, labor, and sociology to name a few fields are often uneasy about engaging Muslims and Islam as a racialized group or phenomenon, since this is outside of their constructed canon. A third major challenge is that an increasing number of security and terrorism studies that are focused on the Muslim subject are at the core built on a latent Eurocentric and Islamophobic orientation to knowledge that views Islam/Muslims as a unique and subhuman, apt to produce violence that requires new modes of research and engagement. Here, the emerging fields of

securitization and terrorism studies (with some exceptions) are running to affirm the core problematics that the Islamophobia Studies field is working to challenge. A fourth challenge at universities comes from the explicit links and funding sources that are connected directly or indirectly to the US government with heavy contribution from the Department of Defense and other security-related programs. Heavy dependence on federal funding for various programs and area studies causes institutions to keep a distance from engaging critically and objectively the Muslim subject and Islam. These programs tend to produce a "safe" area of engagement that broadly reflects federal funding priorities. A fifth major challenge to universities embracing the Islamophobia Studies field is the prevalence of pro-Israel voices within the Islamophobia industry, which tend to produce a constant pressure on administrators and leadership to remain at a distance from Muslims and programs that might expose the existing Islamophobic networks and the links to Israel's PR strategies in the USA. This has produced a constant pressure to keep the academic programs away from a "normalized" relationship or engagement with Muslims at the university level.

In the months and years ahead, the Islamophobia Studies field will take shape, and more resources coming into the mix will energize and provide needed space and the academic support. We can end on a positive note by calling attention to the growth in numbers of graduate students, a few with completed Ph.D. theses during the past 3 years, who have engaged and energized the field. This new stream of academics and practitioners in the field, which will contribute to opening new vistas for research and engagement, will forge spaces in universities and centers that otherwise would not have examined the issues due to lack of specialists in the field. The field is here to stay, and the current volume, coming from a new field of scholarly research, will contribute to its continued growth and impact.

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3 History and Principles of Islam and Islamophobia

Khurram K. Durrani, Ahmed Zakaria Hankir, and Frederick R. Carrick

Introduction

The term Islamophobia was first used in 1910 in the French language ("Islamophobie") by Alain Quellien in his report for the French government "Muslim Policy in West Africa" [1]. According to the Oxford English Dictionary, the word first appeared in the English language in 1923. The latest edition of the Merriam-Webster Dictionary defines Islamophobia as "an irrational fear of, aversion to, or discrimination against Islam or people who practice Islam."

Unlike other phobias, "Islamophobia" is neither described in the *Diagnostic and Statistical Manual of Mental Disorders 5th edition* (DSM-5) nor coded in the *International Classification of Diseases 10th edition* (ICD-10). In the DSM-5, phobias are disorders causing distress and functional limitations to those afflicted. Islamophobia's main distinction when compared with classical medical phobias is that it seldom causes distress to the one harboring it but may visit heavy physical and emotional distress and damage on those to whom it is directed. The etiology of Islamophobia is distinct from that of classical phobias with the former more heavily influenced by social and cultural determinants compared to the latter.

The aim of this chapter is to present the facts about Islam in a dispassionate manner and to allow readers to formulate their own conclusions about this way of life. To fathom the ascent of Islamophobia, we must first provide a brief history of the Islamic faith and discuss and describe its basic principles.

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Basic Principles

The preeminent examples of monotheistic religions are Judaism, Christianity, and Islam. Chronologically, from a Western scholar's perspective, Judaism started in the seventh century BCE, Christianity in the first century CE, and Islam in the seventh century CE. However, Muslims believe that the Islamic faith started with Adam and was finalized and "sealed" by the prophet Muhammad and that all prophets between Adam and Muhammad were sent by God to teach the same monotheistic principles (i.e., Islam).

A Muslim (which, in the Arabic language, means "one who submits") is a believer of Islam (Arabic for "surrender"). A Muslim is a person who achieves a state of peace by surrendering himself or herself to the will of Allah (Arabic for "God") in the manner that was prescribed by Him. Muslims believe that the Quran (Arabic for "the recitation") is the word of Allah. The Quran is divided into 114 Surahs (Arabic for "chapters"), which are divided into over 6000 Ayah (Arabic for "verses"). The Quran was revealed to the prophet Muhammad by the archangel Gabriel over a time span of more than two decades. Hadith (which in Arabic means "news" or "story") are the sayings of the prophet Muhammad. The practices derived from Hadith, along with the accounts of prophet Muhammad's actions, words, deeds, permissions, and disapprovals, are collectively termed Sunnah. The Quran, Hadith, and Sunnah are the sources of Islamic jurisprudence.

History and Genesis of Islam and Islamophobia

The prophet Muhammad was born in Mecca in the Arabian Peninsula in 570 CE. Many Western scholars often describe Muhammad as the founder of Islam. Muslim scholars, however, report that the prophet Muhammad reaffirmed and continued the monotheistic teachings of previous prophets including, but not limited to, Adam, Abraham, Moses, Jesus, Noah, and various others. The Quran mentions 25 prophets by name, but according to some Muslim scholars, there were approximately 124,000 prophets of God all of whom subscribed to the principles of the Islamic faith (i.e., monotheism).

Muhammad's parents belonged to the Quraysh tribe which was the most powerful and prestigious one in Mecca. Muhammad's father died before his birth and his mother passed away when he was 6 years old. The emphasis in Islamic society on offering love and care to orphans may be influenced by Muhammad's own childhood experiences and by the guidance of the Quran. Muhammad was cared for by his paternal grandfather Abd al-Muttalib, who died when the prophet was 8 years old, and then by his paternal uncle Abu Talib.

When Muhammad was 25, he received a marriage proposal from a wealthy Meccan business woman named Khadija. Even before she commissioned him to run some of her businesses, she had heard about Muhammad's nobility of character and his truthfulness. He accepted the marriage proposal and did not marry another woman until after her death.

Muhammad would often leave the city for a spiritual retreat to a cave in mount *al-Hira.* He received the first revelation of the Quran there in 610 CE and continued receiving revelation for the next 23 years until just before his death in 632 CE. These revelations took a physical and psychological toll on the prophet. Initially he confided these revelations only to his wife, Khadija, his confidant and support, who believed that these revelations were divine. After most of these revelations, he would return home trembling vigorously and he would seek solace from his spouse. According to historians like Muhammad ibn Jarir al-Tabari and Ibn Shihab az-Zuhri, the prophet experienced suicidal ideation when he beheld the spectacle of the archangel Gabriel and when it was revealed to him that he was the prophet of God (although there are scholars who dispute this narrative) and accusations were leveled against him that he was possessed by demonic spirits (known in Arabic as Jinn) [2–4]. According to other scholars, Khadija was not only Muhammad's beloved wife but a consoling mother figure and a spiritual advisor [5]. According to Muhammad ibn Ishaq ibn Yasin ibn Khiyar, Khadija would allay the prophet's self-doubts by reassuring him about his physical and emotional well-being by saying "You are kind and considerate toward your kith and kin, you help the poor and the forlorn and bear their burdens. You are striving to restore the high moral qualities that your people have lost. You honor the guest and go to assistance of those in distress…" [3]. Khadija also sought the consultation of Waraqah ibn Nawfal, the first cousin of Khadija – a Christian, scholar, and poet, who confirmed that Muhammad had been chosen as God's prophet.

Soon thereafter, Muhammad started preaching these revelations publicly. Muhammad warned the people of Mecca not to worship objects made by man (idols) and to obey Allah alone. As this new movement gained momentum, powerful individuals in Meccan society fought fiercely against it. Abu Lahab the prophet's paternal uncle and Abu Jahal, a cousin of the prophet's father, were very disturbed by the idea of abandoning and forsaking their ancestral faith and some scholars describe the resistance that they mounted toward Islam (which included the persecution of Muslims) as Islamophobia.

Abu Jahal imposed a total embargo on business, personal, or financial dealings with Muhammad and his followers, forbidding anyone to marry or sell any food to Muslims. Muslims were emotionally and physically tortured. Bilal, an Ethiopian slave, was brutally tortured when his master placed a smoldering boulder on his torso under the sweltering Arabian sun. Assassination attempts were made on Muhammad's life. He was publicly ridiculed and abused on the streets of Mecca. Garbage, including animal intestines, was poured on him. During these trials and tribulations, most of Muhammad's followers became refugees as they were compelled to migrate to Yathrib (present day Madinah in Saudi Arabia). Additionally, Muhammad suffered several severe personal losses. His wife of 24 years, and the first person to embrace his message of Islam, passed away on the 10th of Ramadan in 619 CE. During the years of siege, Khadija had spent all her wealth so that the newly reverted Muslims could have necessities like water, food, and clothing. Once the richest woman of Mecca, she had nothing left for herself. She was buried in her husband's cloak as nothing else was available. According to a Hadith, prophet Muhammad included Khadija as one of the four great/perfect women of history.

The other three were Asiya the wife of Pharaoh (also known as Bithiah in other Abrahamic religions and the foster mother of Moses), Mary (Maryam in Islam) the mother of Jesus, and Fatima, the daughter of Muhammad and Khadija.

During the same year, Muhammad's second devastating loss was the death of his uncle – his guardian, protector, and foster parent, Abu Talib. A few years earlier, between 613 CE and 615 CE, the newly converted Muslims fled from the persecution that was being meted out against them by the Quraysh and sought refuge in Abyssinia, a Christian kingdom. The ruling Arabs sent envoys to King Negus of Abyssinia demanding the Muslims be extradited. The Christian king who was known for his fairness decided to hold a court on the issue. Muslims won the *great debate* demonstrating that they believed in the same God as the Christians, by directly reciting from the Quran about the Virgin Mary. While announcing the verdict, the king wept, saying "it's the same source."

In 622 CE, after sending some of his followers to Abyssinia, the prophet together with about 70 families made the hijrah (*Arabic* "migration") to Yathrib, marking the beginning of the Islamic lunar calendar. In 628 CE, after the battle of Badr, Uhad, and Trench, Muhammad's peace initiative resulted in the Treaty of Hudaybiyyah, between Mecca and Medina. The Meccans later violated the treaty and Muhammad, along with an army of 10,000 reverts and tribal allies, marched on the city of Mecca. The Meccans surrendered and voluntarily opened the city gates, and, without bloodshed or forced reversion to Islam, the Quraysh were vanquished, and the mighty city of Mecca was conquered.

On March 632 CE, Muhammad espoused his memorable last sermon, in which he eloquently summarized the teachings of Islam. Prophet Muhammad died on June 08, 632 CE. Following the prophet's death, the religion of Islam went through its peaks and valleys. Four caliphates followed, starting with the Rashidun Caliphate and ending with the Ottoman Caliphate. The four caliphs of the Rashidun Caliphate were chosen by a Shura (consultation among the notables). In the Shia faith, Ali, as Muhammad's cousin and son-in-law, was the rightful successor instead of the first three. The assassination of the third caliph, Uthman, and the ineffectual caliphate of Ali that followed sparked the first sectarian split in the Muslim community [6]. As Ali failed to arrest Uthman's murderers, Muawiyah, the governor of Damascus, considered Ali as an accomplice. Consequently, the battle of Saffin broke out in 657 CE between supporters of the Caliph Ali and supporters of the assassinated Caliph Uthman and permanently divided Muslims into Shia and Sunni.

Sadly, today we still observe the geopolitical implications of the battle of Saffin in the Middle East and most of the Muslim world. Azerbaijan, Bahrain, Iran, and Iraq are predominantly Shia Muslim countries. Kuwait, Lebanon, and Yemen also have significant Shia Muslim populations. Within the Shia sect, some of the other denominations, such as the Alawhites, are rejected by the mainstream. Similarly, the Ahmadiyya movement was founded in 1889. According to belief, the founder Ghulam Ahmad, was the promised Mahdi (the guided one) and the Messiah (the second coming of Jesus). As a result, in most Muslim countries, they are considered non-Muslims and subjected to persecution and oppression.

Islamic mysticism, popularly known as Sufism, is not a sect of Islamic faith, but a way of worship that exists within various sects of the faith itself, including Sunni

and Shia. Sufism emphasizes introspection and closeness with Allah, through transcendental, subjective experiences. The movement grew out of early Islamic asceticism, to counterbalance the increasing worldliness of the expanding Muslim community; later, compatible, non-Islamic sources from Europe and even India, were adopted and made to conform to Islam. Vast conversion to Islam happened because of the work of the Sufis from the ninth to eighteenth century, and they still comprise the bulk of the Muslim world [7]. Most of the converts to Islam, including those from the West, come to Islam through Sufism. Some prominent examples are Ivan Aguéli (d. 1917), also known as the Swedish Sufi, and Ellen Burstyn, an American actress (b. 1932). Today, we see opposition to Sufism and atrocities against those who practice it. Some radical groups consider them odd and eccentric; others consider them as not true Muslims and even idolaters and polytheists. Based on a best seller, Monsieur Ibrahim is a beautiful movie that shows the wisdom of a Sufi, its influence on the life of young Jewish boy, and a depiction of interfaith relationships.

The US Supreme Court recognizes Muhammad as one of history's greatest 18 lawgivers. The Court's 1935 frieze (not a true depiction) includes Muhammad alongside Menes, Moses, Hammurabi, Solomon, Napoleon, William Blackstone, John Marshal, King John, and others. Michael H. Hart, an American attorney, astrophysicist, and author, designates prophet Muhammad as the most influential person in human history [8].

During its golden years, Islam made huge contributions to the fields of medicine, astronomy, chemistry, and mathematics. Muslim physicians such as Rhazes, Avicenna, and Ibn Jaazlah not only made tremendous contributions to the field of medicine during the Dark Ages but also significantly contributed to psychotherapy and psychiatry.

In 1095 CE Pope Urban II called the first crusade. In the city of Jerusalem, where Jews, Christians, and Muslims had lived in harmony for almost half a millennium under Islamic rule, the crusaders mercilessly massacred 40,000 inhabitants in 1099 CE [9]. The City of Jerusalem has a special significance in Islam and for Muslims. Jerusalem was the first Qibla in Islam (the place Muslims turn toward while worshipping) and the sacred mosque of Al-Aqsa is also located there. Jerusalem is also the city from where the archangel Gabriel took the prophet Muhammad for his holy night journey of *Miraj*.

From the Mongol killings in 1220 to the current time, the persecution, often brutal, of Muslims has continued. In various countries, in various times, these have included human rights violations, ethnic cleansing, rape of women, bullying of children, desecration of the Quran, and attacks on mosques. Even so, it remains one of the most rapidly growing faiths, practiced around the world.

Articles of Faith and Fundamental Pillars in Islam

It is very difficult to explain Islam in a few paragraphs or a chapter of a book, but the below-mentioned six core articles of faith and the five pillars will give some basic understanding.

The articles of faith *(arkan al-iman)* form the foundation of the Islamic belief system.

1. Belief in One God: The central belief and the most important teaching of Islam is that there is no deity worthy of worship save Allah (God) and that Muhammad, may peace and blessings be bestowed upon him, is the messenger and the last prophet of Allah.
2. Belief in Angels: Angels in Islam are unseen beings who serve the purposes of Allah. Gabriel (Jibreel), Michael (Meeka'eel), Raphael (Israfeel), Azrael, the Noble recorders (Kirman Katibin), and Munkar and Nakeer (angels of death) are a few examples of angels recognized in Islam. Notably, some of these names are also found in the Bible. A crucial distinction between the angels of Islam and the angels of Christianity is that Muslims believe that angels cannot disobey Allah and hence there is no such thing as a "fallen angel" (i.e., Lucifer in the Christian faith). Unlike Christians, Muslims believe that Satan is an alternative lifeform known as Jinn and that he is not an angel.
3. Belief in Revealed Books: Quran mentions three other books by names: the Torah (revealed to Moses *Musa*), the Zubur (revealed to David *Dawud*), and the Gospel *Injil* (revealed to Jesus *Isa*). The Quran also mentions a number of scrolls (*Sahifah*) but names only two: the Scrolls of Abraham and Scrolls of Moses (aside from Torah). In Chap. 19 (Surah Maryam), Verse (ayah) 12, Quran mentions or alludes to what to some scholars is a reference to the Book of John the Baptist (Kitab Yahya).
4. Belief in Prophets of God: The Quran mentions at least 25 prophets by name and states that prophets of God were sent to every nation on Earth. These prophets in Islam start with Adam and include Abraham, Moses, Noah, and Jesus and end with Muhammad. According to the faith, all prophets have the same monotheistic message of one God.
5. Belief in the Day of Judgment (and the life hereafter): Muslims believe in the continued existence of the soul after physical death. After the day of the judgment, all humans will be divided, depending on their deeds, into those destined eternally for Heaven or Hell.
6. Belief in the Divine Predestination and Divine Decrees: Muslims believe that only God knows everything and that nothing happens without His will.

The five fundamental pillars of Islam *(arkan al-Islam).*

(i) Shahadah (testimony) is the first of the five pillars of Islam. It is normally recited in Arabic. "There is no god but Allah; Muhammad is the prophet of Allah." It must be recited by a Muslim at least once in a lifetime, aloud, correctly, and purposefully, with full understanding of its meaning and with the assent of the heart [6]. In Shia Islam, a phrase concerning Caliph Ali is sometimes added.

(ii) Salat (prayer) is the second pillar of Islam. There are five daily obligatory prayers and the name of each prayer refers to their respective timings: *Al- Fajr*

(dawn prayer), *Az-Dhuhr* (midday prayer), *Al-Asar* (afternoon prayer), Al-Maghrib (sunset prayer), and *Al-Isha* (night prayer). There are many additional prayers, the more important one being the weekly *Jummah* (Friday prayer) and the two annual Eid prayers, namely, *Eid al-Fitr* and *Eid al-Adha.*

(iii) Zakat (charity) is the third pillar of Islam. It is an obligatory tax which is the personal responsibility of every Muslim. It's the duty of every Muslim who meets the criteria of wealth to give a calculated (minimum) amount of their wealth to the poor. This important pillar is meant to reduce social and economic inequality in a society.

(iv) Sawm (fasting) is the fourth pillar of Islam. In Islam there are various types of fasts, but fasting during the month of Ramadan is obligatory. Ramadan is the 9th month of the Islamic lunar calendar. Muslims fast from dawn till dusk. Sawm is an Arabic word which means *to refrain*. During fasting, it is an obligation to refrain not only from water, food, and intercourse but also from any form of immoral behavior and words. Thus, during Sawm, a heightened sense of spirituality helps in breaking bad or immoral habits. The Quran acknowledges the existence of fasting in the preceding faiths.

(v) Hajj is the fifth fundamental pillar of Islam. It is a pilgrimage to the holy city of Mecca, in present day Saudi Arabia. It is obligatory for every Muslim who is physically and financially able to make the pilgrimage, but only if their absence causes no hardships to their families. Hajj begins on the 8th day of the last month of the Islamic calendar, *Dhu al-Hajj*, and usually ends on the 12th day of the same month. Over two million people perform Hajj every year. This religious rite brings unity among Muslims from different backgrounds and different parts of the world.

Conclusion and Relevance

Islamophobia describes a state of mind and a set of consequences which affect Muslims and those who are perceived as such throughout the world, especially in the West. The roots of this complex "phobia" are embedded in the history of the faith of Islam and those who have feared or rejected it over many centuries.

Setting aside the sociopolitical issues, for mental health workers Islamophobia's presence in our patients can manifest as disorders in both the owner and the object of the condition – but most often in the latter. Acute stress reaction or post-traumatic stress disorder (PTSD), several types of mood and anxiety disorders, and even suicide may follow.

What is a mental health professional to do, given the rising tide of Islamophobia and its consequences? We need to educate ourselves about various religions, particularly the faith of Islam, and about how Islamophobia forms and grows against Muslims and those perceived as such. Integration of religion and spirituality into psychiatric education, training, and practice is critical. Even today, in secular societies, religion is very important to the majority. We see the incorporation of religious themes into the dreams, delusions, hallucinations, various types of personality

disorders, and many other psychological and psychopathological phenomena. In academia, a more comprehensive understanding of religions and psychiatry (other than *The Future of an Illusion*); the work of Jung, Winnicott, and Erickson and many other modern analysts should be given a balanced exposure. Similarly, in the case of Islamophobia, being aware of its presence, explicit or implicit, is important in our society and our patients. We need to be aware and then prepared to identify and address this uncontrolled fear and its tragic consequences. We are best served by educating ourselves and our trainees to understand and respect those who have different religious understandings.

As a psychiatrist who has a reasonable understanding of Islam, KD will take the liberty to say that we all need to be more like Muhammad as described by the one who knew him best, his beloved wife Khadija: "You are kind and considerate towards your kith and kin, you help the poor and the forlorn and bear their burdens. You are striving to restore the high moral qualities that your people have lost. You honor the guest and go to the assistance of those in distress."

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4 Islamic Perspectives on Psychological and Spiritual Well-Being and Treatment

Hooman Keshavarzi and Bilal Ali

One of the most significant barriers for seeking treatment among American Muslims is the limited availability of Islamically integrated mental health services that correspond to their desire for an incorporation of Islamic spirituality into their treatment [8, 27, 30, 52]. Given such barriers, coupled with behavioral healthcare disparities for American Muslims, it is important for mental health professionals working with Muslims to become familiarized with the Islamic spiritual and intellectual heritage as this can be a means of empowering oft-marginalized American Muslim communities. As opposed to Eurocentric frames of reference, Islamic theological concepts can be incorporated in order to advance therapeutic rapport and to optimize psychiatric treatment with this population [17]. Thus, a presentation of the Islamic intellectual heritage that is not confined by the European historical or modern developments of the field of medicine or behavioral science is necessary in order to gain a true appreciation of Islamic traditional views on health and pathology. An unbiased presentation of the Islamic tradition can engender a fuller grasp of Islamic conceptions of well-being that are built upon Islamic epistemology and ontology. Though there is considerable convergence between modern psychiatric practice and Islamic views on well-being, it is important to understand some key underlying distinctions as well. One such key distinction is the complete absence of a process of secularization of healthcare practice that was more characteristic of Western Europe and which was later inherited by the Muslim world due to colonialism. In fact, the holistic outlook on mental health as an aspect of spiritual and physical

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health has long been a defining characteristic of Islamic civilization. Classically, Islamic scholarship did not disengage rational, sacred, or empirical knowledge, as all were viewed as valid sources of knowledge and manifestations of God's signs [5]. Thus, strong empirical evidence was not seen as being at odds with sacred knowledge; rather empirical evidence has always been an important aid to understanding the sacred and the adjudication of Islamic ethics and law [45]. It is critical to appreciate this lack of tension between the secular and sacred in understanding classic and holistic Islamic perspectives on health. More specifically, Islam's inherent recognition of mental illness, the field of medicine, and expert testimony that is inherently built into the Islamic legal process in the determination of the applicability of Islamic legal injunctions to cases is a testament to the complementary role of medicine and Islamic law [4].

Historically, in the nineteenth through fourteenth centuries, the diversification of health systems in the Muslim world may have included such conversations between various sectors of human services and helped inform the development of spiritual lodges, or *zāwiyahs*/*khānqāhs*, that functioned in conjunction with and oftentimes in close proximity to the colleges (*madrasah*) and/or hospitals (*bīmāristān/māristān*) (see Fig. 4.1) [48].

Physicians were typically trained in Islamic theology and law and thus did not solely focus on external dysfunction but rather interacted with Islamic legal jurists in determining the ethics of medicinal practice, offered religiously oriented psychotherapy, or referred patients to hospitals or spiritual lodges who needed more intensive care [11, 40]. At the same time, much of medical or psychiatric treatment was in communal care settings, and only during extreme duress or severity of illness was institutional care warranted [40]. Community practice was commonly offered by local physicians or through visitations to spiritual practitioners [31]. Understandably, during this era the Muslim world also witnessed an explosion of literature on human behavior (*tahdhīb al-nafs*), character reformation (*tahdhīb al-akhlāq*) and works on

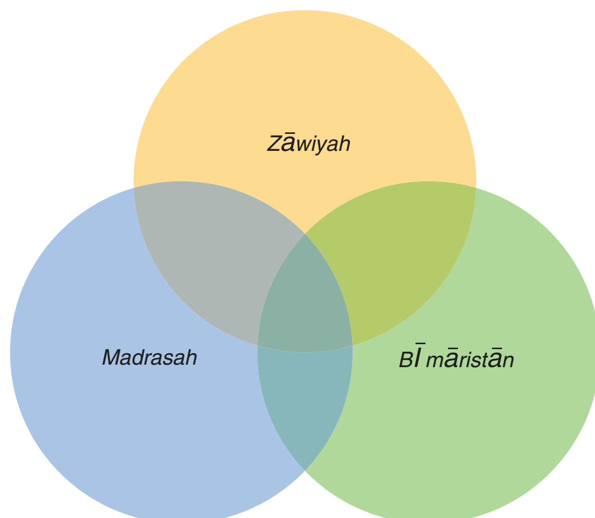

Fig. 4.1 Overlapping Islamic spaces in the delivery of Islamically integrated holistic healthcare

human ontology, incorporation of Hellenistic philosophies, medicine, and metaphysics [43]. For example, in the formal works and, in some cases, written exchanges between the erudite scholars Abū Bakr al-Rāzī (d. 311 AD/925 CE), Ibn ʿAlī ibn Miskwayh (d.421 AD/1030 CE), Ibn Sīnā (d. 427 AD/1037 CE), Ibn Rushd (d. 595 AD/1198 CE), and later Abū Ḥāmid al-Ghazālī (d. 505/1111), one can find rich and diverse contributions to the Islamic intellectual discourse in addressing the physical (*ḥissī*), metaphysical (*ghaybī*), and rational (*ʿaqlī*) branches of knowledge. These conversations demonstrate a clear intersect between theology (*kalām*), law (*fiqh*), philosophy (*falsafah*), medicine (*ṭibb/ḥikmah*), and spirituality (*taṣawwuf*) and contribute to the abundance of literature related to human cognition, behavior, emotions, and spirituality despite the absence of a distinct field of psychology. During this era, the seminal publication of the ninth-century Muslim polymath Abu Zayd al-Balkhī's (d. 322 AD/934 CE) *Maṣāliḥ al-Abdān wa al-Anfus* (which translates as "The Sustenance of the Body and the Soul"), the first known documented manuscript on mental health that incorporates discussions of the treatment of both physical and mental disorders within an Islamic context, is a clear evidence of such an integration [11]. The sophistication of al-Balkhī's discussions is indeed fascinating, as Awaad and Ali's [10] recent comparative analysis of the classical text indicates a complete convergence between the current symptomology for obsessive-compulsive disorder (OCD) according to the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (DSM-V) and Abu Zayd's delineation of obsessive disorders in his original manuscript.

The richness of intellectual discourses during this era included classical Muslim contestations on human ontology. Al-Ghazālī's writings are replete with discussions on the composition of the human psyche and its division into mind, spirit, and behavioral inclinations, or *ʿaql* (intellect), *rūḥ* (soul), and *nafs* (ego) [29]. Over two centuries later, the Ḥanbalī polymath Ibn Qayyim al-Jawziyyah (d. 751 AD/1349 CE) challenged whether the *nafs* (ego) and *rūḥ* (soul) were truly distinct entities [1]. The Ashʿaris, one of the two main categories of Muslim dialectic theologians (*mutakallims*) (the other being the Māturīdīs), provide a wealth of information on the role of the mind (*ʿaql*) and its distinctiveness from the spirit (*rūḥ*). While some of them maintained that the spirit is physically localized in the heart, some jurists argued that the mind is localized to the brain [28].

The richness of this Islamic intellectual heritage is rarely documented in modern texts of psychology/psychiatry. Due to the limited presentation of mental health perspectives that draw from this rich intellectual heritage, an introduction to some theological perspectives on the role of mental health in the Islamic tradition is presented below.

Mental Health in Islamic Theology

From an Islamic theological perspective, psycho-spiritual health is directly related to a human being's ability to actualize their primordial spiritual purpose. All human beings are created to tread a path that will ultimately ensure their salvation in the

afterlife and their ability to acquire God's pleasure. Health is thus, from an Islamic theological perspective, indicated by an individual's successful ability to remain on this path of worship. Hence any obstacles that obstruct their ability to tread this path is seen as detrimental to human functioning, irrespective of whether it meets the clinical threshold or not and whether or not it merits intervention. As this pursuit is lifelong, there are moments when individuals will be able to successfully maintain a level of optimal functioning, while at other times spiritual or psychological impairment may cause them to stray from the path. This pathway to God is achieved through an adherence to the divine directives God places upon the individual.

Dysfunction is then indicated by a divergence from these directives, and its severity is gauged by the degree of distance from the "straight path." God's directives in Islam are divisible into three categories: (i) belief in the Islamic creed, (ii) external conduct, and (iii) inner character, or spirituality. As far as Islamic creed (*ʿaqīdah*) is concerned, Islam requires at a minimum a conviction of the existence and oneness of God and a variety of other essential tenets delineated in the classical theological works, such as the finality of prophethood, the existence of angels, divine scriptures, and prophets, belief in predestination, etc. Thereafter, Muslims are responsible for obeying and following the laws that have been legislated for them pertaining to their outer conduct, otherwise known as Islamic law (*fiqh*). *Fiqh* covers a vast array of matters related to human behavior, including, of course, the laws of ritual worship but also matters of familial, criminal, and civil importance. For example, Islamic law prohibits theft, requires Muslims to fulfill civic duties to others and to offer their five obligatory daily prayers, fast 1 month every year, offer at minimum 2.5% of their wealth in charity, and offer a pilgrimage to Makkah once in a lifetime. Yet, lastly, Muslims are also required in their obligations to the faith to refine their inner character and to implement good character traits, such as generosity, forgiveness, gratitude, mercy, patience, compassion, good manners, courage, etc., while simultaneously striving to eliminate negative character traits such as envy, jealousy, arrogance, condescension, malice, etc.

Modern psychiatric practice, on the other hand, defines disorder based on the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) [6] and *the International Classification of Disorders* (ICD) that views mental illness as a significant impairment across social, occupational, or familial functioning with marginal attention afforded to human character flaws that lie beneath the clinical threshold. Thus, clinical terminologies are not synonymous with Islamic conceptions of optimal mental health, dysfunction, or even impact of disorder upon a patient's religious status as this lies outside of the scope of normative clinical practice. A fundamental difference between an exclusively clinical conception of dysfunction and Islamic holistic health is that Islam does not restrict dysfunction solely to the temporal world or to clinical impairment. As outlined above, character flaws that adversely impact a patient's afterlife are also taken into consideration as well as those character traits that lead to poor functioning prior to their becoming significantly impairing. Clinical treatments within the Islamic theological framework are considered to be in service of the larger Islamic ethos rather than being

restricted to symptom reduction or restoration of normative worldly functioning. These afterlife considerations significantly play into clinical decision-making on the part of a practitioner's or patient's selection of or compliance with various modalities of treatment. Behaviors that may not be clinically significant according to the DSM or ICD may be seen as pathological in Islamic terms. For example, narcissistic traits that may not meet the clinical threshold of narcissistic personality disorder are seen as a severely pathological character flaw in Islamic spirituality. The prophetic traditions, for example, warn of three spiritual "destroyers" (*muhlikāt*): "avarice (*shuḥḥ*) that is obeyed, material longing (*hawā*) that is complied with, and a man's admiration of himself (*iʿjāb al-marʾ bi nafsihi*)" (al-Bazzār [3], *Musnad al-Bazzār* hadith no. 7293; see also al-Mundhirī, [36], *al-Targhīb wa al-Tarhīb*, hadith no. 3943 in which he grades the ḥadīth as fair, or *ḥasan*). Islamic spiritual masters warn that admiration of the self invites one down the path of arrogance (*kibr*), and arrogance is the root of a multitude of spiritual diseases. Most importantly, however, the ḥadīth informs us that the severity of arrogance in the heart is such that "he who has an atom's weight of arrogance in his heart will not enter the Garden" (Muslim, hadith no. 147 (91)) [46]. Though in modern clinical practice, treatment of character defects may be seen as potentially ethically controversial, a reconciliation between the two approaches is to offer such treatments within the religious frame of reference of the client that is consistent with their self-identified treatment goals as opposed to through a proselytizing approach [29]. This mode of thinking is consistent with growing trends toward bringing spiritually oriented psychotherapies into the mainstream healthcare practice [44]. Certainly there exists significant research to demonstrate the clinical efficacy of the incorporation of spirituality into psychological practice oftentimes associated with better mental health outcomes [9, 22, 35, 50, 53–55]. In fact, Cloninger [15] argues only a spiritual approach to well-being can effectively provide lasting satisfaction and health to individuals who are naturally inclined to desire deeper meaning in their lives as they face the inevitable reality of sickness, suffering, and mortality. Finding hope and meaning in one's life through spirituality, he asserts, can help reduce vulnerability and increase resiliency to clinical pathologies [15].

Given that Islamic categorizations and qualifications of behaviors differ from modern psychiatric classifications, it is important to delineate the traditional Islamic framework of understanding human conduct. In brief, all human conduct in Islam is governed by a set of divine laws called the *sharīʿah* (literally "the way"). Often misunderstood or intentionally misrepresented as a set of legal rulings focused entirely on legal and criminal punishments, the *sharīʿah* is in fact a vast concept, a code of conduct that encompasses rules that govern Muslims both personally and collectively at the ethical, social, spiritual, economic, and political levels and is aimed to facilitate a functional society. Precepts of the *sharīʿah* are divisible into two major categories: those that deal with (i) outward conduct (*fiqh al-ẓāhir*) and those that deal with (ii) inner conduct (*fiqh al-bāṭin*). An illustration of how psychiatric considerations may apply differently for these two respective categories of behavior in the Islamic tradition is provided below.

Outer Conduct and Mental Health Considerations

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

According to all of the four schools of Islamic law, a central prerequisite for legal responsibility (*taklīf*) of an adult Muslim is *ahliyyah*, or legal competence. Complete competence (*ahliyyah kāmilah*) requires the existence and soundness of two faculties: (i) mental competence and (ii) physical capacity. A child possessing both of these faculties (*ṣabīyy mummayiz*) and a mentally ill person with deficient intellect (*maʿtūh*) are considered possessive of only partial competence (*ahliyyah qāṣirah*) and thus, able to voluntarily transact and perform legal obligations, albeit with the permission and consent of their guardian (*walī*). The postpubescent (*bāligh*) person of assumed sound intellect (*ʿāqil*), however, is considered fully responsible (*mukallaf*), competent of disposing wealth and engaging in contracts, bound to fulfill ritual obligations, and subject to criminal and civil law [25].

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

By this standard and definition, it is clear that clinical definitions of mental illness may or may not fit into some of these categories. With respect to clinical mental illnesses, they may be categorized into three possible scenarios based on legal consequence in Islamic law [13]:

1. Complete impairment and loss of mental faculties (*ʿaql)* such that it compromises one's ability to appreciate the consequences of their behavior *(idrāk)*. This category qualifies an individual to meet the conditions of *junūn* (insanity), thereby exempting them from all legal obligations and mandating interdiction (*ḥajr*) from executing legal/contractual affairs. This category generally includes the more severe maladies such as psychotic disorders, manic episodes, moderate to severe intellectual deficiencies, and potentially panic attacks.
2. Partial impairment or loss of mental faculties, sometimes referred to as *junūn juzʾī* (partial insanity). This category refers to an individual who is impaired only in a specific area of functioning and thereby legally exempt only in those circumstances. An example of this might include an extreme obsessive-compulsive disorder in which an individual is unable to control their compulsive behaviors and

which can potentially impact the legal effectiveness of contractual statements like that of divorce, for example.

3. Potential mental impairments, which have no impact on *ahliyyah*. These include milder depressive clinical episodes and do not alter the legal status of the individual. The patient is still fully responsible under the law irrespective of their clinical status. This may include dysthymia or milder expressions of anxiety disorders.

It must be kept in mind that the absence of impact upon *ahliyyah* does not preclude or undermine the potential importance of treatment. Although impairment may not meet the legal threshold to afford any dispensation for fulfilling their legal obligations, treatments are still valuable, particularly if they can nurture optimal functioning and enhance their ability to more fully carry out religious duties.

Islamic legal jurists actually differ with regard to the status of clinical treatments and interventions. Whereas all four Sunnī schools concur that seeking medical treatment is permissible, the Shāfiʿīs elevate it to being religiously praiseworthy (*mustaḥabb*) if a positive prognosis of treatment is established in the scientific literature, and it is established that treatment will enhance one's ability to be a fully contributing member of society [45]. On the other hand, some Ḥanafīs offer that if prognosis of treatment is positively established, then treatment is mandatory (*wājib*), since the established means of being able to fulfill religiously obligatory acts are themselves mandatory. In other words, since psychological treatment is a means of being able to meet the basic prerequisites of *taklīf* and rendering one capable of following the commands of Islamic law, adopting such means would be mandatory.

Mental health treatments can be of two types: (i) clinical treatment or (ii) pastoral/spiritual interventions. Though there is significant overlap between the two, clinical or medical care as a modality of mental health treatment has historically been recognized by Muslims and evidenced by numerous hospital systems in the Muslim world that contained psychiatric wards and specific treatments for the mentally ill [40]. Spiritual or pastoral interventions were likely directed toward spiritual sicknesses considered to be less severe and which did not cause significant clinical impairments. These formal psychological, behavioral, and spiritual interventions were offered by spiritual guides or healers, often times in communal settings but generally in spiritual lodges, or *khānqāhs* (also called *zāwiyahs* or *ribāṭs*). The latter form of pastoral treatment will be discussed later in the section on inner conduct. Illustrations of how mental illness can impact Islamic law have been elucidated in the following section.

Criminal Law

For the most part, the Islamic and Western law traditions converge on basic definitions of criminal defense and share core presumptions in forensic psychiatry, the most pivotal being the recognition of the mental element (*mens rea*) as a prerequisite

of criminal liability and the potential for an insanity defense. While the principal differences between the systems of Islamic and Western law in issues of forensic psychiatry within a criminal context are minor, one point of comparison is the way the Islamic legal system differentiates between the rights of God (*ḥuqūq Allāh*) and man (*ḥuqūq al-ʿibād*). When dealing with the rights of man, an Islamic judge (*qāḍī*) is generally required to investigate cases in great detail, thus warranting or even mandating the use of expert testimony. In matters of an adherent's obligations to God (such as prayer, charity, pilgrimage, adultery, etc.), however, a judge is afforded some license to avoid the scrutiny of apparent evidence of mental incapacity in a spirit of mercy and avoid a ruling of punishment.

Another difference across the two traditions is apparent in how insanity is proven in each system. In Islamic law, if someone who is accused of a crime can present some evidence of their insanity prior to the time of the offense—which even if not of a strong nature is sufficient to cast doubt on their responsibility—they can be relieved of liability and punishment based on the prophetic legal maxim "to avoid the prescribed punishments (*ḥudūd*) whenever possible" (al-Tirmidhī 2009 [51], ḥadīth 1424). Even when the evidence of their insanity significantly predates the time of the offense, the legal principle of *istiṣḥāb* (the presumption of continuity) may be applied to automatically presume the insanity of the accused at the time of the crime. On the other hand, under English law, even when the time between the proven insanity and the offense is short, and even though there may be sufficient reason on the balance of probabilities to prove insanity at the time of the crime, it is fully left to the court to accept or reject the insanity defense ([47], pp. 35–36).

Ritual and Civil Law

In ritual law, Muslim jurists unanimously agree that during a period of complete insanity, the *majnūn* (mentally insane) is relieved of the legal responsibility to perform any of the acts of worship. Differences among the jurists did arise, however, regarding the clinically insane individual who could recover, temporarily or permanently, from their insanity during the period of *taklīf* (legal responsibility) ([24], 2:247; [33], 5:41). In the case of ritual prayers, a complete day of uninterrupted insanity qualifies an individual to be classified as continuously (*muṭbiq*) insane and thus absolved of the responsibility to pray, while for fasting the minimum is a month and in charity a year ([14], 4:264). Regardless of the duration of insanity, a *majnūn* is treated as exempt from liability and legal responsibility with the exception of cases of damage to property or body, in which cases the guardian (*walī*) of the insane is obligated to compensate for damages or pay blood money (*diyyah*) from their wealth ([33], 5:41; al-Maqdisī [34], 8:383).

Insanity additionally affects issues of personal status, including marriage, divorce, informed consents, healthcare decision-making, and child custody. Insanity, for example, may be considered valid grounds for annulling a marriage contract ([24], 3:501; [26], 4:303–306). A mentally ill husband is considered incapable of deciding on a divorce (*ṭalāq*) or even mutual annulment (*khulʿ*). On the issue of

child custody and legal guardianship, virtually all Islamic jurists agree that a child's custodian has to be sane and mentally competent as insanity may be grounds to revoke the right of child custody for the duration of the madness ([12], 5:498–499; [24], 3:556; [49], 5:198; [57], 4:475).

The *majnūn* is also incapable of serving as a witness in court (*shāhid*), making a bequest (*waṣiyyah*) from their own wealth, and serving as a guardian (*walī*) or legal representative (*wakīl*) or even as a judge (*qāḍī*) or manager of an endowment (*waqf*) ([24], 5:486, 417; [33], 2:163; [41], 8:292).

Inner Conduct (*Akhlāq*)

Perhaps the most significant convergence between modern psychology and Islamic scholarship on the subject of human behavior is evident in the field of Islamic spirituality (*taṣawwuf*). The science of *taṣawwuf* is arguably the richest intellectual source of Islamic thought surrounding human cognition, emotions, behavioral reformation, and applied spirituality. This science of behavioral modification extends itself well beyond clinical care, including a spiritual, holistic approach that is thoroughly concerned with the treatment of nonclinical spiritual sicknesses (*amrāḍ al-qul*ūb). In contrast to external law (*fiqh al-ẓāhir*) described previously, *taṣawwuf* (or Sufism) focuses on the rules and laws of the inner self and with human conduct (*fiqh al-bāṭin*). The focus of Sufi practice is ultimately inward rectification. This includes rectifying the cognitive process in which one understands and interacts with God, the world, and people and, further, a proper recognition of the virtuous characteristics (*akhlāq ḥamīdah*) as opposed to the detestable one (*akhlāq radhīlah*). The goal of this rectification process is ultimately the modification of one's behavior through an external manifestation of the positive inner traits and the elimination of the negative traits. The spiritual practitioner (*murshid*) may initiate their disciples (*murīds*) into a spiritual program, or "path" (*ṭarīqah*), and offer long-term spiritual mentorship or treatment aimed at helping the *murīd* achieve spiritual perfection. In order to achieve these higher aims, various means or modalities of interventions are developed in order to facilitate spiritual growth [23]. Spiritual practitioners adopt principles of spiritual reformation from the Qur'an but more specifically from an examination of how the Prophet of Islam (upon him be God's blessings and peace) facilitated change in his own disciples. Subsequently, the spiritual practitioners studied how those spiritually perfected disciples (known as the Companions of the Prophet) carried his teachings and facilitated change in others and extracted principles and strategies of behavioral modification and spiritual improvement. The strategies were polished and advanced through, among other things, experiential evidence (*tajribah)* and came to inform many of the prescriptive behaviors and litanies that differentiated the various spiritual methodologies (*ṭarīqah)*.

One of the most widely celebrated works in the field of spiritual purification was Abū Ḥāmid al-Ghazālī's *Iḥyā ʿUlūm al-Dīn* (translated as "The Revival of the Sciences of the Faith") [16]. Al-Ghazāli is known to have divided the human psyche into the *ʿaql* (intellect), *nafs* (self), *rūḥ* (soul), and *qalb* (heart). According to him,

these elements of the psyche are interconnected, and a healthy development of all of these components engenders holistic mental well-being.

Al-Ghazālī makes a distinction between formation (*tarbiyah*) and reformation (*iṣlāḥ*). While formation focuses on developmentally instilling and inculcating healthy thinking, behaviors, and spiritual activities in a person, oftentimes in childhood, reformation, on the other hand, focuses on uncovering and modifying spiritual ills that have emerged throughout one's life. Al-Ghazālī and other Sufis concur that an essential part of spiritual reformation is to adopt a spiritual guide who will help gain awareness into the inner depths of one's psyche (*inkishāf*). Once awareness is facilitated, the spiritual practitioner works on facilitating psycho-spiritual equilibrium within the self. In this approach, he identifies a need to reform and cognitively restructure thinking such that the cognitive interpretive lens of the believer is informed by the *sharīʿah*. The purpose is to painstakingly discipline and repel the hedonistic or animalistic desires of the ego in order to reshape it to incline toward healthier behaviors, and finally, to nourish and feed the spirit with prayer and spiritual exercises or rituals.

The inner science of Islamic spirituality (*fiqh al-bāṭin*) can be incredibly powerful as a potential resource to integrate into mainstream psychotherapy. Given the significant overlap in the subject matter of behavioral reformation, Islamic concepts can be useful in enhancing treatment goals and compliance. The current literature is beginning to uncover the utility of Islamic concepts and spirituality in psychotherapy [19]. Hamdan [17] and religious cognitive behavioral therapy [39] can serve as useful guides to help adapt CBT principles to include Islamic concepts that can potentially enhance treatment with Muslims. For more inherently or indigenously Islamic interventions, Haque and Keshavarzi [18] have provided marker-oriented specific techniques that can be integrated into the psychotherapy encounter.

Conclusion

Finally, mental health in Islamic theology is seen as a broader domain of health as indicated by holistic health that serves to facilitate patient's spiritual growth. Thus, barriers to actualize religious objectives due to mental illness considerations may be explored through external law (*fiqh al-ẓāhir*) in order to facilitate ease or corrected through faith-based counseling directed at the inner character and psyche (*fiqh al-bāṭin*). Both are relevant considerations for efficacious and religiously sensitive mental health treatment. Recently there has been an emergence of spiritual psychologies that has led to an openness to explore faith-based modalities and frameworks for application with the religiously observant [37, 38, 42]. This has led to spiritual psychology concentrations in some graduate training programs in the USA as well as the addition of the psychology of religion, division 36 of the American Psychological Association. The American Psychiatric Association recently published a mental health guide for clergy, opening the door for religious integration and collaboration [7]. This momentum has led to investigations among Muslim psychologists/psychiatrists and theologians to explore Islamically oriented theoretical

models of mental healthcare that are rooted in Islamic belief, though such an undertaking is significantly underdeveloped despite the growing need for mental healthcare. Additionally, the American Medical Association has supported the usage of mindfulness and hypnotherapies into medical practice as well as welcoming spiritual integration into even healthcare practice. In fact, a national poll found that 64% of a sample of patients believe that physicians should pray with patients if asked [56]. It is evident that many Muslims cope with their psychological distress through their spirituality [2] and want psychiatric care to be spiritually integrated. Additionally, Muslims are reluctant to seek non-Muslim mental health practitioners because of the fear that their practice conflicts with their Islamic beliefs [20, 21, 32]. Given these considerations, it is imperative that psychiatric treatment and psychotherapy with religiously oriented Muslims continue to grow in the direction of spiritual integration. Expansion of such literature and resources will be imperative to provide practitioners with greater resources and tools to service their patients.

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5 Religiosity and Mental Health in Islam

Harold G. Koenig and Saad Saleh Al Shohaib

Islam is the second largest religion making up 23.4% of the world's population in 2010 [28], is projected to increase to 29.7% by 2050 and to 32.3% by 2070, and will reach 34.9% by 2100 (when it will be the largest religion in the world) [29]. Three-quarters of the world's Muslim population lives outside the Middle East and Northern Africa, largely in the Asia-Pacific region (particularly Indonesia and Malaysia). Although only 0.3% of Muslims live in the Americas (or 5 million) in 2010, by 2030 that number is expected to double to more than 10 million. Among other Western countries, Muslims make up 5% of the population of the United Kingdom (0.2% of all Muslims), 2–3% of Canada (0.1% of all Muslims), and 2% of Australia (0.1% of all Muslims) [28]. It is important, then, to know about the relationship between religiosity and mental health in Muslims, since it is likely that clinicians worldwide will see more and more Muslim patients in their practices over the next decades.

Muslims are now in a difficult situation due to stigma, exclusion, and sometimes persecution, particularly those outside of Muslim-majority countries (and even within some Muslim countries). Mental illness stigma is a huge issue among Muslims and serves as a major barrier to help-seeking for individuals with mental illness [10]. Stigma involves the belief that because of a certain condition, they are disqualified from full social acceptance. Given the importance of family honor and community acceptance among Muslims, mental illness is often concealed and

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hidden. This, in addition to the way Muslims are often stereotyped by Westerners, adds an additional burden to feelings of being an outsider [12]. Consequently, psychological distress among Muslims is common.

Significant depressive symptoms in American Muslims, for example, have been reported in as many as 62% depending on assessment method and population studied [1, 3, 19]. Significant anxiety symptoms are reported to be present in from one-quarter to two-thirds of American Muslims [1, 3]. The question that this chapter seeks to answer, however, is whether religiosity among Muslims is associated with better or worse mental health.

We must begin this topic by saying something about the book that is at the heart of the Muslim faith, the Holy Qur'an. Muslims believe that what is written in the Qur'an is God speaking to them directly through the Prophet Mohammed. What does God say to Muslims with regard to how they should live in order to maximize their mental health and well-being?

> Seek the life to come by means of what God granted you, but do not neglect your rightful share in this world. Do good to others as God has done good to you. Do not seek to spread corruption in the land, for God does not love those who do this. (28:77)[1]

The Qur'an emphasizes fairness, forgiveness, and mercy, potentially neutralizing guilt and preventing the holding of grudges. The former is a particular problem in Muslims because many feel guilty about deviating from the path of Islam and may consequently be consumed by guilt. This may or may not be a nihilistic symptom of depressive illness. The Qur'an promises swift and severe punishment for disbelief and sin (which may deter a Muslim from committing a sin and consequently developing the immobilizing emotion of guilt). However, mercy and forgiveness are available to those who seek it. Consider the following verses:

> But if you avoid the great sins you have been forbidden, we shall wipe out your minor misdeeds and let you in through the entrance of honor. (4:31)

> Say, '[God says], My servants who have harmed yourselves by your own excess, do not despair of God's mercy. God forgives all sins: He is truly the Most Forgiving, the Most Merciful. (39:53)

The Qur'an also stresses that Muslims should place high value on family, community, and work, putting people before possessions. Since the Qur'an encourages such positive attitudes toward human weaknesses, family, and community, a deeply religious Muslim ought to be productive and experience good mental health and well-being (everything else being equal, which of course it is not, given the many genetic, developmental, and biological differences between humans).

[1] English translations are from Abdel Haleem MAS (2004). *The Qur'an* (Oxford World Classics). New York: Oxford University Press.

However, there are also verses in the Qur'an that might generate or worsen emotional distress among individuals who are vulnerable or who will misunderstand what the Qur'an is saying. For example, some Muslims may become anxious because of fear that they have not done enough good deeds to outweigh their bad deeds. The Quran promises that everyone's deeds, good and bad, will be laid out before them and weighed on the last Day. If their good deeds outweigh their bad deeds, then they will spend eternity in a beautiful and wonderful paradise (Jennah); but if their bad deeds outweigh their good deeds, then there will be trouble (Jehannam). The Qur'an says:

> On that Day, people will come forward in separate groups to be shown their deeds: whoever has done an atom's-weight of good will see it, but whoever has done an atom's-weight of evil will see that. (99:6–8)

> The one who's good deeds are heavy on the scales will have a pleasant life, but the one who's good deeds are light will have the Bottomless Pit for his home. (101:6–9).

> On that Day when the Trumpet is blown [Judgement Day], the ties between them will be as nothing and they will not ask about each other: those whose good deeds weigh heavy will be successful, but those whose balance is light will have lost their souls forever and will stay and will stay in Hell—the Fire will scorch their faces and their lips will be twisted in pain. (23:101–104)

> We shall send those who reject our revelations to the fire. When their skins have been burned away, we shall replace them with new ones so that they may continue to feel the pain… (4:56)

Such verses may evoke fear and anxiety among those who misunderstand their meaning and intention. These verses are designed to motivate people to change their ways and live a life submitted to God, so that they will experience a truly full and happy life here on earth. Indeed, these verses reflect God's love for and mercy toward all those he has created. But, they can be misunderstood, and when that happens, emotional turmoil may result. The Sunnah, the sayings of the blessed Prophet that are not the word of God, also provides guidance and instruction for Muslims on how to live a successful and happy life and help to clarify the meaning of many passages in the Qur'an.

Back to our question, then, is religiosity among Muslims associated with better or worse mental health? Systematic research can help us in this regard. We now summarize the results of a systematic review of research published prior to 2010 [23] and provide examples of research published since 2010 that reflects more recent findings [24, 25]. We will examine research on religious coping, negative mental health (depression, suicide, anxiety, substance use/abuse, psychosis, cognitive impairment), and positive mental health (psychological well-being, life satisfaction, happiness).

Use of Religion to Cope

Muslims often turn to their religious beliefs to cope with stress and loss. Our 2012 systematic review of religious coping studies [23] indicated that 2.4% (11 of 454) involved Muslim-majority populations. The use of religion to cope in distressing circumstances ranged from 80% to 100%. For example, these studies included parents of children with cancer [16], Afghans coping with war [35], children in Indonesia following a tsunami [18], and persons with schizophrenia in Jordan [14]; many persons in these studies without prompting mentioned the primary role that religion played in their coping. Other more recent studies since our systematic review have likewise confirmed these observations. Consider a survey by Nurasikin et al. [27] who examined psychiatric outpatients in Kuala Lumpur, Malaysia, and found that Muslims who engaged in private religious activities to cope were significantly less likely to experience depression, anxiety, and stress. Likewise, Saffari and colleagues [33] found in a study of hemodialysis patients in Tehran, Iran, that those who indicated higher levels of religious coping experienced greater quality of life and even better physical health.

Depression

The research reviewed here again reflects studies identified in our systematic review that covered a time span of nearly 50 years up through 2010. A total of 17 studies were identified that measured religious involvement and depressive symptoms in Muslim-majority populations (see [24], p 135). Nearly three-quarters of those quantitative studies (71%) found an inverse relationship between religiosity and depressive symptoms. In fact, only one study (6%) found a positive relationship between religiosity and depression, and that relationship was an indirect one operating through perceived intolerance and anger among Belgian Muslim immigrants. Furthermore, of the three randomized clinical trials that examined a religiously integrated psychotherapy for depression in Muslim populations, all (100%) found that effects were superior to nonreligious interventions [5, 6, 32]. More recently, we found that reciting the Qur'an significantly reduced depressive symptoms among hemodialysis patients compared to a control group [8]. The effect size (Cohen's $d = 0.85$) was larger than that found in many psychotherapy studies.

Suicide

Among all outcomes resulting from mental disorder, suicide is the one that is feared most by family members and clinicians. It is a serious and worldwide problem. Between 2% and 15% of depressed persons will eventually end their lives by committing suicide [11, 17]. Our systematic review identified nine studies among Muslims that examined the relationships between religiosity and suicidal ideation, attempts, or completions. Of those, seven (78%) reported an inverse relationship

between religiosity and suicide outcomes. Given strong prohibitions in the Qur'an against suicide ("Do not kill each other, for God is merciful to you. If any of you does these things, out of hostility and injustice, We shall make him suffer Fire: that is easy for God" [4:29]), it is not surprising that Muslim-majority countries have some of the lowest suicide rates in the world, although underreporting of suicide may account for part of these low rates [30].

Anxiety

As noted above, given the verses in the Qur'an concerning the weighing of good and bad deeds on Judgment Day, one might expect greater religiosity to be positively related to higher anxiety in Muslims. Indeed, among studies that compared Muslims and non-Muslims, 86% (six of seven studies) found that Muslims experienced significantly more anxiety ([24], pp. 148–150), which seems to confirm that speculation. However, the increased anxiety is not among Muslims who are religious. Our systematic review identified 24 observational studies that examined the relationship between religiosity and anxiety in Muslim populations. Of those, 15 (63%) reported significant inverse relationships between religiosity and anxiety. This percentage is even higher than that found in Christian populations (49%). Of four randomized clinical trials that examined the effects of religiously integrated psychotherapies for anxiety in Muslims, all (100%) report that these therapies reduced anxiety significantly more than did secular psychotherapies or standard care [7, 20, 31, 32].

One study has examined the relationship between religiosity and posttraumatic stress disorder (PTSD) in American Muslims post-9/11 [1]. Researchers surveyed 350 Arab and Muslim Americans (29% response rate). The largest group of participants lived in New York (49%). PTSD symptoms and depression were assessed using standard scales, along with religiosity (measured by a three-item scale; more than 50% indicated they were religious or very religious). Among all participants, 77% reported negative experiences; 63% reported discrimination and bad treatment in the workplace; 26% reported name-calling in negative attitude; and 11% reported physical attacks, violation of human rights, loss of employment, or discovery of others talking behind their backs. Religiosity and spiritual support were unrelated to PTSD or depressive symptoms; only community and family support were inversely related to these emotional symptoms.

More recently, we examined the effects of listening to the Qur'an being recited on anxiety symptoms among Iranian Muslim hemodialysis patients, comparing effects to those in control patients [9]. Again, results among members of the Qur'an recitation group were superior. The intervention group experienced a reduction in overall anxiety score of 46.4 points on the State-Trait Anxiety Inventory, compared to an increase of 1.8 points in the control group, an effect size that is considered quite large (Cohen's $d = 1.03$). Thus, while anxiety may be higher among Muslims compared to members of other religious groups, it is only high among less religious Muslims.

Substance Use/Abuse

Our systematic review identified only two studies that examined the relationship between religiosity and alcohol use in Muslims, but four additional studies were identified in our more recent review ([24], p 154). Each of these six studies also examined drug use/abuse. Of those studies, all six (100%) found significantly lower substance use among Muslims who were more religious. The Qur'an says: "You who believe, intoxicants and gambling…are repugnant acts – Satan's doing – shun them so that you may prosper. With intoxicants and gambling, Satan seeks only to incite enmity and hatred among you, and to stop you remembering God in prayer…" (5:90–91). Not surprisingly, three-quarters of 12 studies that compared Muslims and non-Muslims on alcohol use found significantly less use in Muslims [24].

Psychosis

Conditions associated with psychotic symptoms include chronic mental disorders such as schizophrenia, delusional disorder, and bipolar disorder. In our systematic review, we identified four studies on the relationship between religiosity and psychosis (Koenig and Al Shohaib, p 154).

Of those studies, two found positive relationship with psychosis and two reported an inverse relationship. In the first study, researchers compared hospitalized patients in Cairo who had received "spiritual healing" (excessive use of prayers, reading verses from the Qur'an, exorcism, etc.) with those who had not experienced such healing [34]. They found that psychotic relapse was more common in those with spiritual healing experiences. A second study examined Muslim psychiatric inpatients in Pakistan, finding more delusions of grandeur of a religious nature in religious patients compared to nonreligious patients [36]. The third study examined a community sample from 18 countries, this time finding that schizotypal traits were significantly less frequent in highly religious Muslims [22]. Finally, Amr and colleagues found better compliance with psychiatric medication among Muslim psychiatric outpatients who reported having more daily spiritual experiences [4].

A common concern of Muslims with regard to mental health is Jinn possession and the "evil eye." These are part of the explanatory models that Muslims formulate about certain psychological phenomena, and a major reason why many Muslims do not access and consume mental health services (i.e., they don't believe that mental illness is a cause of their symptoms/psychological distress but rather that someone has cursed them). Moreover, when a Muslim who attributes their misfortune/turmoil of mind to being possessed by a Jinn, mental health practitioners from the West should not consider this a delusion since this is a widespread belief in Muslim groups.

Cognitive Functioning

Engagement in Islamic religious practices may also influence cognition over time. Researchers conducted a door-to-door survey of 778 women aged 65 or over in Israel, examining midlife leisure activities that might relate to cognitive impairment [21]. Praying was measured by asking about the number of hours spent in prayer per month during midlife. Participants were divided into three groups: 448 normal controls, 92 with Alzheimer's disease (AD), and 238 with mild cognitive impairment (MCI), determined using standard measures. Results indicated that a higher percentage of women with normal cognitive functioning reported praying during midlife (87%) compared to those with MCI (71%) or AD (69%) ($p < 0.0001$). After controlling for age and education, women engaging in prayer during midlife were 45% less likely to experience MCI (OR = 0.55, 95% CI 0.33–0.94), although there was no relationship with AD. Amount of prayer (i.e., hours/month) was not related to MCI or AD. Although cross-sectional and retrospective, this is the first study to document an association between religious activity and cognitive decline in later life among a largely Muslim population. This is consistent with research in non-Muslim populations [13, 37]. However, Muslims do develop cognitive decline with aging or dementing disorders just like members of all other religious groups, and this may interfere with their ability to recite verses from the Qur'an and perform the five daily prayers, which for religious Muslims may be very upsetting.

Psychological Well-Being

We have been discussing the relationship between religiosity and mental disorders or distress in Muslims. What about well-being and happiness, the positive side of mental health? Our systematic review identified 20 studies that quantitatively examined this relationship ([24], p 172). Of those studies, all 20 (100%) found significant positive relationships between religiosity and well-being in Muslims. Regardless of country or age of participants, whether conducted in Pakistan, Kuwait, Malaysia, Algeria, Saudi Arabia, Egypt, Lebanon, or Qatar, whether participants were young or old, religiosity was uniformly associated with greater well-being in Muslims.

Summary and Conclusions

Based on this systematic review of the literature prior to the year 2010, as well as more recent research, religiosity is related to less depression, less suicide, less anxiety, less substance use/abuse, more or less psychotic symptoms, less cognitive impairment, and greater well-being in many studies conducted in Muslims. Indeed, reading and reciting the Qur'an, frequent prayer, devout religious beliefs, careful adherence to Quranic teachings, and a strong and close knit family and community

may help to neutralize feelings of stress and distress and enhance well-being and happiness. Although Islamic teachings set the bar high in terms of ethical values and behavioral expectations, promising dire consequences in the hereafter for those who fail to meet that bar, Muslims who abide by those teachings appear to have better mental health than those who do not.

Recommendations for Clinicians

Clinicians should be aware of these findings, particularly when encountering Muslim patients who are less religious (and those who are religious but may be misunderstanding or misinterpreting Islamic teachings). What then should clinicians do? Here are a series of short recommendations that are further elaborated on elsewhere [25].

First and foremost, take a spiritual history. A careful and detailed spiritual history should be taken early in all Muslim patients, usually as part of the initial evaluation (with further elaboration during subsequent visits). The purpose is to identify the patients' religious beliefs (or lack thereof) and determine how important these beliefs are to the patient and to what extent they are being adhered to. Ask about the five pillars of Islam: Do they believe that there is no god but Allah and that Muhammad is his messenger? Do they pray five times per day? Do they fast during the holy month of Ramadan? Do they give zakat (charity)? Have they been to Hajj (the pilgrimage)? In addition, clinicians should inquire about the religious beliefs and practices of the patient's family, social group, and other members of their surrounding community, and of course, any history of mental illness in the family. Note that many Muslims are ashamed to reveal that a member of the family has a mental health problem which, as noted earlier, is a barrier to their engaging with the mental health system. For example, a Muslim man might not marry a lady who is from a family that has a history of mental health problems – such is the stigma of mental illness in Muslim communities.

Determining whether their religious beliefs (and those of their family and support system) have helped or contributed to the patient's illness is the clinician's primary goal in taking the spiritual history. Of particular importance, the mental health practitioners should ask if a Muslim with mental health problems has consulted a faith healer or someone who claims to be a purveyor of *ruqyah*. There are many cases of vulnerable Muslims who consult people who claim to have knowledge in ruqyah (similar to exorcism in Christianity) who then take advantage of them.

At no time, however, should less religious patients be made to feel that they are less religious than they should be, i.e., further burdened with guilt. Rather, information gathering should be done as objective, nonjudgmental, and neutral as possible. Always maintain a respectful, interested, and receptive attitude to what the patient says about their Islamic beliefs and practices, whether or not the person is currently active in their faith (and regardless of what they say about their faith). Good and bad experiences with religion should be inquired about. This information will help to

inform the treatment approach and communicate respect for the patient's personal beliefs and values, whatever they may be.

Second, be alert for feelings of anxiety or excessive guilt over not being religious enough or over past behaviors that have gone against Islamic beliefs. Seek to identify core religious beliefs that are driving the anxiety, but be very careful in challenging those beliefs until a therapeutic relationship has been firmly established and unless one is well-informed in that regard.

Third, if the patient is religious, utilize their religious beliefs and practices as resources in therapy, regardless of whether a formal religiously integrated treatment approach is being considered or not. Even in secular therapy, there will be times when the patient's religious beliefs may be utilized to support a change in attitude or behavior. The Qur'an can be a tremendous resource in this regard, as well as the Sunnah. The Prophet himself experienced great psychological distress during times of persecution and, according to some Islamic chroniclers and scholars, even periods of depression. As a Muslim, having mental health problems is nothing to be ashamed about. The first psychiatric hospitals ever to be established were in the Muslim world [24].

Fourth, consider utilizing a religiously integrated approach to therapy from a Muslim perspective. We have developed resources for clinicians to help in this regard. For patients experiencing depression, particularly those with chronic medical illness, a Muslim cognitive behavioral therapy (CBT) manual to guide clinicians and therapist and patient workbooks and an introductory video are now available on Duke University's Center for Spirituality, Theology, and Health website [15]. This form of therapy is now an evidence-based treatment that has proven effectiveness for depression, particularly among highly religious patients [26].

Finally, if the clinician lacks the desire or expertise to address religion or integrate it into therapy, particularly when a religiously integrated approach is indicated in a highly religious patient, then consideration should be given to consulting with, referring to, or conducting co-therapy with Muslim clergy. This may be an imam with mental health training, a Muslim chaplain, or a Muslim pastoral counselor [2].

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6 The Social Psychology and Neurobiology of Intergroup Conflict

Sara E. Gorman and Jack M. Gorman

The true hero is one who conquers his own anger and hatred. – the 14th Dalai Lama

How does the formation of prominent group identities impact conflict between groups and perhaps ultimately lead to phenomena such as Islamophobia? In this chapter, we will review some of the social psychological theories about group formation, focusing particularly on the formulation of contentious and exclusive "ingroups" and "outgroups."

We will explore some of the factors that make these groups particularly strong and therefore more likely to come into conflict with one another. Then we will look at the evidence from both social psychology and sociology regarding reducing intergroup conflict. In the second part of the chapter, we will move to an investigation of some cutting-edge neuroscience research that helps explain how groups are formed, strengthened, and reinforced as well as what works to reverse bias and conflict.

Most of the research we cite in this chapter deals with intergroup conflict across racial lines. We do of course recognize that Islam is a religion and not a race and as such is comprised of different types of people from around the globe of many different races. Nonetheless, this research is relevant because Islamophobia itself is not founded on an accurate understanding and appreciation of the racial and ethnic diversity of people who practice the religion of Islam. Although there continues to be debate in academic circles about whether or not Islamophobia is technically a form of racism, we agree with the many scholars who argue that racist ideologies do not depend on the existence of a technical "race" [1]. Indeed, many scientists note that "race" is in any case a societal construct and not a technical, scientific phenomenon [2]. Insofar as Islamophobia derives from a set of biased and stereotyped assumptions about a group of people who, although in reality incredibly diverse, are

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artificially grouped together as objects of fear, hatred, and even violence, we consider it for the purposes of this chapter enough a form of racism for the research we cite here to be relevant to this phenomenon.

Prominent Social Psychological Theories About Groups

Forming groups is a prominent and common human impulse, and there has been a great deal of literature in an array of social science disciplines both to define different kinds of groups and to form theories about how and why groups form in the ways they do.

In the most basic sense, groups fall into two main categories: primary and secondary. Primary groups tend to be small and characterized by extensive interaction and close, emotional bonds [3]. Family is a good example of a "primary group," although very close peer groups can also function as primary groups. Primary groups tend to be long-lasting, often persisting for the entire lifetimes. Secondary groups, on the other hand, tend to be larger and are not characterized by particularly close emotional ties [3]. Secondary groups also tend to exist for shorter periods of time and come into being in most cases to fulfill a particular purpose. Examples include religious groups, social organizations, and professional organizations. Typically larger groups, such as sports teams and fraternities, can sometimes act as primary groups if emotional bonds are particularly intense.

There is also another interesting type of group called a "reference group." A reference group is not a group we are necessarily part of but may be a group we wish to be a part of someday [3]. Reference groups actually determine many of our attitudes and behaviors, as we behave in accordance with what we aspire to be. For example, we might exercise more if we view a subset of young, athletic females who prioritize fitness and exercising as our reference group. In fact, some recent studies have suggested that our attitudes and behaviors are determined more by what we aspire to be than what we are today, rendering reference group identifications quite important in understanding an individual's attitudes and behaviors [4].

Most of us can intuitively understand the very prevalent and prominent human impulse to join groups. So what are some of the key psychological features that cause groups to be so ubiquitous? Social psychologists have long posited that groups serve an essential function in defining our identities and allowing us to categorize both ourselves and other people we encounter. The social identity and categorization functions of groups create the need to define "ingroups" of "us" and "outgroups" of "them."

We use these ingroup and outgroup definitions to categorize ourselves and others, to determine our own attitudes and behaviors in accordance with our ingroups and in contrast to our outgroups, and to define and identify ourselves through social comparisons between ingroup and outgroup members. In other words, forming groups and subsequently devising the defining features of the ingroup "us" vs. the outgroup "them" allows us to complete important social processes including creating our own social identities and social categories. Social categorization can be extremely important because it allows us to understand others and even to begin to predict their behaviors. It helps us survive by understanding who will cooperate

with us and who is a threat [5]. Forming defined ingroups and outgroups creates essential shorthand information about who will help us and who will harm us. Most of our social behaviors lie on a continuum between interpersonal and intergroup behaviors. Thus our group memberships and our perception of the role of these group memberships in our overall social identity form a vital component of a large portion of our ultimate actions in society.

Ingroup and Outgroup Formation and Perception

As we have seen, from an evolutionary perspective, ingroup formation has many benefits, especially if the groups are formed along kinship lines. Forming groups helps people attain various goals through resource sharing, distribution of labor, and self-protection [5].

Once groups are formed and identified as groups, a number of group psychological processes tend to take shape quickly. What we find repeatedly is that people tend to form groups in somewhat haphazard ways and *then* go through a series of psychological steps to make sense of them. The most basic form of groups, kinship groups, has a basic organizing principle: blood relation. But even when people form groups based on far weaker links than family relationships, they tend to view those groups as "naturally occurring" [5]. Even the most obviously constructed, forced group can come to be viewed as "natural" once group psychological processes are set in motion.

Once the psychological recognition of a group occurs, a number of other assumptions and biases kick in that in many cases result in the formation of a strong sense of "us" versus "them."

The first of these biases is called "ingroup favoritism bias." Ingroup favoritism is exactly what it sounds like: the belief that members of your own group are somehow innately superior to members of other groups [6]. If we really think about it, this belief does not make a lot of sense. Why would New York Yankees fans be innately superior to New York Mets fans? There's no actual, plausible reason for any such disparity. Members of these groups are not substantively different on a population level in any significant way, and the division between the groups is relatively arbitrary. Nonetheless, once someone comes to feel strongly identified with the "ingroup" of New York Yankees fans, he or she will most certainly come to believe that on some level New York Mets fans are inferior.

In addition to forming ingroup favoritism biases, members of groups tend to also exhibit self-serving bias and make a number of attribution errors along group lines. Self-serving bias refers to the tendency to attribute positive outcomes to internal causes and negative outcomes to external causes [7]. In the case of ingroups and outgroups, this translates into a tendency to attribute all positive outcomes in intergroup relations and other group-related activities to the supposed "ingroup" and all negative or undesirable outcomes to the supposed "outgroup" [6]. This phenomenon is closely related to another type of group-related cognitive error, attribution error, which refers to the tendency to make more flattering attributions about members of one's own group than about members of another group [6].

Take a brief example to illustrate these two concepts. Say two groups, Group A and Group B, are attempting to negotiate a deal and the deal ends up falling apart due to conflict on both sides. Members of Group A will interpret the events according to a certain framework that benefits Group A's self-image. Members of this group will find some reason to believe that the negotiations fell apart due to something Group B did. If the negotiations went well, however, members of Group A would come away thinking that the positive outcome was solely due to Group A's valiant efforts. At the same time, members of Group A will start to attribute positive qualities to their group, perhaps in this case including attributes such as tolerance, patience, negotiation skills, and the like. Meanwhile, members of Group A will also attribute negative qualities to members of Group B, perhaps including impulsivity, aggressiveness, and a lack of diplomacy. While all of this is going on, members of Group B will begin to think in similar ways about their own members and about members of Group A.

Part of the problem here is that no matter the outcome, biases such as ingroup favoritism, self-serving bias, and attribution error will be strengthened. Even if Group A and Group B negotiate, have a positive interaction, and come to some sort of cooperative agreement, these biases will still ensure that ingroup members continue to judge themselves as markedly and naturally superior to outgroup members.

Determinants of Strength of Ingroup and Outgroup Bonds

Aside from understanding how ingroups and outgroups form and crystallize, social psychologists and sociologists have long been interested in identifying what exactly makes ingroup bonds particularly strong. One theory has to do with something called "social identity complexity." Social identity complexity refers to a spectrum of self-perceptions in social settings ranging from simple to complex [8].

At the low end of the social complexity scale, people tend to identify with a single ingroup as the intersection of all their group identities. This identification has the effect of creating a single, highly exclusive ingroup category that fundamentally excludes anyone who is not very similar to the individual on traits associated with the ingroup. These types of highly "simple" social identities have the tendency to create very strong and often very sharply opposed ingroups and outgroups [8].

On the other hand, individuals who are at the high end of the social complexity spectrum tend to recognize that each of their group memberships incorporates a different set of people as ingroup members and that their combined identities are the sum of all of these group identities. In other words, they tend not to see themselves as highly exclusive members of a single strong group but as complex individuals with a variety of unique group memberships that together make up a large part of their overall social identities. Complex social identities often form when there is low overlap among group memberships held by a single individual. A good example of a complex social identity is a female corporate executive: since most corporate executives tend to be male, there is little overlap between "female" social identity and "corporate executive" social identity, which inevitably results in a complex social identity with different facets and group memberships that may not always have a lot in common [8].

Having multiple group memberships reduces the importance of any one social identity for defining and identifying an individual. In other words, individual groups become less salient for individuals who glean their identities from a complex amalgamation of different group memberships and other defining factors [8]. People with high degrees of social complexity, usually meaning they are members of various groups and do not define themselves simply by association with a single group, tend to have achieved a higher level of education and show higher degrees of tolerance and acceptance of diversity and multiculturalism, even when controlling for age, socioeconomic status, and ideology on social issues. In many of these studies, intergroup contact alone did not make people more accepting of "outgroups" [9]. This is an important finding because we often find suggestions that contact between opposing groups is a kind of panacea for intergroup conflict. The reality is far more complex than this.

Can Ingroup Bias Be Changed?

Is the intensity of ingroup identification and outgroup ostracization immutable? Research suggests that in fact the strength of one's identification with particular social groups is actually subject to change depending on the situation [8]. Most notably, researchers have repeatedly found that whenever there is a high degree of need for a sense of certainty, people tend to strengthen their ingroup bonds and demonize outgroups more [8, 10]. The need for certainty is often influenced by high degrees of stress: the more stressful the situation is, the more people search tirelessly for any evidence of certainty in their lives. This craving for certainty often leads to something called the "ingroup oversimplification effect," which causes people to make vast, oversimplified generalizations about the differences between the ingroup and the outgroup and often indefensible assumptions about who is a member of the ingroup versus the outgroup. When we feel somehow threatened, we are more likely to viciously denigrate the outgroup, in part because this kind of denigration of the "other" has been associated with increased self-esteem, especially under highly stressful and uncertain circumstances.

In some instances, ingroup affiliations may even compensate for challenges to our feelings of self-worth. In one interesting study, researchers had groups of college female students perform a creative task. They were later told their individual performances had been poor, but that another woman in the group had performed well. This created a feeling of reduced self-esteem in the subjects. However, when they were subsequently told that the experiment actually compared men versus women in performance of this task, a move meant to increase perception of group membership, they maintained a positive self-image despite the negative evaluation of them individually. The researchers gleaned two conclusions from these results: (1) that people whose self-worth and thus sense of identity and certainty have been challenged will cling more tightly to group memberships as a result and (2) that opportunities to venerate and demonstrate the "superiority" of someone's ingroup affiliation can compensate for low individual self-esteem [11].

Although these kinds of experimental circumstances always carry methodological issues with them, including the fact that the environment in the laboratory often does not mimic the real-world environment of everyday life, we can see that research findings like these may have significant implications for understanding human social behaviors and phenomena. This study in particular suggests that people who have undergone serious life stress, experienced perceived or real challenges to their identities and self-worth, and/or come to find themselves in situations marked by a tremendous amount of uncertainty have the tendency to rely much more on ingroup identification *and* perception of ingroup superiority, which may involve extreme denigration of perceived "outgroups" by comparison, in order to maintain a basic sense of self and stability.

This observation is extremely important because it should allow us to be able to effectively predict situations that may cause exacerbation of intergroup conflict. Circumstances involving massive amounts of stress and change, including economic downturns accompanied by massive job loss, natural disasters, and armed conflict, all have the potential to cause heightened intergroup aggression. Indeed, these research findings have more recently led many in the USA to assert that Donald Trump's successful presidential campaign was made possible at least in part by heightened outgroup hatred among American populations undergoing extreme stress due to economic changes and job losses in traditional manufacturing industries that have globalized in the past few decades [12]. The theory is that these people have turned to the "ingroup" to maintain their sense of self during turbulent times. Unfortunately this turn inward has also caused a more nefarious impulse to shun the "outgroup," leading to phenomena such as widespread Islamophobia and even a resurgence of white supremacy.

What Can Be Done to Reduce Intergroup Conflict?

Given what we know about ingroups, outgroups, and group psychology in general, is there anything that might work to reduce tension and prevent conflict and violence between groups? Social psychologists have been working on this question for a long time, and while this is undoubtedly a difficult set of attitudes and behaviors to change, there is some reason to be hopeful about a few techniques that do seem to make a difference.

One of the ways that increasing intergroup cooperation has been tested uses the prisoner's dilemma game. Traditionally in this game, the scenario is that two members of a gang have been arrested and imprisoned. They are subsequently simultaneously offered a deal by the prosecutor. The terms of the deal are as follows:

- If A and B betray each other, each of them serves 2 years in prison.
- If A betrays B but B remains silent, A will be set free, and B will spend 3 years in prison (and vice versa).
- If A and B both remain silent, both of them will serve 1 year in prison.

Logically, the best course of action for any individual would be to betray the other person, but the degree of cooperation in this game is much higher than one might expect. When the game is played on a group rather than an individual basis, however, rates of cooperation are extremely low. When communication between players is allowed, this difference between individual and group response becomes even larger, demonstrating that individuals tend to feel more comfortable trusting another individual after communication has taken place, while groups tend to feel more distrustful because they assume the other group is lying [9].

Contrary to what might seem logical, encouraging group members to do more "perspective taking" to increase intergroup trust tends to be counterproductive [9]. When group members in these situations are asked to take the position of the other side, they end up distrusting them more, projecting that the other group members will act in a completely self-interested manner. This phenomenon is called "reactive egoism," in which self-serving behavior is activated by presumed egoistic behavior on the part of others [9].

One strategy that may work is to ask participants to think about the effect of their behaviors on the future behaviors of the other group. In one study, researchers asked members of one group to think about how the other group would respond on a second iteration of the prisoner's dilemma game considering their own choice during the first game. Subjects in this condition were more likely to cooperate and were also less likely to express distrust of the other group in a follow-up assessment [9].

Much of the research on reducing intergroup conflict has come from Tajfel's original research and theories of how ingroups and outgroups form and are strengthened. This research found repeatedly that with relatively meaningless categories, anonymity, and limited contact, people can "devolve" into us versus them mindsets relatively easily. As a result, people have tended to assume that reducing the sense of differentiation between groups is the best way to reduce intergroup conflict [11]. This strategy is useful in some circumstances but in many cases it does not work and in some cases it can even backfire. Merging boundaries or creating "superordinate" groups has made things worse. One good "natural" example of this is what happens during company mergers. Often the creation of a superordinate category of one company over and above two previously rival companies simply strengthens preexisting subgroups and ingroup favoritism [11].

Whenever the group identity is an important part of an individual's sense of self, differentiation reduction techniques will likely backfire. To test this, in one experiment, researchers first measured subjects belonging to different group level of ingroup identification (the degree to which individual identity is bound up in group identity) and then had participants list characteristics shared by the ingroup and outgroup to stimulate the process of reducing differentiation. Then subjects completed a repeat assessment measuring ingroup favoritism. The study found that higher identifiers at the baseline assessment, meaning people whose individual identity was more tied to the group identity, showed higher ingroup favoritism *after* listing similarities between groups [11]. This finding, among others, suggests that interventions to reduce intergroup conflict must be tailored to specific populations to avoid ineffective practices or, worse, techniques and interventions that could backfire.

A better strategy may be to attempt to modify attitudes within a group rather than about another group. Eran Halperin and colleagues at the Interdisciplinary Center Herzliya in Israel have examined approaches to encouraging negotiation between Israeli Jews and Palestinians. In one study, they showed that subjects are more critical of the outgroup when they believe that in general a person's attitudes are fixed rather than malleable [13]. They then randomized subjects to read an article that portrayed opposed groups as being either of a fixed nature or a malleable nature. The articles did not mention Israel, Jews, or Palestinians. Nevertheless, both Jewish and Palestinian subjects who read the article indicating that groups have malleable attitudes themselves expressed more positive attitudes for members of the opposite group and a greater willingness to compromise. Work such as this is critical in developing evidence-based interventions to reduce bias and group conflict.

Neurobiology of Ingroup/Outgroup Identification

Understanding some of what is known about the neurobiology of the ingroup/outgroup phenomenon may also point to opportunities for interventions that may successfully reduce bias. We have shown that racial prejudice is supported by membership in a group that shares a biased idea. We also know that a strong promoter of social affiliation is the hormone oxytocin. Therefore, it is worthwhile to speculate about whether oxytocin plays a role in promoting affiliation with a group that is based on a shared value of racial prejudice, like Islamophobia.

In a series of seminal experiments, Thomas Insel and colleagues showed that oxytocin is critical for an unusual behavior among the prairie vole: mating for life and shared parental offspring rearing [14]. Only 5% of mammals, including humans, exhibit this behavior, and it is not present even in other species of voles. This led to many studies showing that oxytocin increases social affiliation and maternal bonding among mammalian species. In humans, oxytocin has antianxiety effects [15], enhances parental behavior [16], and increases trust [17]. Many of these behavioral functions of oxytocin rely on hormone activity within the brain rather than in the peripheral circulation. Oxytocin receptors are found in numerous brain regions including the lateral septum, hippocampus, and amygdala.

When we move from the individual to social groups, however, oxytocin plays a less clearly beneficent role. It is clear that oxytocin, by promoting social affiliation, also strengthens ingroup bonding and outgroup hostility [18]. Oxytocin increases aggressive behavior in rat mothers when their pups are threatened by an intruder [19]. In the wild our nearest genetic neighbor, the chimpanzee (*Pan troglodytes*), engages in remarkably organized group behaviors, some of which include violent raids by one group of animals on another. Chimpanzees also go on well-coordinated group border patrols in which there may not be actual interaction with members of another group. In anticipation of conflicts with members of other groups, during border patrols, and during violent encounters with outgroup, urinary levels of oxytocin rise to higher levels than seen in no-conflict control situations [20]. Oxytocin is therefore involved among chimpanzees in maintaining ingroup hostility toward an outgroup.

In humans, there is similar evidence that oxytocin's ability to increase interpersonal trust and bonding functions mainly within an ingroup. In one study, male volunteers were given oxytocin and placebo under conditions in which lying could help themselves or members of their group. Compared to placebo, subjects who received oxytocin lied more to benefit their group, but there was no difference between placebo and oxytocin on lying to benefit oneself [21]. Thus, oxytocin specifically enhanced the tendency for ingroup dishonesty. Oxytocin promotes ingroup favoritism and cooperation and "derogation" of the outgroup [22–25]. If oxytocin is a "feel-good" hormone, then, it has clearly developed to make us feel good doing what our ingroup does and to resist the lures of any other group. Thus, oxytocin is one aspect of the neurobiology of ingroup affiliation.

If oxytocin makes us feel comfortable lying to benefit members of our ingroup [21], it is nevertheless possible that other brain systems can oppose this action. Of note in this regard is a study showing that lesions to the dorsolateral prefrontal cortex (dlPFC), a highly evolved brain region in humans responsible for reason and judgment, impair honest behavior [26]. The dlPFC, which unlike oxytocin is far more developed in humans than in any other mammalian species, may be able to override the effects of oxytocin and promote reasoned choices even when they violate ingroup norms. We will return to this idea after examining the role of another brain structure, the amygdala, that has important influences over the PFC and group affiliative behavior.

Prejudice and the Amygdala

Brain imaging studies have consistently implicated the amygdala, the part of the brain most readily associated with fear, in unconscious racial prejudice. In the typical experiment, subjects are shown pictures of members of their own and of another race while in the fMRI scanner. In many of these studies, the pictures are shown for lengths of time too short to permit conscious registration of the race of the faces in the pictures. In most studies, the amygdala is selectively activated by pictures of an outgroup race.

That the amygdala is activated when subjects view pictures of an outgroup race is hardly surprising. Preclinical and clinical studies have consistently shown that the amygdala is involved in emotional learning and is central to the recognition of threatening stimuli and the acquisition and expression of fear. In one of the first imaging studies evaluating neural response to race, Phelps et al. found that the level of amygdala activation among white subjects when viewing pictures of unfamiliar black males was correlated with unconscious but not conscious measures of race evaluation [27]. However, the amygdala was not preferentially activated when white subjects viewed pictures of familiar black faces. This study thus also suggested that amygdala response to a racial outgroup is modifiable by an individual's own background and experience. This conclusion is supported by the finding by Hart and colleagues that amygdala response to outgroup racial pictures among both black and white subjects did not occur on the first presentation of the pictures but only

after subsequent presentations [28]. This implies that it is only after the subjects processed the personal meaning of the pictures that the outgroup is evaluated as threatening. In another experiment, Wheeler and Fiske found that the cognitive instructional set – what the subjects were told to do and think while looking at pictures of unfamiliar black and white faces – had a profound effect on amygdala activation. That is, amygdala activation was highly dependent on the instructional set given to the subjects before viewing the faces.

A perhaps more direct test of the idea that racial prejudice is modifiable came from a study in which white subjects were shown pictures of black faces for 30 ms, well below the threshold for conscious detection, and 525 ms, above that threshold. Only in the former condition, when subjects were unaware of the faces they were viewing, did white subjects show a greater fMRI amygdala response to pictures of black faces. The result implies that conscious processing modified the response [29].

An important and at first startling finding comes from a study in which both African-American and Caucasian-American subjects showed greater amygdala activity to African-American than to Caucasian-American faces [30]. The study's authors suggested that the amygdala response is related to cultural learning rather than simply to innate outgroup prejudice. According to this interpretation, African-Americans have been taught by the dominant race to have a fearful reaction to representations of members of their own ingroup.

These studies of amygdala response to outgroup facial pictures tell us two things. First, to the extent that a picture of someone is associated with risk, the amygdala will be activated. Second, amygdala responses are modifiable by the conditions under which we consider any potentially threatening stimulus, including appraising it over time, having seen it before, or being told what to think or do when confronting it. The implication, then, is that racial prejudice is not entirely "hardwired" into the human brain but rather at least in part a function of learning and acculturation. Furthermore, the brain's automatic response to perceived threat is subject to reason when parts of the prefrontal cortex exert top-down inhibitory control over limbic structures like the amygdala.

How the Brain Learns to Adhere to an Ingroup

It is of interest, therefore, to understand how the brain learns to identify with the values of an ingroup. One theory is that this occurs by following a charismatic leader. We generally make decisions based on one or more of three specific factors: our own personal experience, our observations of what other people do, and/or our observations of what particularly confident people do. A brain imaging study showed that when making decisions based on personal experiences or the experiences of others, activation occurs throughout the entire ventromedial prefrontal cortex (vmPFC) [31]. However, the most powerful determinant of subjects' choices was the behavior of another, particularly confident, person. Following the lead of a confident person selectively activated a specific part of the vmPFC, Brodmann's area 10, the most anterior part of the human brain and likely the most recently

evolved. Thus, a specific section of the vmPFC makes us susceptible to the influence of confident people, even if what they recommend is discordant with our own experience.

The more powerful that confident person is, the more convincing is her argument. This is mirrored in a remarkable group brain activation pattern in which rhetorically powerful political speeches, but not weak speeches, are associated with alignment of listeners' brain activation patterns with other listeners [32]. Moreover, the brain also has a mechanism to adapt to dishonesty. An fMRI study showed that repeated lying decreased amygdala activation, lessening the aversive signal we experience when we first tell a lie [33]. Thus, the confident, charismatic leader can reduce his own sensitivity to lying and exert an influence on an entire group, such that members of the group become inured to dishonesty as well.

Once the brain has established a pattern of adhering to the ingroup's norms, it protects itself from change. The default bias is simply our tendency to do what is routine and customary. Once again, we can see the default bias at work in the brain. In simulated gambling tasks during brain imaging acquisition, switching from the default option activates the anterior insula, a brain region associated with fear and disgust, whereas staying with the default option activates the ventral striatum, a part of the basal ganglia that is the terminus of the brain's main reward pathway [34]. Our brains make us feel uncomfortable when we entertain the risk of departing from customary behavior, whereas "selecting the default might be rewarding in itself ([34], p 14706)."

These studies strongly suggest, then, that the amygdala alerts us to perceived threats from members of an outgroup and the insula makes us feel uneasy when we contemplate any action that deviates from the ingroup's norms. The ventral striatum promotes an iterative process that teaches us to anticipate reward from sticking with the ingroup and punishment from opposing it.

Once we accept the fact that ingroup/outgroup bias is at least in part a learned phenomenon, it is reasonable to ask to what extent it can be unlearned. An interesting experiment took advantage of the fact that memory traces acquired during the day are reactivated and strengthened during deep (also known as slow-wave or non-REM) sleep [35]. Researchers were able to use a conditioning paradigm to show that both unconscious gender- and racially biased ideas could be reduced while subjects took a 90-min nap. Commentators on the experiment noted that even though the gender- and racially biased ideas these subjects harbored were implicit – that is, unconscious and only accessible by a test specific to implicit attitudes – and common, it still proved possible in this study to disrupt them at the deep, unconscious level at which they exist [36].

Prefrontal Cortex Can Assert Reasoned Appraisals

There is a long literature on the role of several subregions of the PFC in inhibiting the amygdala and asserting reason over emotion [37]. For example, the PFC is active when individuals self-correct erroneous ideas that were provided by others

[38]. As noted above, damage to the dlPFC decreases honesty [26]. We have seen that conscious appraisal and instructional set modify both brain and behavioral responses to bias. Although the sleep experiment described above demonstrates that prejudicial ideas can be modified, such unconscious manipulation of attitudes would be both practically and ethically impossible on a wider scale. We propose that methods that activate PFC regions and involve reason and learning may be effective in reversing bias.

Children as young as 5 already show affiliative behavior toward their ingroup. For example, young children were found to attribute fewer mental abilities and uniquely human traits to people who do not share their gender or hometown [39]. This begs the question of how much ingroup preference is genetically determined and how much is learned. Given that we are currently unable to alter any genetic predispositions to bias, it is reassuring that at least some of the variance for outgroup prejudice appears to be learned and therefore potentially modifiable.

The neurobiological studies discussed here are for the most part early attempts to understand very complex human emotions and behaviors. It is entirely possible, indeed likely, that continued research will render much of what we think we know today obsolete as more studies using more sophisticated technologies are performed. Nevertheless, they point to intriguing, and in many ways hopeful, signs that even the biases commonly and deeply held by groups can be changed for the better.

Conclusions and Clinical Implications

Social psychological and neurobiological studies of ingroup/outgroup identification and conflict agree on three basic principles. First, the tendency to affiliate with a group and to malign other groups is a natural phenomenon observed in multiple mammalian species, including both nonhuman and human primates. As such, there is unquestionably an evolutionarily conserved, heritable tendency to affiliate with and defend, however irrationally, an ingroup.

Second, despite the first point, ingroup affiliation and outgroup hatred are learned phenomena. While we may be born with a propensity to belong to a group, which group or groups we belong to and how fiercely we defend the values of those groups are largely products of learning, culture, and socialization.

Finally, given that at least some of ingroup identification is learned, there is clear opportunity for modification. Experiments discussed in this chapter demonstrate that both behavior and its underlying biological foundation can be altered by learning and conditioning aimed at reducing bias.

Psychiatrists, psychologists, and other mental health professionals are of course not immune to unconscious biases, including those engendered by ingroup membership. It might be worthwhile for therapists themselves to take the Implicit Association Test (IAT), which is a validated instrument for uncovering unconscious bias. A heightened awareness for unconscious, automatic beliefs such as thinking

that minority patients are more likely to have violent impulses, female patients will prefer to study humanities over science, or Islamic patients will secretly harbor terrorist sympathies needs constant surveillance and identification. Therapists often resist acknowledging such ideas because they believe themselves to be liberal and enlightened, but unconscious bias is common to all of us.

The data reviewed here also suggest that members of outgroups may learn and adopt self-deprecatory attitudes from the ingroup. When Islamic people live in countries in which they are a minority, for example, they may be susceptible to anti-Muslim rhetoric and harbor feelings of low esteem, isolation, and powerlessness. When they present for help from mental health professionals, it is important to identify these learned, culturally determined feelings, and it is important for therapists to be sensitive to their existence and know how to manage them.

Identifying unconscious bias among therapists and feelings of inferiority among marginalized minorities is a step toward reversing them. Data support the idea that conscious, reasoned processes, as are supported by many forms of psychotherapy, may help people assert control over their biased attitudes and reduce their susceptibility to the rhetoric of the outgroup marginalization and prejudice at the hands of dominant ingroups.

There is also an opportunity for social psychologists and neuroscientists to collaborate on work to both understand ingroup/outgroup conflict and to develop interventions to prevent and dispel it. Work needs to be pursued at both an individual and at a group level. Although laboratory studies show we can change attitudes one person at a time, destructive prejudicial attitudes like Islamophobia demand population-level solutions. Science already indicates likely directions for accomplishing this critical task.

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7 Art for a Better World

Saad Ghosn, H. Steven Moffic, and Ahmed Zakaria Hankir

Editor's Statement

Perhaps it was serendipity when I, Dr. Moffic, came to view the artwork of Saad Ghosn, M.D., M.P.H. In the early stages of putting together this book on Islamophobia, I, as a very amateur visual collage artist of sorts, happened upon some of the work of Dr. Ghosn while perusing a magazine devoted to artists, known as "the artist's magazine."

On the cover was a reference to one of the articles described as "Prints as Propaganda for Peace and Social Prosperity." That seemed to be paradoxically suggesting that propaganda could be used for the good, for positive psychology and psychiatry, if you will.

Turning to the editor's statement, it said that "Saad Ghosn creates Woodcut prints promoting peace, equality and justice among humankind" [3]. Just what we wanted to convey in general in our book, I thought.

Saad Ghosn is the Founder of "SOS (Save Our Souls) Art" and editor and publisher of the yearly *For a Better World, Poems and Drawings on Peace and Justice by Greater Cincinnati Artists*

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Quickly moving on to the article itself, the images right away cut to my emotional quick [1]. The subtitle said that “in Woodcuts of simple, yet powerful design, Saad Ghosn decries injustice and exposes the pain of both psychic and social isolation.”

Who was Saad Ghosn? Was he a Muslim? Was he addressing Islamophobia? No, he wasn’t directly or intentionally, as I found out, yet my unconscious thought so.

Reading the article, I found out that Saad Ghosn was a retired medical physician, just like me. He was born and educated in Lebanon, just like one of our book’s co-editors and contributor to this chapter, Ahmed Zakaria Hankir, M.D. Such serendipity couldn’t be ignored, at least in the sense of the Jungian collective unconscious connections.

The article describes him as Greater Cincinnati’s Thomas Paine, that is, America’s first visual propagandist. His political work began after the 9/11 terror attacks in the form of Woodcuts. He began using the concept of terrorism as a metaphor for poverty and political repression.

Woodcuts seem to have a particular ability to express emotions, such as in the case of screams. One of his prints shown in the article, “Scream of a Broken Dream” (see Fig. 7.1), portrayed circles within circles of Arabic text, seemingly going nowhere. Dr. Ghosn’s accompanying text states:

“For many who have selected America as their adopted country for all the values it once represented, the American dream is broken and torn apart daily. Perceived initially as a land of freedom, opportunity, tolerance, and happiness, the America they live in is increasingly the land of inequality and disparity, injustice, subversive material domination, condoned political lies.”

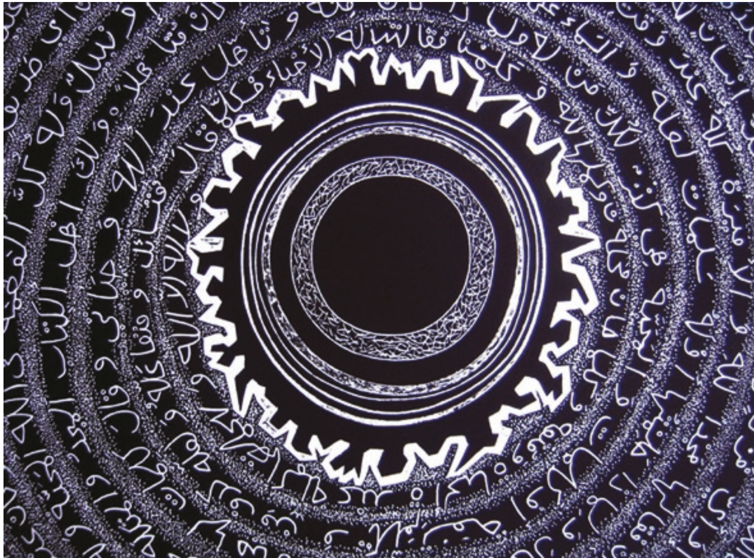

Fig. 7.1 Scream of a Broken Dream. Woodcut print; 22 × 30″

The Woodcuts of figures seemed designed to represent the "isolation of those not in the American mainstream." Could that be translated into what many Muslims feel in America?

After being further moved by the article, I had to contact Dr. Ghosn himself, if not only to see if his work could have a place in this book, but to get to know this unusual healer who combines the compassion and skills of a physician with the imagination and skills of an artist. So began a series of e-mail interchanges, during which Dr. Hankir also became involved. Here are some of the initial interchanges, beginning with my outreach to the magazine publisher:

Dr. Moffic (October 3, 2017): "I just read the most moving article in "the artist's magazine" on the work of my fellow retired physician, Saad Ghosn. I am currently editing a book on Islamophobia and Muslim Mental Health, and had the idea that perhaps his artwork could be included in some way."

Dr. Ghosn (October 4, 2017): "Yes, I will be happy to consider including some of my relevant images in your book. Please tell me a little more about it and how you would see my images included … My prints do not relate specifically to Muslims but are meant to be universal. Many have an Arabic allusion since I am originally from Lebanon and that during the Bush's 'war on terror' Arabs became the focus of prejudice, and it has not stopped since, but of course the current prejudice against and stereotyping of Muslims makes the images quite relevant."

Dr. Hankir (October 8, 2017): "Our mutual friend Steve informed me that you are an artist, academic and physician and that you might be interested in contributing a book chapter on challenging Islamophobia through the power of art. I am more than happy to offer you any assistance and support that you require… I was fortunate enough to launch an anti-stigma program a few years ago that blends the performing arts with psychiatry and the feedback that we received from audiences (particularly students) throughout the world has been exceptionally positive."

Dr. Ghosn (October 8, 2017): "My personal artistic work and the work I do through my charitable organization SOS (Save Our Souls) ART focuses on promoting the arts as vehicles for peace and justice in general; and in this respect the general issue of prejudice is something I would tackle."

Eventually, this interchange led to another collaborative endeavor, wherein we all provided our perspectives creating this chapter, followed by the Woodcuts which may convey an infinite number of words.

Contributor's Statement

As a clinician and academic who has a research interest in pioneering and evaluating innovative programs that challenge mental health related stigma and Islamophobia through the power of the performing arts, I could not help but be intrigued by Dr. Moffic's introductory description of Dr. Ghosn and his creative work. Even before entering a direct communication with Dr. Ghosn, I could sense that there was a kindred spirit between us not only because we both believe in the healing power of art but also because both hail from "the heart of the world." Dr.

Ghosn's images transcend time and place; as a proud British Muslim who has been a victim of Islamophobia, it brings me tremendous comfort to behold and experience Dr. Ghosn's artistic expressions through the medium of imagery which, I am sure, will be appreciated for many generations to come. When Islamophobia causes a deafening silence that cannot be stifled by words, may Dr. Ghosn's artistry offer you solace and a means of escapism. His precious contribution, without a doubt, has improved the quality of our book and for that we are immensely grateful.

Artist's Statement

Art can add beauty to the world, as well as celebrate the beauty and the positive that already exist. But also, and more importantly, when it is truthful, art reflects the artist, who the artist is, what she/he believes, and her/his own vision of the world. Art can then function as a force of sensitization and of change regarding what happens in the world. The artist becoming an active, concerned, and engaged participant in the partaking of a better world points to what needs to be changed (flaws and imperfections) as well as imagines and creates the alternative, showing how change and improvement might be brought about. As Ernest Fischer wrote in 1959 [2]:

> Art is necessary in order that man be able to recognize and change the world… In a decaying society, art, if truthful, must also reflect decay …art must show the world as changeable. And help create it.

But what is art? Art is a creative process where the artist uses imagination and skill to bring to life something new and beautiful or to express important ideas or feelings. As a creative expression, it represents an integrative activity that involves the entirety of the individual and during which the artist's experience, intuition, emotions, mind, soul, vision, beliefs, values, views, exploration of truth, and search for beauty all merge together. As such, true art is artist-centered, free to dismiss outside rules and regulations, transcending the immediate moment, the here and now, the material, the conventional wisdom, connecting to the spiritual.

This creative act allows the artist to bring to life a new form, original to the artist and reflective of the artist's self, thought, imagination, and inner self. It does not merely transmit what the artist thinks but also allows the creation of a new possible world that the artist dreams of. Genuine creativity transcends the final product; it becomes embodied in it, the product an expression and a reflection of the creator and of the process. As a result, art acquires a "subversive" and potent quality and becomes an influential tool for a change. The artist, being a creator, and in a way god-like, adds to the creation that already exists.

When art is at its most authentic, it implicates, engages, and reflects the artist. It transcends the material form and ceases to be only for the sake of art itself, or for the

sake of a consumable object, the commodity product that society often expects or even imposes on the artist. It becomes for the sake of the artist, reflecting who the artist is, connected to her/his experience, vision, values, and life path. It becomes the artist's emerging voice, to assert the artist and her/his original identity, to strengthen the artist's voice, to empower and heal the artist, and to reach normalcy and harmony within her/himself and with the surrounding world. Art becomes also the artist's communication tool to touch, inform, dialogue, confront, and trigger emotions.

Though being for the artist's sake, the artist does not function in isolation. She/he lives a daily experience in the society/community where she/he is, communicates, and works. As a result, the artist's creative activity connects her/him to life in general and to the social, political, and spiritual. Art thus becomes for the sake of life in general.

Through the artist's voice, art reflects what is taking place, what needs to be changed, and how to reach the full potential of humanity. Art becomes an active pageant in the ongoing processes of life. This creative, godly quality given the artist implies an ongoing duty and responsibility of the artist not only to commit fully to her/his own work but to confront injustices and to work for peace and contribute positively to creating a better world.

By creating art, artists not only empower themselves and contribute to their own growth and harmony but also engage viewers who respond to their work, resonate with it, are moved or challenged by it, who discover a new possible world, thanks to it, and who are led into thinking and action by it. Art becomes the important, powerful, and motivating communication tool of the artist to change and recreate this world and make it better.

Artists have a distinct advantage through their art, thanks to its free and unlimited creative imagination to transcend established norms, to function outside the boundaries of conventional thought, and outside the framework of traditional society. Through their art, artists can open doors to what can be dreamt, to a utopian world of beauty, different values, and beliefs, to a better world that can be made real.

The Art

We're living an increasing age of profiling and discrimination where an individual is judged based on his looks, clothes, beliefs, the color of his skin, etc. In the USA recently, being Arab or Muslim has been another reason for being suspect (Fig. 7.2).

My print addresses discrimination and prejudice which frame and imprison individuals in preconceived clichés and stereotypes, taking away their freedom and their real identity (Fig. 7.3).

The beauty of diversity should bring enrichment and tolerance to our world. Unfortunately, in our righteous society, racial, ethnic, and religious differences are often causes for discrimination, denigration, separation, isolation, prejudice, enmity, etc. (Fig. 7.4).

Fig. 7.2 Issmee Arabee (My Name Is Arab). Woodcut print; 22 × 30″

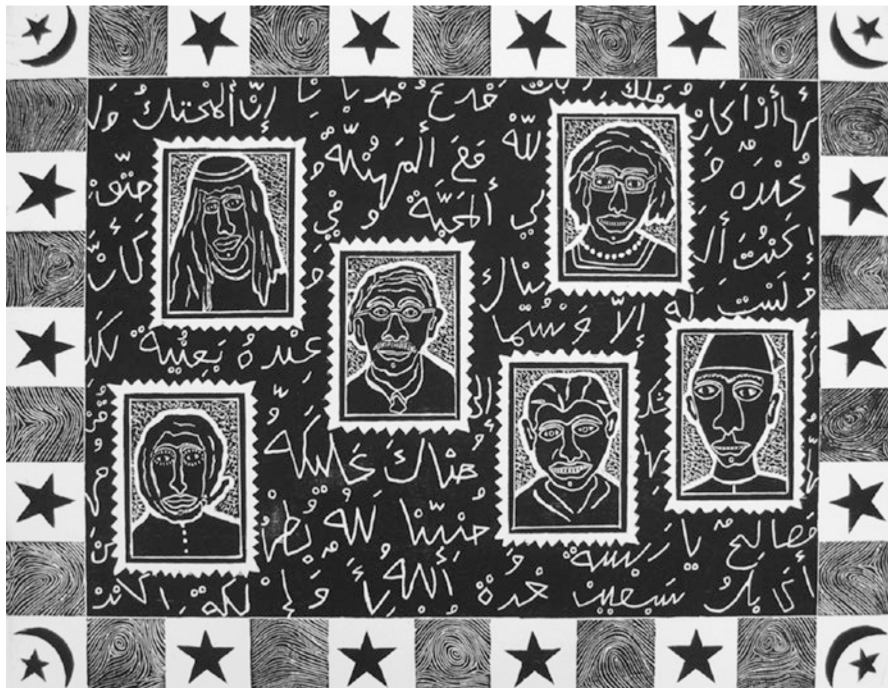

Fig. 7.3 You Are What You Look. Woodcut print; 22 × 30″

Fig. 7.4 Faces of Races. Woodcut print; 22 × 30″

How large is the freedom space of these “free,” non-caged, birds, facing persistent obstacles? In America “the land of the free,” we take pride in our “freedom,” while in reality we are daily prisoners of our many lacks and imposed limitations (poverty and striking economic disparity, lack of universal health care, lack of free and equal education, gender, racial, religious and ethnic discrimination, etc.) (Fig 7.5).

John Doe is a target of terrorism, not the terrorism brought upon by foreign “terrorists” but the one he lives daily: lack of human rights (education, health, environmental protection, etc.), lack of privacy and of freedom of expression (secret surveillance, unjustified arrests, patriot act, etc.), poverty, discrimination, etc. (Fig 7.6).

In a world of violence and injustice, one often feels like a helpless observer, an impotent witness to a course gone astray, to belief values trodden upon, to dominating and destructive violence impossible to control and stop. One feels badly in need of active arms to stop the bullying, the circle of despair. Alas, most of the time one feels powerless (Fig. 7.7).

My works address issues of societal injustice, violence, discrimination, and abuse of the vulnerable and the weak. In “We See Nothing, We Hear Nothing,” I point to our deliberate ignorance and dismissal of the wrong around us in order to protect, preserve, and not disrupt our own privileges and comfort (Fig 7.8).

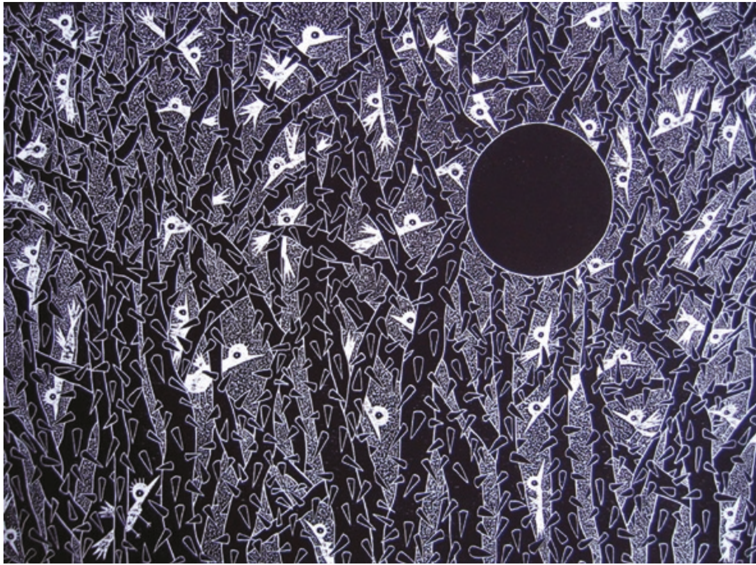

Fig. 7.5 In the Land of the Free. Woodcut print; 22 × 30″

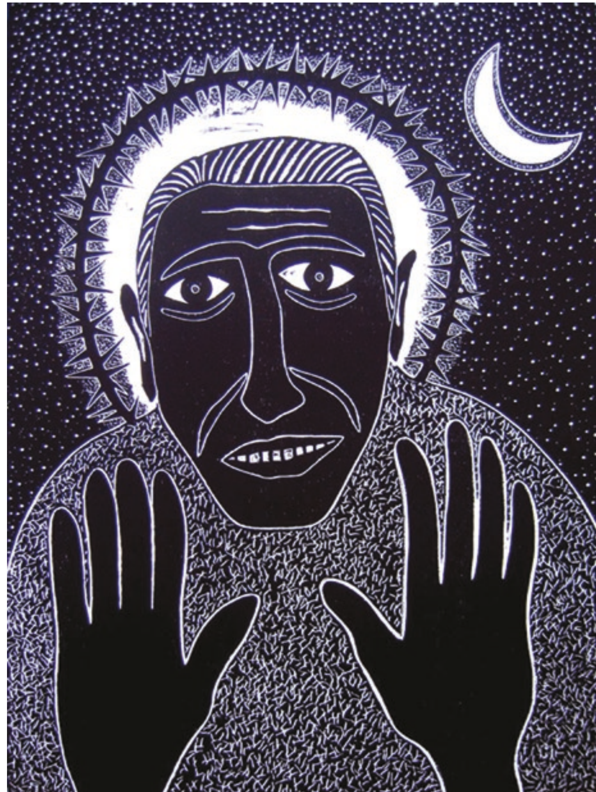

Fig. 7.6 John Doe. Woodcut print; 30 × 22″

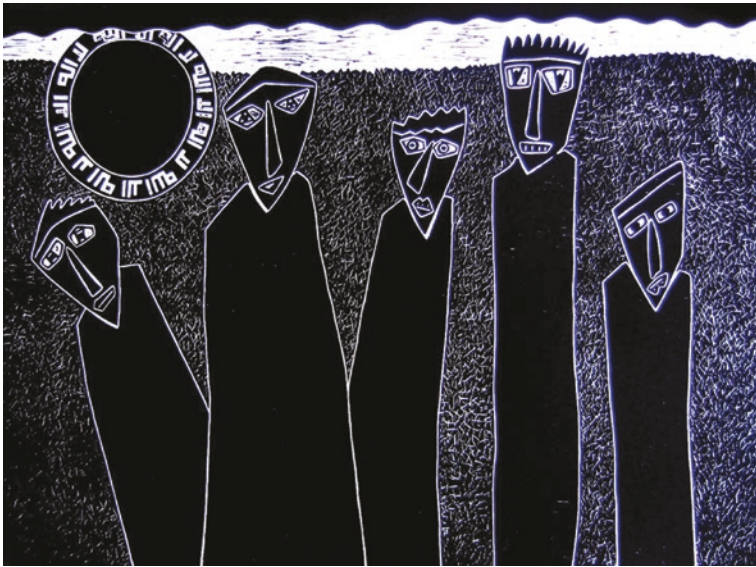

Fig. 7.7 Impotent Witnesses. Woodcut print; 22 × 30″

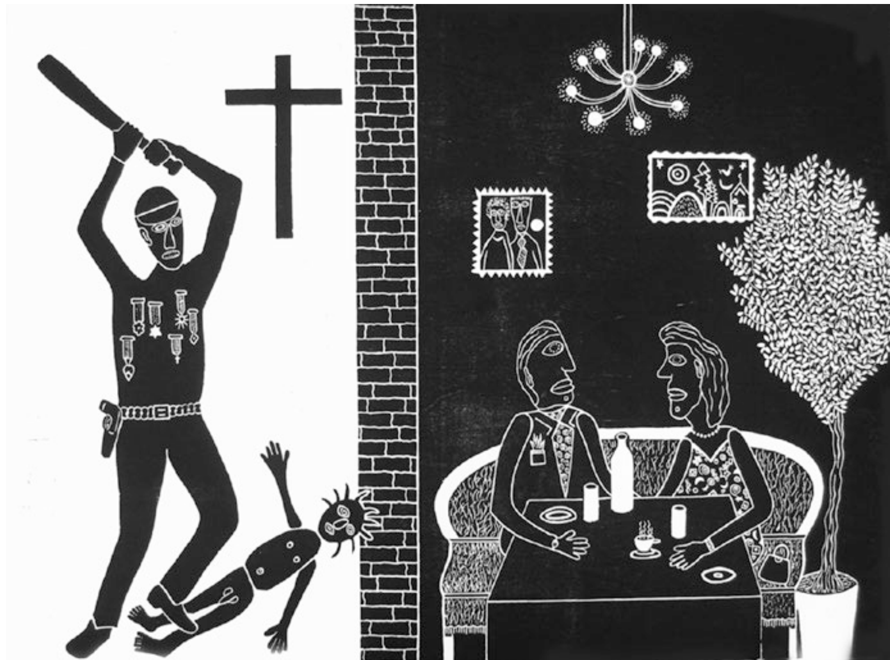

Fig. 7.8 We See Nothing, We Hear Nothing. Woodcut print; 22 × 30″

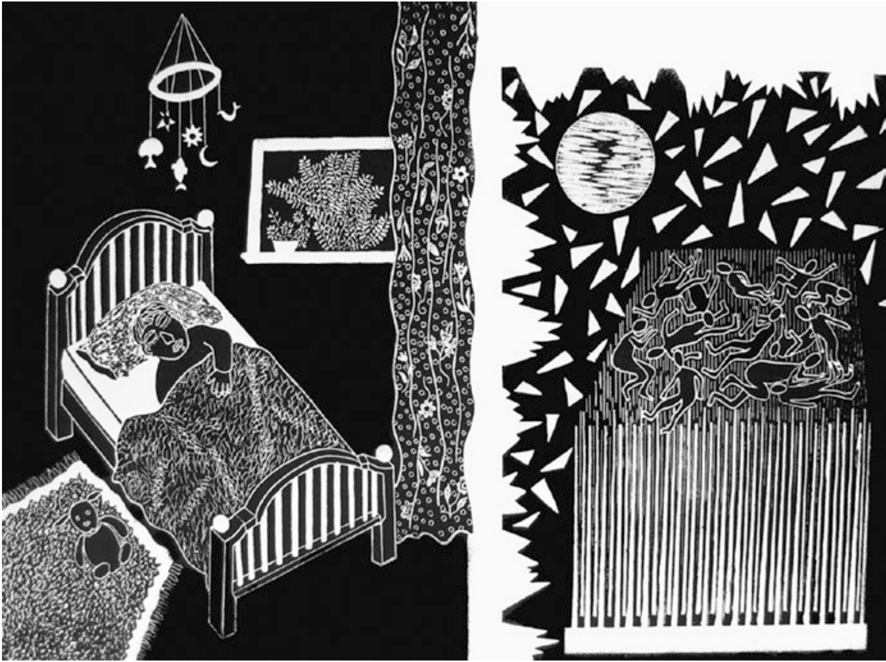

Fig. 7.9 Beds and Beds. Woodcut print; 22 × 30″

In our society and world, inequality, unfortunately, often starts in a child's bed. Some children have very early on a bed of comfort, while others a bed of nails. These life experiences have a major influence on who we are and what we do. In addition to being cognizant of the unjust disparity of the types of beds that people may grow in, we need to be nonjudgmental, always aware of, sensitive to, and compassionate about the type of beds others have slept in (Fig. 7.9).

My three collages deal with the issue of prejudice, generally born from the fear of the different and of the unknown. Our differences, however, should be viewed as sources of richness; they contribute to the diversity and to the beauty of the world. We're all here together, each an essential and important link, adding harmony and well-being to the circle of life (Fig. 7.10).

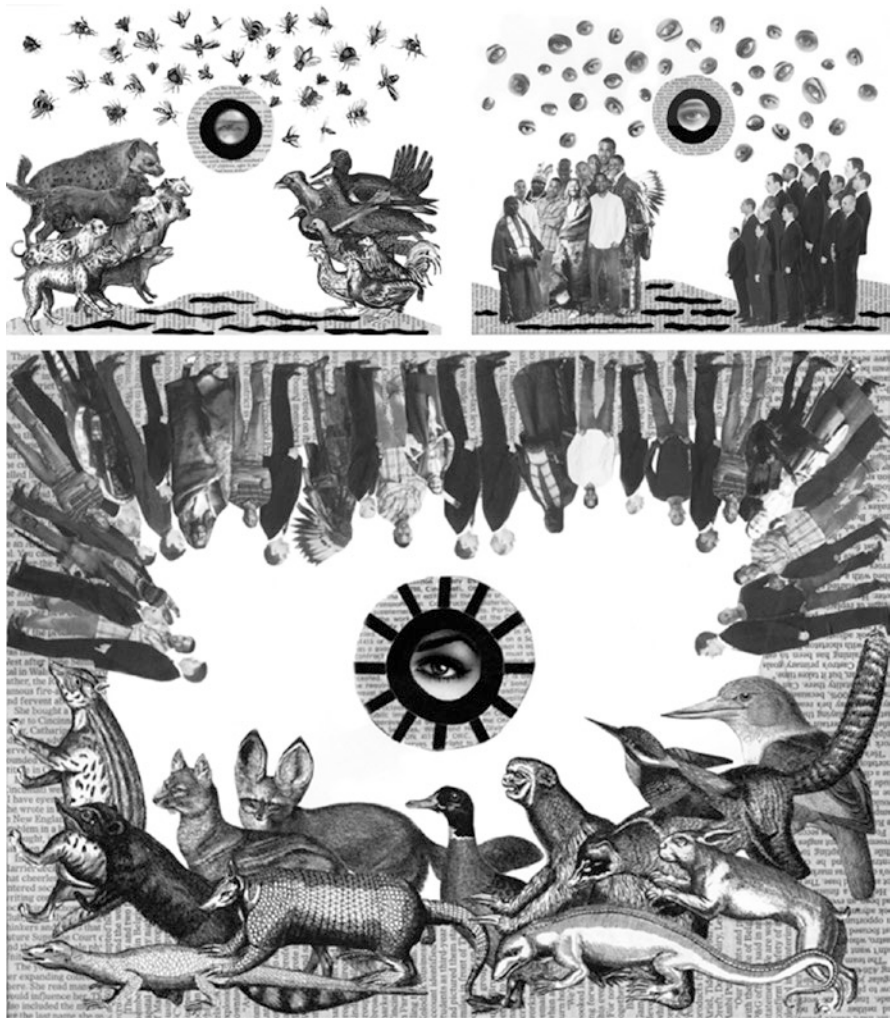

Fig. 7.10 Who Are You, #1; Who Are You, #2; We Are. Collages; each 9.5 × 12.5″

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8 Symbols and Identity in Islamophobia

Shridhar Sharma, Sidra Ghafoor, and Rama Rao Gogineni

Introduction

Islamophobia has been defined as exaggerated, irrational fear, hatred, and hostility toward Islam and Muslims perpetuated by negative stereotypes resulting in bias, discrimination, and marginalization of Muslims from civil, social, and political life. Islamophobia has important implications for the inclusion of Muslims in society since the evidence suggests that religion, in this case Islam, may be a more influential determinant of prejudice and discrimination than either race or ethnicity [1].

A symbol has been defined as a mark or character used as a conventional representation of an object, function, or process. This book chapter will try to briefly explore the impact of Islamophobia on the development and disruption of identity in people of the Islamic faith, with an emphasis on symbols and symbolic expression.

Symbols and Language

As a representation, a symbol's meaning is neither instinctive nor automatic but rather something that must be learned and, over time, relearned. Symbols occur in different forms; they can be verbal or nonverbal and written or unwritten. A symbol is essentially anything that conveys a meaning, such as the words on this page, drawings on a cave wall, pictures in an art gallery, or gestures in social interactions [2].

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Perhaps the most powerful of all human symbols is language—a system of communication that can be spoken or written which is culturally specific and which can facilitate the understanding of others and the world we live in.

In the 1930s, Edward Sapir and Benjamin Lee Whorf proposed that languages influence perceptions. The Sapir-Whorf hypothesis (also known as the linguistic relativity hypothesis) suggests that a person will more likely perceive differences when he or she possesses the words to describe them.

Language is a crucial component of culture that contributes to its continuity and longevity. Some groups, such as the French-speaking residents of Quebec in Canada, refuse to speak English for fear of losing their cultural identity, although both English and French are Canada's official languages.

Symbols also exist in religions; examples include the Cross in Christianity, the Wheel of Dharma in Buddhism, the Crescent and Star in Islam, and Star of David in Judaism. These symbols can best be understood or interpreted though the lens of the culture to which they pertain; otherwise they may lose their unique significance. One example of a misinterpreted cultural symbol is the "Whirl Log" symbol commonly used in Native American blanket weaving. This symbol is almost identical to the design of the Nazi Swastika and almost always evokes negative responses from many Americans. Although the "Whirl Log" has nothing to do with Nazi symbolism, this design is rarely used on blankets today because of this symbolic misinterpretation.

Culture has often been defined as the learned, shared, and transmitted values, beliefs, and norms of a particular group of people that guide their thinking, decision-making, and actions in patterned ways. As with religion, symbols also exist across cultural groups. Cultural symbols can be gestures. For example, think of a handshake versus a hug and the meaning behind each. In the West one should generally not accept a job offer by hugging a new boss, although this may be acceptable in certain cultures in the East. These symbols can be part of a person's religious, ethnic or cultural identity, and pride. They can be used as expressions of power and as tools to intimidate with. They can also be used to discriminate, induce fear, and even terrorize the "other." Some examples of such intimidating symbols are the swastika of Nazis and the dress code of the Ku Klux Klan and other hate groups.

The hijab is an example of a symbol in Islam which has attracted a substantial amount of negative attention and media coverage. One reason for Muslim women to wear the hijab is to preserve their modesty and to protect them from the gaze that emanates from lustful eyes, with the subsequent fornication and adultery that can ensue. It is important to note that there is no compulsion in Islam and that Muslim females must decide to wear the hijab of their own volition. Unfortunately, Muslim women who wear the veil often bear the brunt of Islamophobia.

The controversy surrounding the veil has recently been highlighted in France and has been characterized as a debate of freedom of belief and expression [3]. The media focused on young Muslim women who were determined to obtain a modern education while also wearing the veil as a positive symbol of their values and faith. These women were often crudely stereotyped as potential brides of militants of terrorist organizations such as Daesh.

Below is a brief description of the varieties of dress coverings for Muslim women.

1. The *hijab* is a term used for a variety of headscarves. It is the most popular veil worn in the West. These veils consist of one or two scarves that cover the head and neck. Outside the West, this traditional veil is worn by many Muslim women in the Arab world and beyond.
2. The *niqab* covers the entire body, head, and face; however, an opening is left for the eyes. The two main styles of niqab are the half-niqab that consists of a headscarf and facial veil that leaves the eyes and part of the forehead visible, and the full niqab that leaves only a narrow slit for the eyes. Although these veils are popular across the Muslim world, they are most often seen in the Gulf States.
3. The *chador* is a full-body-length shawl fastened at the neck by hand or pin. It covers the head and the body but leaves the face completely visible. Chadors are most often black and are most common in the Middle East, specifically in Iran.
4. The *burqa* is a full-body veil. The wearer's entire face and body are covered, and one sees through a mesh screen over the eyes. It is most commonly worn in Afghanistan and Pakistan. Under the Taliban regime in Afghanistan, its use was mandated by law.

The Star and Crescent is an iconographic symbol that originated in the former Ottoman Empire and extended to the Islamic world. Its iconography developed in the Hellenistic period (fourth–first centuries BCE) in the Kingdom of Pontus, the Bosporan Kingdom, and notably the city of Byzantium by the second century BCE. It is the conjoined representation of the crescent and a star, both of which constituent elements that have a long prior history in the iconography of the ancient Near East as representing either sun and moon or moon and morning star (or their divine personifications). Coins with crescent and star symbols represented separately have a longer history, with possible ties to older Mesopotamian iconography.

Another example of prejudice focused on symbols involved the "Dotbusters," a hate group in Jersey City, New Jersey, that attacked and threatened South Asians, particularly Indians, in the fall of 1987. The name originated from the fact that traditional Hindu women and girls wear bindis on their foreheads. In July 1987, they published a letter in *The Jersey Journal* stating that they would take any means necessary to drive the Indians out of Jersey City. Numerous racial incidents from vandalism to assault followed. Later that month, a group of youths attacked an Indian man of Parsi (Zoroastrian) origin and beat him into a coma; he died 4 days later. A similar prejudice focused on the Yamuka/Kippah prejudice was seen in Paris and other parts of Europe in retaliation against people of Jewish faith.

Identity

*S*ecular societies may not tolerate symbols of religious identity in public places. A veil worn in public may carry a religious message for the person who is wearing it

but also a public appeal to recognize equality and diversity. Muslim women, by insisting on their distinctiveness, want to be accepted as equal citizens of the society in which they live [4].

Anthropological study of tribalism and hatred for the "other" reveal that tribalism springs from the innate human drive for survival. Loyalty to one's "tribe" may be based on a variety of shared traits—including geography, religion, ethnicity, or one's skin color. Not all tribalism leads to violence. Historical and sociological explanations of religions underline that religion has served to bring an order to society. Its central message is often one of social justice and order.

Ethnicity, the concept of a group's "peoplehood," refers to a group's commonality of ancestry and history, through which people have evolved shared values and customs over the centuries. Based on a combination of race, religion, and cultural history, ethnicity is retained, whether or not members realize their commonalities with one another. Its values are transmitted over generations by the family and reinforced by the surrounding community. It is a powerful influence in determining identity [5]. Ethnocentrism constitutes a readiness to act in favor of in-groups and in opposition to out-groups, offering a general group delineation that divides people into "us" and "them." Nativism, which overlays explicit political ideology and/or national identity (such as the "American way of life"), can divide the human world into in-groups and out-groups while claiming to "protect against foreigners or foreign influence."

The "identity of legitimacy" is reinforced by dominant social institutions to expand and rationalize their domination. "Identity of resistance" is created by subjects in positions/conditions in which they feel degraded or stigmatized by the rationale of domination. "Projective identity" appears when social agencies, on a basis of whatever cultural material is available, build a new identity which redefines their position in society and by doing so look for a transformation of the overall social structure. Islamism is considered to be the identity of resistance. Its public manifestations since the 1970s are oriented toward resistance to domination. Islamism is a modern political movement whose aim is to win power and to shape the society according to the Islamic ideal—creation of unified Muslim modern identity, with little room for liberal and secular Muslims. Islamism can also be seen as an answer to modernity. As such, it is often called Islamic fundamentalism and is considered a group identity. A group identity enables an individual to see himself or herself as equal to others that are of the same origin (we) but also highlights the difference and uniqueness that one experiences in relation to members of other groups or categories (they). Seen in this light, the modern identity of many Muslim women, which includes the wearing of the veil, and the modern identity of many Muslim men, which includes growing beards, can be in part an identity of resistance.

According to Allen and Nielsen, the single most predominant factor in determining who is to be a victim of an attack or infringement is their visual identity as a Muslim [6]. This raises the question of whether this violence reflects a phobia or anger and hatred against Islam. The primary visual identifier appeared to be the hijab, or headscarf, worn by many Muslim women.

Islam has become the "negative other" and symbolic of problems related to ethnic minorities and immigration. Religion is an important meaning system for making sense of existence and for buffering against existential anxiety. We argue that it will be helpful to examine this issue from a perspective of the role of symbols and identity.

Religion represents a dynamic social and ideological context for self-development. Religious youth are often more committed to their faith and also concerned with identity and the meaning of their lives in relation to their religious strivings. Their religion is a crucial aspect of their identity, along with certain cultural rules and traditional values. While religious plurality can generate fears through identity destabilization, religion offers resources for coping with Islamophobia. The media accentuates sensational and exotic news in order to attract attention, the politician uses demagogic statements in order to attract voters, and the scientist generalizes, thereby violating the ethical rules of science, to enlarge his influence outside the scientific community—fueling more propagation of the negative attitudes in society toward the group concerned rather than resolving the problem. Succinctly put, there is a complex relationship between religion and implicit and explicit prejudice.

What Is the Remedy?

The United States and France have always been proud of their liberal and democratic values. Ironically, after all the work over the centuries to escape religious oppression, these Western countries are now oppressing people based on biased generalizations of Islam. People do not go to Christian nuns and ask them to unveil, so why should Muslim women be targeted and taunted for their religious practice? Clearly, the veil is misunderstood in the West, and because of this uncertainty, many Westerners are afraid. This is why they unconsciously oppress women, hoping to solve their "Islam problem." Learning about the veil from a first-hand perspective can offer non-Muslims a deeper understanding of its meaning and help to diminish discrimination and tension. Similarly, the stereotyped Muslim male has been constructed as an ominous figure: the bearded, dark-skinned, turban-wearing terrorist guided by perceived archaic religiosity.

Psychiatry can help resolve conflicts through greater understanding of the dynamics of pride and group interaction. Pride is the symbolic extension of the biological drive to assure the survival of oneself and one's group by mastering the environment, including one's fellow creatures. In secular terms, pride is an effort to overcome existential anxiety and one's feeling of insignificance and helplessness arising at feeling that humans are merely tiny flashes of experience in a vast impersonal universe. Yet, the very trait that has enabled us as humans to dominate the rest of creation contains the seeds of our self-destruction. The link between pride and violence lies in the fact that driven by pride and frustration, individuals and groups constantly try to exceed their limits.

Conclusion

Psychiatrists have a key role in understanding and solving the problem of Islamophobia both at individual and collective levels. No matter how irreconcilable the differences among individuals, races, nationalities, and religions may appear to be, all humans have similar hopes, fears, and aspirations, and all share a common fate.

Gandhi [7] expressed hope that "the world of tomorrow will be, must be, a society based on nonviolence," and Confucius [8] saw dialogue and social contact as the means to achieve this goal. Understanding our tribal nature is a step toward moving thoughtfully away from the feelings and behaviors that often lead to tragic violence and self-destruction so frequently written in our history. How do we reconcile our reflexive need to lump the "other" into a homogenous entity while at the same time disowning the outliers of a group with whom we may or may not identify with? This requires courage to recognize our own shortcomings and embrace the common ground which we share. We do not have to agree with each other, but we do have to try to understand each other, including our symbolic differences. Finding common ground is not about debating or arguing one's own perspective. It is about understanding the shared struggles, dreams, and hopes we share as human beings. That is what we try to do as psychiatrists.

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9 Cultural Literacy

R. Cecilia Jefferson

In 2007, the Liaison Committee on Medical Education (LCME) published a revised set of standards for the accreditation of medical education programs in the USA and Canada. The LCME now mandates that medical schools in the USA and Canada include "cultural competency" as one of their central educational goals [1]. Over the course of the last decade, medical schools have responded to this mandate by implementing a wide variety of programs. The American Psychiatric Association has also begun recognizing the need to address social diversity, cultural heterogeneity, and associated disparities in healthcare delivery and, as part of their efforts, included the Cultural Formulation Interview (CFI) in DSM-V, along with definitions of several so-called culture-bound syndromes.

It is tempting to describe these programs as having varying levels of success, but because the measures of what constitutes success are as varied as the programs themselves, such a declaration would be inaccurate. A recent (2014) Cochrane review of cultural competence education programs in health professions training essentially concluded as much, stating that "The quality of evidence is insufficient to draw generalisable conclusions, largely due to heterogeneity of the interventions in content, scope, design, duration, implementation and outcomes selected." Notably, in order to perform the review at all, the Cochrane reviewers had to develop their own "four-dimensional conceptual framework" of what constituted a cultural competence education program in the first place [2].

This last point is the one I find most interesting. The 2014 Cochrane review could not come to a generalizable conclusion, because while everyone involved seemed to agree that "cultural competence education" is a necessary thing, it does not seem there was any consensus about how such a thing ought to be taught, or, by extension, what the meaning of that phrase, "cultural competence education," might be.

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How can we move forward without defining our terms? That is, without knowing what constitutes movement, or which direction is forward?

Before we can begin to contemplate cultural competence education, we must define the term. What do we mean by "cultural competence?" When I was presented with the opportunity to redesign the cultural competence curriculum for the psychiatry residency program at the University of Wisconsin-Madison, I contemplated that very question. As I strove to define my terms, I came to the conclusion that "competence" is the wrong word to describe the real educational goal. It remains my belief that until we are using the right words, we will be dismal failures at changing both our own thinking and the thinking of the new generation of psychiatrists.

The AMA code of medical ethics states: "A physician shall be dedicated to providing competent medical care, with compassion and respect for human dignity and rights." This is a laudable principle. My critique of the use of the word "competence" in this context is not intended to diminish this ethical principle. Of course physicians should provide competent care and do so with compassion and respect. My contention is that in the particular case of cross-cultural understanding, a goal of competence falls short of what is needed to provide care with compassion and respect. It falls short because such a competence is not possible, and it is not possible because competence is simply the wrong standard by which to measure the skill in question. Competence, in the realm of cross-cultural understanding, is not an appropriate goal, because if one examines the meaning of the word, the idea that one could ever be "competent" in understanding culture does not make sense.

What is competence? Merriam-Webster defines it as "the quality or state of being competent," which is then defined as "having requisite or adequate ability or qualities; legally qualified or adequate." Competence is a finite state, an endpoint. It is reached, and then one stops moving. One can, by definition, be finished becoming competent.

How does one attain "requisite or adequate ability" in culture? What is requisite? What is adequate? What would constitute a culture "ability"? What would we actually want mental health clinicians to do in order to adequately understand "culture," whatever we may take that to mean? This is not merely a semantic point. We cannot teach something properly until we define what it is that we are teaching. If culture, like language itself, is always in flux, it would be disingenuous of us as clinicians to pretend it can be taught as a competency, as something that one can finish. As Drs. Kumagai and Lypson state in their excellent 2009 article for the *Journal of Academic Medicine*: "Cultural competency is not an abdominal exam. It is not a static requirement to be checked off some list but is something beyond the somewhat rigid categories of knowledge, skills, and attitudes: the continuous critical refinement and fostering of a type of thinking and knowing—a critical consciousness—of self, others, and the world" [3]. For these reasons, I prefer the term cultural literacy—literacy, because with books as with human beings, one is never really finished learning to read. Psychiatrists know this better than most. Or we ought to, anyway.

I am hardly the first person to suggest using the term "cultural literacy." The idea of characterizing the development of a cultural consciousness as an act of reading is

rooted in the work of Paolo Freire, who described the act of "reading the world" [4]. In Freire's work, learning to read the world involves becoming aware of the inequities that are built into the social relationships and environment all around us, and learning to both reflect and think critically about these relationships and inequities—a process similar to literary criticism and analysis. This ability to read the world is the first step in developing an orientation toward social justice.

Again, what I am saying has been said before. To those with a background in social justice, social science, or the humanities, it probably sounds old hat. But for too long, medical education in this country has not viewed the creation of a cultural consciousness as part of its mission. It has tended to align itself with the "hard sciences," relegating the idea of social justice to the realm of public health. Counterexamples are, of course, to be found in various individual programs, but there is very little consistency.

The push for "cultural competency" in medical education should not be viewed as one more arbitrary measure to meet, one more correct-sounding thing to which we should pay lip service. Rather, it should be viewed as a call for a shift in our mission as clinical educators, to move into a space where the humanities, in particular the social sciences, have already outdistanced us: the space of creating a broader social consciousness in our new young doctors, to help them view themselves as part of a larger mission not just to care for the physical health of other humans, but to view that care as one part of the uplifting of humanity as a whole. The practice may need to be tailored to the needs of individual programs, but the principles, at least, should be generalizable.

When I began planning my redesign of the cultural literacy curriculum at UW-Madison, I sought some guidance from the medical literature. Like the Cochrane reviewers, what I found was occasionally helpful, but not terribly consistent. In Hawaii, for example, an entire team had been assembled to investigate the task I was doing on my own [5]. Other institutions had attempted to address the problem of cultural bias in faculty educators themselves [6–8]. Still others enacted practical, but limited interventions, such as seminars on working with interpreters [2, 3]. I had been given a limited number of hour-long seminars, to be geared toward second-year psychiatry residents. In this particular program, the second year involves the heaviest burden of emergency and inpatient call, making it the year of most sleep deprivation and burnout and simultaneously the year of most exposure to the most in need. How does one ignite the spark of a change in mindset, in minds whose resources are already being pushed to the limit?

There is often a temptation in designing cultural competency curricula to treat it as a sort of introduction to mental health in various categories of people: in women, in the LGBTQ community, in Muslims, in African Americans, and so forth. This type of curriculum design has the advantage of being well-suited to limited episodic contacts and fits well with the pattern of providing easily categorized bits of information to which residents are likely accustomed by the system-focused or disease-focused lessons of medical school. However, I would argue that this type of curriculum design is dangerous, and likely to undermine the aim of cultural literacy itself, because it encourages not only stereotyping, but reductive thinking in general.

The message of this type of curriculum is that there is a finite amount of information a medical student or resident could acquire about any particular religion, ethnic group, or culture, and once that information is satisfactorily acquired, the trainee will be adequately prepared for any encounter with any individual from one of these populations.

Such an approach is easy to implement, and therefore seductive in an environment like medical school or residency, where teaching time may be limited, and any substantial change in the core academic structure is likely to be slow and face many institutional hurdles. However, because it does not explicitly involve self-reflection, it is unlikely to effectively target implicit bias. Further, the choice of faculty to teach this type of curriculum can be problematic in at least two different ways: firstly, if a faculty member who may have a great deal of experience with one ethnic group, but is not a member of that group, teaches a seminar (e.g., a white male psychiatrist leads a seminar about delivering mental health care to a marginalized ethnic group), then no matter the level of experience or sensitivity of the lecturer, the content of the presentation will be filtered through his perspective and experience only, and the voice of the marginalized group itself will not be heard. However, the alternative places an undue burden on faculty members or community leaders who happen to be members of marginalized groups, to continually speak on behalf of their group, regardless of what their own experiences have been.

There are those individuals from marginalized groups who enjoy educating others and take both pride and pleasure in that position. These individuals should be allowed the space and agency to speak, and be heard, as much as they wish. But placing the burden of cultural ambassadorship on marginalized people should not be a default position. It is not the job of any group to explain itself to outsiders in order to “earn” or “deserve” respectful treatment. Rather, it is the duty of the outsider to seek education, to listen openly, and to give respect without demanding to be made comfortable first.

This kind of open, curious attitude is (rather ironically) not usually encouraged in higher education, particularly not in the sciences. Instead, medical students are often encouraged to cope with the overload of information being firehosed at them by learning to break it apart and rapidly categorize it into small, easily digestible component parts. Because the information in question is about human beings, medical students are often, therefore, inadvertently encouraged to stereotype. For those medical students with undergraduate science majors, the encouragement to compartmentalize, sort, and stereotype begins even before medical school, due not only to the challenges of the curriculum but to the traditional, top-down, memorization-focused ways in which the material is taught. Stereotyping is, after all, highly efficient. It is, by definition, a mental shortcut. In any educational or organizational culture where efficiency is highly valued, stereotyping is bound to thrive, and if we do not believe medical education and medicine are cultures of this sort, we are fooling ourselves.

In addition, the competitive admissions process for medical school encourages students to fear failure, tacitly if not directly discouraging them from taking courses that might in any way detract from a “perfect” application. The fear of failure and

the avoidance of risk are further strengthened in medical school, where the first 2 years are still often graded in a ranked system that keeps these already competitive students in competition with one another, always seeking the “correct” answer, the end and not the means, the top mark that guarantees survival with the least possible risk. Later, in their clinical years, students learn that failure to provide a correct answer on rounds results in shame, and possibly the loss of opportunity. The fear of failure and the avoidance of risk are further cemented as performance pressures on students mount.

Thus a group of intelligent people are molded by their very education into black and white thinkers, stereotypers, and seekers of ends rather than means. To cultivate an attitude of open curiosity in medical students and residents, an attitude that embraces mistakes as inevitable rather than fearing them, is to seek to undo many years, in some cases half a lifetime, of rigorous training. And, I would argue, this cultivation cannot be done effectively by an outsider, who is not familiar with the effect of medical education on the mind. Just as a man is more apt to listen to feminist ideas when a man speaks them, just as white people are less threatened by discussions of institutional racism when they come from other white people, we are the ones who did this to our residents and students. We must be the ones to undo it. To teach cultural literacy effectively, we must both model and instill new habits of mind. To model cultural literacy effectively, we must be always teaching ourselves to undo our own habits of mind, instead of perpetuating them.

To begin cultivating an open and curious habit of mind, we must first help the group of residents that we are teaching to see each other as trusted allies, not competitors, in a classroom environment. This last clause is important. Residents will naturally learn to rely on each other in a work or on-call environment, because doing so is essential to survival. But in a classroom environment, or in rounds, in the presence of an authority figure such as an attending, the old closed, stereotyping, risk averse, and competitive habits of mind will be apt to emerge again. Attendings can choose to perpetuate these habits, teaching in the way that they were taught, or they can choose to disrupt them. How do we disrupt competition in a classroom environment? How do we encourage openness, and willingness to admit limitations, to make mistakes?

One way is to model such traits in ourselves, as attendings, as authority figures, and as teachers. The first session of our cultural literacy seminar functions as a modified version of a traditional T-group. (Notably it became more effective when our residency programs implemented T-groups as part of training from year 1, so less time had to be spent acclimating residents to the framework.) In this session, the attending models vulnerability by being the first to offer his or her own cultural history. It is important that the attending not take any aspect of their own background for granted as “normal,” from skin color to religion, to gender, names, and pronouns. In this way, residents who may be used to viewing themselves as “default” or “without culture” will see an alternate perspective modeled [9]. The facilitator works to encourage awareness of one’s own background and experience, taking nothing for granted, and to encourage self-reflection. Doing this as a group encourages trust that will be useful when more contentious subjects, such as bias and

institutional racism, are explored. Clinical cases are then brought forward and explored from this base.

During clinical case discussions, the attending, as an authority figure, must be particularly careful not to fall into the trap of encouraging judgments. It is important to model a mindset in which there are no right or wrong answers, so that students do not feel afraid to express their viewpoints or to have their viewpoints interrogated—an experience that can feel incredibly threatening, particularly for those students from backgrounds of multiple privileges, who are used to academic success and social rewards. The point is not to judge who among us is the least Islamophobic, the least racist, the most right-thinking—the most culturally competent, if you will. The point is to disrupt the idea that learning is, in any way, a contest. The point is to begin to create a new mindset, a consciousness of injustice, and one's own role both in perpetuating it, and in fighting it, that can be carried into every social interaction, clinical and otherwise, with the ultimate goal of improving both healthcare delivery and the culture of medicine itself.

The most difficult sessions of our framework involve exploring how to implement these concepts in practice, as this is where students and residents are most vulnerable, most eager to prove themselves, and, often, most defensive regarding the skills they've already acquired. (The same is often true of experienced clinicians, who can in fact be even more defensive of their skills, experience and methods.) It is often helpful to begin by using an example from the news, if possible from a different state or facility, to help it feel more neutral, and then gradually shift to more personal examples. Again, it also helps tremendously when the instructor is willing to model vulnerability for the students and share an encounter that could have gone better.

One story I often tell is from my family medicine rotation as a fourth-year medical student. I was working with a family medicine doctor at a clinic in Minneapolis that served a large Somali population. He asked me to start seeing a young woman who had come in for her annual exam, as she preferred to be examined by a female clinician. I had done a lot of reading about the Somali immigrant population and was eager to demonstrate my competence and sensitivity in working with them. For instance, I had read that modesty, propriety, and traditional gender roles were important to this population due to their strict observance of Islamic law, and I assumed this was why the young woman preferred a female clinician. I assumed she was a strict observer of the tenets of a culture I thought of as repressive, and I assumed she had probably undergone a female circumcision ritual. I was prepared to speak to her in hushed, sympathetic tones and find subtle ways to inquire about abuse. My intentions were entirely compassionate, and none of the assumptions I made were necessarily unreasonable. But the fact remains that I had made them all before even speaking a single word to the patient herself. In fact, I'd made some of them before I'd even entered the room.

When I walked in, I met a young woman in her 20s, with a hijab and scarf wrapped carefully to create an artful two-tone effect that perfectly matched her lipstick and eyeshadow. She was very chatty, with a loud laugh and several different decorations hanging from her phone. She reminded me forcibly of myself. When I

asked apologetically if I could examine her underneath her headscarf, she asked me if I could just push it aside for the exam, because it had taken her a good half hour to get it wrapped perfectly, and she would rather not redo it. When I started to ask my hushed, carefully sympathetic questions regarding her sexual history, she rolled her eyes and looked embarrassed for me.

"You want to ask me if I've been cut, right?" she said. "I was. My husband and I are dealing with it. You don't have to talk to me like I'm some little oppressed person. We're not all the same."

It transpired that she had wanted to talk to a woman that day not only because she preferred it but also because she had been hoping to get some straightforward answers on the subject of lubricant, and she thought her questions might embarrass her regular doctor. She was disappointed in how little I knew on that subject and impatient with a sympathetic concern that I now realized had actually been condescending. My intentions were good, but my sympathy had come from a place of paternalism in myself that I had not even been aware of before that day.

What I did in that visit might not have been in line with the more obvious examples of racism and Islamophobia, the dramatic examples that are easy for most people to spot, satisfying to decry. But it was much more in line with the kinds of well-intentioned but ultimately frustrating and silencing assumptions that minority groups deal with every day—the sort of thing even the best clinicians have been guilty of at some point, every single one of us. Here I was, complacent in the conviction of my own cultural superiority when it came to feminism and women's rights, thinking that I knew that I was competent and that I could understand. But in practice I had made assumptions based only on reading, not on data from the patient, and in the end did not have enough knowledge to even address the question the patient was there to ask me. I had been condescending without ever intending to be. I had stereotyped her. In the end, she was remarkably patient with me, and I learned a lot from her about the sexual experiences of women following FGM—more, I should note, than she was obliged to teach anyone, and I remain grateful to her. But if this patient had not been such an open sort of person, or if she'd had a long day of explaining, and assumptions, and was too tired to do anything but play along with the role into which I had chosen to put her (as often happens), think of the opportunity for true learning, connection, and communication that I would have missed.

This story may seem like a small, relatively harmless example of stereotyping, but its smallness is part of the point. The Islamophobia and racism typically encountered in a clinical setting, particularly in clinicians ourselves, are not usually about open, obviously violent, hate. The key often lies in the small things, the little shortcuts, the assumptions and stereotypes masquerading as facts, and the little bits of condescension hiding behind good intentions. It is in these small things that we find the seed that grows the bigger fears, the bigger silencing walls, and the barriers to real, meaningful understanding, across cultures and between human beings.

The goal of this book as a whole is to explore Islamophobia in psychiatry, how to recognize it, how to prevent it, and how to treat it. I would argue that the project of a well-designed cultural literacy curriculum is foundational to all aspects of that goal. Islam may be one of the world's major religions, but it is not a cultural

monolith, and viewing it as such has the same dangers as any bias. Ireland and Mexico are both largely Catholic nations, with a long history of colonial involvement, but would we ascribe the same needs and cultural values to an Irish Catholic as we would to one from Mexico? Can the Westboro Baptist Church be reasonably compared to any other Southern US Baptist community? And even within larger groups, there are divisions based on sect, location, family heritage, family culture, etcetera. If we can acknowledge these distinctions, why would we think for a moment that we could lump Rohingya Muslims in with those from Pakistan or Somalia? Education is a wonderful cure for ignorance. But to provide it in broad strokes, inside an educational mindset that is already primed for reductive thinking, will not prevent bias and is less likely to disrupt it than we may want to believe.

If we want to build a better future clinician, if we want to become better clinicians ourselves, we must begin within. We must begin by cultivating a mindset that is open and curious, unafraid to admit our own failings, and able to at least begin interrogating what aspects of our worldview we are taking for granted. In the moment, in the room with a client, what aspects of our experience are we assuming they share? What attitudes are we ascribing to them? And what is our evidence? Where did we get that evidence? How high is its quality? Can we slow down? Can we ask a question without fear of mistakes or embarrassment? Can we show humility when we are caught in a bias, as we inevitably will be, and when we make the errors we will inevitably make?

Bias is pernicious, but it is also efficient. To be truly flexible and open in our thinking, we need to be able to slow down. In many ways, our healthcare system pushes us away from flexibility, from taking our time. Building a better healthcare system, one that is more apt to reward time spent with patients than quantity seen, is an important part of reducing biased thinking and perpetuating the changes in mindset I have discussed. But as we practice self-reflection and humility, and as we teach it, we can find ways inside ourselves to resist.

To combat the evils of Islamophobia, racism, and prejudice, we must begin, or remember, to acknowledge as a profession that there is no such thing as perfect knowledge. There is only perfect learning. And perfect learning is a lifetime of humility, error, correction, processes and tweaks, perspective shifts, and revelations. Only through cultivating a socially conscious, open mindset, one that strives toward both justice and learning, as processes, not as ends, and that resists the efficient rigidity of bias, can we hope to create a generation of clinicians equipped to practice truly good medicine.

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10 Psychiatric Cultural Formulation in the Islamophobic Context

Osman M. Ali and Carol S. North

Introduction

Growing numbers of Muslims in America are affected by Islamophobia, a fear and/or loathing of Islam, Muslims, or those who are perceived as Muslim or sympathetic to Muslims, that is fueled by misinformation and discrimination. Mental health professionals need to provide competent and compassionate care for Muslims who may subsequently develop mental health problems as a result of the psychological distress associated with Islamophobia. Although culture by definition includes religion, for many Muslims, the opposite holds: the religion of Islam defines a culture. However, in some places, the regional culture may be assimilated by Muslims who migrated there. In such cases, it is important to understand which aspects of the person's values, beliefs, and behaviors are derived from the region in which they live and which are derived from their religion.

This chapter uses the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) [1] Outline for Cultural Formulation as a tool to help explain the relevance of Islamophobia to the clinical assessment and care of Muslims presenting with mental health problems. Because the Muslim community is so culturally diverse, the focus here is on those aspects of Islamic culture that is common across Muslims

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from different ethnic backgrounds and nationalities. As such, the formulation may need to be repeated for other aspects of the person's culture to enable an appreciation of the impact of those factors separately. The cultural formulation includes five elements: (1) cultural identity of the individual, (2) cultural conceptualizations of distress, (3) psychosocial stressors and cultural features of vulnerability and resilience, (4) cultural features of the relationship between the individual and the clinician, and (5) overall cultural assessment.

Cultural Identity of the Individual

As faith and identity are often intimately intertwined, clinicians need to have a good understanding of Islam and related terminology, particularly in the context of the current Islamophobic environment. A person identifies as Muslim either by upbringing or by taking the *shahada*. The *shahada* is a sincere declaration in the belief in the oneness of Allah and in the Prophet Muhammad (*sallallahu 'alayhi wa salam)* as His messenger. In Arabic, the term for "God" is "Allah." *Sallallahu 'alayhi wa salam (SAWS)* means "may blessings of God and peace be upon him" and is used out of respect whenever referencing the Prophet *(SAWS)*. Muslims believe in the original scriptures Allah revealed to Prophets Abraham, Moses, David, and Jesus (peace be upon them). Muslims also believe that Allah sent His last and final revelation (called the Qur'an) to Prophet Muhammad (*SAWS*). Muslims have a religious obligation to educate each other and non-Muslims about Islam, but there is a clear direction against forcible conversion [2]. Indeed, there is a plethora of Muslim leaders, historical and contemporary, who have championed and who continue to champion peaceful coexistence of Islam with other faiths.

Although the declaration of faith is a requirement of "qualifying as a Muslim," it is the collection of behavioral elements that solidify one's identity as a Muslim. People learning about Islam are taught the so-called five pillars: *iman* (declaration of faith), *salat* (five daily prayers), *sawm* (fasting in the holy month of *Ramadan)*, *zakat* (annually giving 2.5% of one's wealth in charity), and *hajj* (performing a pilgrimage to the Holy Ka'bah in Mecca). There are other features of Islam that influence a person's character, many of which overlap with those taught in other religions. These features are developed through individual or group study of *Qur'an*, *Hadith* (statements or behaviors of the Prophet *(SAWS)*), and *Seerah* (biography of the Prophet *(SAWS)*). A majority of Muslims in the United States are moderate in their religious practices [3]. Clinicians could use a religiosity scale [4] tailored to determine how much a person self-identifies as Muslim, but simply asking the degree of religiosity may be sufficient [5].

General knowledge about Islam has remained low in the United States. Public opinion about Islam took a sharp negative decline in the last two decades, suggesting that this shift was in part influenced by the events of the September 11, 2001 (9/11) attacks and, in their aftermath, of widespread exposure to the conflation of Muslims with terrorists [6, 7]. In the context of Islamophobia, Muslims who self-impose restrictions in their outward expression of their practice of Islam for fear of

discrimination may experience conflicts with their internalized identity of being Muslim. Additionally, they may feel ashamed or guilty for hiding their identity or carrying on a façade of two selves. For example, although it is one's obligation to perform five daily prayers, a Muslim who is traveling may find it difficult to perform prayers in an airport out of fear of being scrutinized, attacked, arrested, or detained. Or Muslims who wish to perform their prayers during work hours may be faced with choosing between their faith or their job. Women who cover their hair, neck, arms, and figure are practicing one aspect of hijab, a religious mandate for modesty in dress and behavior. Muslim women are very easily identified by their dress and are thus subject to making a difficult personal choice. Some women who wear headscarves have done so with an affirmation of their Islamic identity despite the Islamophobic context, becoming firmer in their religious conviction [8] and reliance on God. Yet there may be others who appear to be Muslim and have traditionally Muslim-sounding names but do not identify themselves as Muslims or practice Islam. They are also subject to the same scrutiny that Muslims face [9]. This can cause such individuals to either develop a disdain for Muslims or to establish a healthier defense: becoming more sensitive to the difficulties faced by Muslims and speaking out against Islamophobia.

One aspect of Islamophobia is the xenophobic rhetoric that Muslims are all foreigners incapable of being true Americans. Muslims in America are diverse in terms of immigration histories, race, socioeconomic status, and practices [10]. Although some historians suggest that Muslims first came to the United States before the fourteenth century, there is more reliable documentation that up to 15% of African slaves brought to America beginning in the seventeenth century were Muslims [11]. Indigenous Muslims also include Latino and White American reverts (converts) both in early America and more recent times. Immigrant Muslim populations include those that came to the United States in the nineteenth and twentieth century, of which there were multiple waves. The first came in the late 1800s to the early 1900s, seeking economic prosperity as they were mostly farmers or manual laborers from the former Ottoman Empire. The earliest mosque in America was founded in 1929 by Syrian American Muslims [12]. From them are multiple generations of Muslims who have been born and raised in America. The Immigration Act of 1924 completely excluded immigrants from Asia and most countries in the Middle East. The 1965 US Immigration Act allowed Muslim scientists, engineers, and skilled workers, mostly from South Asia but also from countries around the world, to immigrate to the United States seeking prosperity and growth. In more recent decades, immigrants include those seeking asylum from genocide or wars (e.g., Bosnia, Iraq, Afghanistan, Myanmar), but they do not account for significant numbers of Muslims in America. The ancestors of Muslims in America today hail from almost every country around the world, and both Muslims born in America and foreign-born Muslims express pride in being American [13].

Understanding the significance of the Arabic language for Muslims and a person's given or chosen name is an important part of assessing the cultural identity of Muslims or those perceived to be Muslim. Only 15% of Muslims are Arab, but many Muslims who are non-native Arabic speakers may learn Arabic because it has

a special status in Islam: it is the language of the Qur'an and Hadith and of the Hereafter. Some learn enough to read and correctly pronounce passages from the Qur'an, although they still need translations to understand it, but fewer learn enough to be conversant. Arabic is the predominant language spoken across the Middle East, not just in Saudi Arabia and not just by Muslims. Thus, for example, a person can be considered Arab but hail from as far away as Morocco, where the culture and nuances of practicing Islam are quite different from those of other Muslims in the Middle East.

Christians from the Middle East who speak Arabic and have names derived from Arabic might be incorrectly perceived as Muslim and subject to Islamophobic bias incidents. Conversely, some Muslims may not be recognized as Muslim just by their name, as there is no requirement to have a traditionally "Muslim name" per se. Traditionally Muslim names include a variation of the name of the Prophet *(SAWS)*, his supporters, or *Abdul* (Arabic for "servant of") followed by one of the 99 attributes of Allah mentioned in the Qur'an. Although such names are usually adopted by those who become Muslim, some choose to maintain their name given at birth and some surnames unrelated to Islam have been passed on through generations of Muslims.

Cultural Conceptualizations of Distress

How a person understands the cause of or contributing factors for distress or illness can influence what the person would do to address the problem. Muslims might ascribe distressing experiences to one or a combination of multiple factors: (1) medical or psychological causes, (2) stressful social circumstances, (3) spiritual or religious issues, (4) moral problems, or (5) supernatural influences.

Muslims face barriers to appreciating the medical model for mental distress, as they have low levels of mental health literacy [14–16]. The medical model of mental illness was more acceptable in Islamic societies during the Medieval period when Europeans largely held to nonmedical causes of distress. Muslim scholars have a rich tradition, dating back hundreds of years before modern psychiatric roots established in Europe, of describing psychological aspects of human existence [17]. The Persian physician Abu Bakr Muhammad ibn Zakariya al-Razi (865–925, also known as *Rhazes*) seemed to appreciate that somehow some patients' physical symptoms were related to their mental states [18]. Islamophobic narratives that lack consistent recognition of Muslim scholarly contributions to science, medicine, and psychiatry increase the difficulties of clinicians and community educators in convincing Muslims of the compatibility of their religious traditions and the medical model of mental illness.

Muslims understand that mental distress can result from stressful life circumstances. In the context of developing the first Islamic community, the Prophet *(SAWS)* and his companions experienced depression, despair, and anxiety which they addressed by maintaining steadfast to the teachings of their Creator, supporting each other in difficult times, and making private supplications in their daily prayers

[19]. Therefore, Muslims today who experience depression or anxiety in the context of life stressors seek to alleviate their symptoms in the same way.

Muslims may interpret depression and anxiety as a religious or spiritual problem—a relative lack of certitude in faith or a lack of complete reliance on the Almighty—as supported by verses from the Qur'an similar to the following:

> And whoever turns away from My remembrance—indeed, he will have a depressed life...
> *– Holy Qur'an, Verse 20:124*

In Islam, although one has choice and free will and faces consequences for one's decisions, only the Omnipotent (one of 99 names used in the Holy Qur'an that are attributes of Allah) determines what will happen. Therefore, Muslims who experience depressive and anxious symptoms such as helplessness, hopelessness, nervousness, or fear might believe they need to spend more time appreciating, remembering, and trusting in God.

Similarly, Muslims who are suffering from depression or hardship might understand these experiences from a moral perspective. They may believe that their own moral failings or bad deeds are causing them to be punished, tested by God, or requiring atonement. Some may even decline treatment or take solace in that, although they are experiencing hardships now, some of their sins may be expunged, which would save them from facing punishment many 1000-fold greater in the afterlife.

In addition to or in lieu of the conceptualizations described above, Muslims maintain a belief in the possibility of supernatural causes of distress. As described in the Qur'an, there are things that exist which cannot be proven or seen. One example is the Jinn (not to be confused with the modern-day depictions of a wish-granting genie in a bottle). Some Muslims might believe that a Jinn has possessed (or influenced) their family member who is experiencing epilepsy or psychotic symptoms [20]. Other forms of the unseen that Muslims may believe are responsible for mental problems are the Evil Eye and Black Magic [21]. The belief in the ill effects of a malevolent and envious glare is found in cultures and religions around the world. Muslims might seek remedy through *Ruqyah*, the recitation of specific Qur'anic verses either privately or with the assistance of a faith healer. Where the practice of *Ruqyah* is not regulated, Muslims, particularly women who are in a vulnerable state, are subject to mistreatment and abuse by self-proclaimed healers. Prophetic guidance encourages turning to prayer rather than either attempting to practice magic or placing credence in the power of individuals (e.g., exorcists) over the sovereignty of God.

Psychosocial Stressors and Cultural Features of Vulnerability and Resilience

The particular stressors faced by Muslims in America may be conceptualized using a case example that highlights the distress that comes from difficulty with (1) meeting basic needs, (2) Islamophobia-related events, and (3) and acculturation/affiliation.

Consider the fictionalized case of Mrs. A, a 58-year-old Iraqi Muslim woman who is brought to a psychiatrist at a community mental health clinic by her refugee resettlement agency caseworker, in search of medication for insomnia. The evaluation reveals that her sleep problems are related to a depressive episode, and she has not recovered from losing her only son who was killed in the months following the US-led invasion of Iraq.

Medications might help her sleep through the night and relieve some depressive symptoms, but the clinician needs to appreciate the psychosocial context of a refugee and consider additional services that may be needed.

Mrs. A is provided an allowance and food stamps from the refugee assistance agency to address her basic needs, and she is enrolled in Medicaid, giving her access to basic healthcare. A local mosque has provided temporary housing and spiritual support through the imam. Eventually she and her husband will be expected to become self-sufficient, but finding employment will require learning better English, a demanding undertaking. They travel to a nearby agency that offers free English as a Second Language (ESL) classes. Including Mrs. A and her husband in activities supported by non-Muslim groups offers these new Muslim Americans a hopeful view of acceptance by other Americans. However, she still experiences anxiety when using public transportation as she is clearly identified as Muslim by her dress, and she experiences subtle and covert bias behaviors and comments (microaggressions) [22].

Islamophobia may manifest in the form of acts of protest by private citizens; discriminatory proclamations by public officials; derogatory statements and depictions in mainstream media; verbal harassment or discrimination in public spaces, the workplace, or schools; desecration of places of worship; government profiling; and violent hate crimes against individuals. Using a population-adjusted analysis of rates, Rubenstein concluded that anti-Arab and anti-Islamic hate crimes after 9/11 were at “levels similar to gay people, Jewish people and blacks” [23]. Although the levels receded, anti-Muslim assaults have again risen in recent years according to an analysis of data compiled by the Federal Bureau of Investigations (FBI) Criminal Justice Information Services Division [24]. Women wearing Islamic headscarves are particularly vulnerable to discrimination in public places [25].

The clinician will need to inquire if Mrs. A has experienced such incidents in the United States and if so, their intensity, frequency, and psychological impact. The clinician will further need to screen for any traumatic experiences prior to immigration that may make her particularly vulnerable to these stresses, as some Muslim immigrant refugees have faced Islamophobic state-sanctioned repression, persecution, rape, and mass killings [26].

Muslims born in the United States and foreign-born Muslim Americans alike face acculturalization pressures [27] and affiliation challenges, which may be exacerbated in the context of an Islamophobic environment. Curiously, however, it has been reported that many foreign-born Muslims (who may appear less acculturated in their dress and mannerisms) are less critical of American society than are American-born Muslims [28].

For Mrs. A, maintaining a connection to the mosque provides continuity with religious activities of daily life familiar to her back in Iraq. Community support and religion are among the factors associated with resilience in forcibly displaced populations [29]. Some of her fellow congregants who are indigenous Muslims or long-time immigrant citizens may themselves be struggling with anxiety arising from scrutiny, monitoring, and questioning of their loyalty as a citizen [30].

Cultural Features of the Relationship Between the Patient and the Clinician

The therapeutic relationship between a Muslim and non-Muslim can be enhanced or impaired depending on how the clinician handles the patient's experience of the clinician related to the patient's assumptions, attitudes, or prior experiences with people with apparent similarities to the clinician. Similarly, clinicians can bring their own assumptions, attitudes, or prior experiences involving people with apparent similarities to the patient, which could interfere with appropriate assessment and treatment of individual patients. Here we discuss three scenarios: (1) a non-Muslim clinician is working with a Muslim patient, (2) a Muslim clinician is working with a non-Muslim patient who is unfamiliar with Islam, and (3) the clinician and patient are of the same religious background, Muslim or non-Muslim.

Muslim patients may have concerns about non-Muslim healthcare professionals. Requests for a same-gender clinician are appropriately accommodated on the basis of religious beliefs. Because perceptions of abuse or discrimination in the wake of 9/11 have been generally found to be associated with worse health outcomes [31], it is reasonable for non-Muslim clinicians to be circumspect about their gaps in knowledge about Islam and make efforts to learn about the patient's perceptions of the clinician as non-Muslim. It is important for the clinician to be aware that the patient's interpretation of Islam may or may not reflect the perceptions of other Muslims. Further, a therapist would not want to ascribe to the religion any characteristics arising from the individual's personality traits or behaviors. Clinicians need to be aware that, although their position of authority may be highly regarded by Muslims, in Islam the ultimate source of healing is not the medicine, not the relationship, and not the doctor; it is the Giver of Life (one of 99 names used in the Holy Qur'an that are attributes of Allah).

When the clinician is Muslim and the patient asks the clinician questions about Islam or about the clinician's background, this may simply reflect curiosity about the unfamiliar. The clinician need not assume that the patient is Islamophobic and need not become defensive. Rather, merely providing some education may relieve the patient's anxiety and redirect the conversation to clinical matters. However, Muslim physicians report experiencing discrimination in the workplace [32]. In such situations, patients who exhibit clearly Islamophobic comments or behaviors, such as requesting "any doctor but a Muslim," need to be approached in terms of patient refusal to see a healthcare professional solely on the basis of race or ethnicity.

When the clinician and patient are both Muslim or when they are both non-Muslim, the clinician needs to maintain a professional stance regarding sociopolitical and/or Islamophobic events described in the news media. Regardless of how clinicians feel, it is more important for them to allow patients to express themselves and not cloud, suppress, or falsely activate a response because of what they anticipate that the patient might expect. However, whenever a patient begins to speak of hatred based upon misinformation, it is perfectly appropriate and responsible for the clinician to gently provide education and to ask clarifying questions that may introduce alternative or more balanced points of view.

Overall Cultural Assessment

Inherent within the diagnostic criteria of DSM disorders is the importance of ensuring that cultural factors do not better explain particular behaviors or symptoms. Therefore, making a diagnosis in Muslim patients logically begins the same way that it does for non-Muslims.

Muslims are more likely to present first to nonmental health professionals for mental health-related issues. This is partly due to the family or community stigma against mental illness. Government policies and statements by public officials that are perceived to be Islamophobic worsen the impact of stigma as a barrier to care. For example, executive orders restricting immigration of those from predominantly Muslim countries may further the reluctance of Muslims with immigration status concerns to seek formal psychiatric services.

Muslims may seek to address their problems without professional assistance through focusing on the essential practices of Islam or seeking guidance from books that can teach supplications to address their problems. Praying or fasting more often are reflections of religiosity, which has been found to be significantly associated with a greater number of character strengths among Muslim youth [33].

Alternatively, Muslims may seek the assistance of elders of a clan particularly for domestic disputes, imams (religious prayer leaders) for mental health-related issues [34], those who assist with *Ruqyah* (incantation of supplications or parts of Qur'an in hopes of bringing about cures), *hakims* or those who practice *Tibb Nabi* (Medicines of the Prophet *(SAWS)* which are based on naturally occurring plants and foods), or Ionian (*Unani)* medicine (Greco-Arabic medicine originally based on the humoral system, practiced in the Middle East and South Asia).

Although Muslims believe that the ultimate source of healing is from Allah, they appreciate that the more proximate source may be from medical treatment. The Qur'an encourages hope: for every illness, there is said to be a cure. Treatments involving alcohol or gelatin, which are usually forbidden for Muslims to consume, are made permissible for the purposes of medical treatment if no alternatives exist. The Islamic prohibition against talking ill about others might deter people from engaging in psychotherapy. In this case, the purpose of talking about others as part of psychotherapy might need to be explained to Muslim patients. Some aspects of psychotherapy are very much in line with Islamic teachings such as mindfulness, gratitude, and acceptance practices.

As suggested earlier, the cultural formulation may need to be repeated so the clinician can fully appreciate the clinical relevance of other cultural features of the individual. For example, African American Muslims not only contend with Islamophobia, but they also face socioeconomic disadvantages and barriers to accessing mental healthcare resulting from longstanding racial discrimination. Notably, Black Americans began to embrace Islam in the 1930s and during the civil rights movement to reclaim their Islamic heritage and to assert Islam's principles of racial equality and social justice.

Mental healthcare professionals are reminded, in their efforts to provide culturally and religiously sensitive care, not to overlook some of the universal aspects of care that span all cultures and religions: conducting objective risk assessments, using culturally and linguistically sensitive psychometric scales, addressing reversible biological issues, making appropriate referrals, and appreciating stressors that are common among people of any faith.

Conclusions

- Islamophobia has the potential to worsen psychological distress experienced by a growing American Muslim population.
- Muslims first seek services from nonmental health professionals for psychological or behavioral problems resulting from their beliefs about the religious or supernatural components of their problems and also from stigma.
- By increasing stigma, Islamophobia worsens barriers for Muslims to seek formal psychiatric services especially if they believe mental health professionals may be influenced by Islamophobic rhetoric.
- Mental health and wellness among Muslims are unlikely to be addressed adequately by clinicians who do not appreciate the impact of Islam on the individual seeking care.
- Individual clinicians can enhance the quality of their diagnosis and care of Muslims by using a cultural formulation as described in DSM-5.
- Until perceptions change and Muslims are more broadly accepted into American society, innovative changes in service delivery may be necessary to ensure that the most vulnerable among Muslims in America receive appropriate and timely mental healthcare.

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11 Clinical Assessment Tools for the Culturally Competent Treatment of Muslim Patients

Neil Krishan Aggarwal

Introduction: The Scope of Culture and Cultural Competence

The concept of culture has captivated the imaginations of social and behavioral scientists who have developed multiple – even contradictory – definitions for hundreds of years [20]. For this reason, it is crucial to begin with a clear definition for culture. In DSM-5, culture is defined as "systems of knowledge, concepts, rules, and practices that are learned and transmitted across generations" which can include "language, religion and spirituality, family structures, life-cycle stages, ceremonial rituals, and customs, as well as moral and legal systems" ([11], p. 749). In accordance with this definition, this chapter addresses systems of knowledge, concepts, rules, and practices that are learned and transmitted insofar as they relate to Muslim patients seeking mental health care. DSM-5 encourages clinicians to adopt a person-centered approach: "Cultures are open, dynamic systems that undergo continuous change over time; in the contemporary world, most individuals and groups are exposed to multiple cultures, which they use to fashion their own identities and make sense of experience. These features of culture make it crucial not to overgeneralize cultural information or stereotype groups in terms of fixed cultural traits" ([11], p. 749). This definition challenges clinicians to assess the openness and dynamism that characterize how we all construct identities and interpret experiences of health and illness – whether we are Muslims or not, patients, or clinicians – in order to avoid the risk of perpetuating stereotypes based on our perceptions of a patient's culture from our vantage point as clinicians. In the case of Muslim patients, this requires clinicians to move beyond presuppositions that are rooted in monolithic conceptions of religion to tailor individual treatments for patients.

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Why should clinicians care about cultural competence? To start, cultural competence is now mandated throughout all levels of medical education. The National Academies of Sciences, Engineering, and Medicine define cultural competence as "the ability of an organization or an individual within the health care delivery system to provide effective, equitable, understandable, and respectful quality of care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs of the patient" ([36], p. 12). Implicit in this definition is the need for clinicians to obtain and then act upon patient cultural health beliefs and practices. At the undergraduate medical level, the Association of American Medical Colleges deems cultural competence initiatives for clinicians as crucial to reducing health disparities: "Culturally responsive health care is a key strategy to reduce health care disparities and promote health equity. Education and training are important, but only represent one element of the complex web of factors that advance quality health care" ([12], p. 9). At the postgraduate residency level, the American Board of Psychiatry & Neurology [9] delineates multiple areas where trainees *must* demonstrate proficiencies in cultural competence: eliciting a sociocultural history; developing a case formulation that incorporates neurobiological, phenomenological, psychological, and sociocultural issues in diagnosis and management; creating a treatment plan that synthesizes biological, psychological, and sociocultural factors; integrating sociocultural interventions within evidence-based psychotherapies; eliciting the experience, meaning, and illness explanations of the patient and family; mastering sociocultural knowledge of illness etiologies, human development, and variations in prescribing practices; and communicating effectively with patients and families. Finally, the independent, nonprofit Joint Commission – which accredits and certifies American health-care organizations – specifies that cultural competence is "no longer considered to be simply a patient's right, effective communication is now accepted as an essential component of quality care and patient safety" ([21], p. 1). A decade ago, cultural competence could be dismissed as a well-meaning intervention rooted in political correctness [41]. Now, it is mandatory.

Moreover, cultural competence reflects an appreciation that cultural factors are central to all work in mental health even though such factors are often taken for granted. Culture influences the circumstances of when, where, how, whom, and why patients narrate their experiences of illness and care [22], i.e., the implicit rules that govern information exchange in medical encounters. Culture determines the systems of knowledge, concepts, rules, and practices that clinicians use to interpret patient illness experiences by finding symptom-based equivalents in classification systems such as the American Psychiatric Association's (APA) various *Diagnostic and Statistical Manuals of Mental Disorders* [25]. Culture shapes patient expectations of acceptable and unacceptable treatments, therapeutic effects, side effects, durations of treatment, and levels of functional recovery through everyday knowledge that is transmitted among family members and friends [31]. Culture manifests in the intersubjective reenactments of transference and counter-transference during the patient-clinician encounter, as each party projects prior modes of social interaction upon one another [2, 16]. Finally, culture informs the system of rules and practices that organize the delivery of health services within organizations [26]. Every

health-care encounter can be construed as an opportunity for making sense of interpersonal experiences at the intersection of patient, clinician, and institutional cultures, and cultural competence can improve the cultural effectiveness, responsiveness, and relevance of clinical services for all people [24]. As long as clinicians lack the ability to diagnose mental illnesses and assess the efficacy of treatments through radiological and laboratory biomarkers, diagnostic assessment and treatment planning remain acts of double interpretation: the patient must first articulate a narrative by interpreting personal experiences that the clinician must then interpret through professionalized systems of knowledge [27]. To avoid overgeneralizing cultural information or stereotyping groups based on our perceptions of fixed cultural traits ("the Black patient," "the Hispanic patient," "the gay patient"), clinicians must conduct routine cultural assessments with all patients, even those who appear similar to us, by obtaining and acting upon patient cultural health beliefs and practices. The following section examines how publications on cultural competence for Muslim patients in mental health settings address these points.

A Review of Existing Cultural Competence Models for Muslim Patients

The following review of the mental health literature exemplifies current recommendations for the culturally competent treatment of Muslim patients. The search terms "(islam *or* muslim) *and* (culture *or* cultural) *and* competenc* *and* psychiatr*" were entered into PubMed in September 2017 to retrieve articles of interest. Every effort was made to make the search evidence based, with the terms originating from a systematic review on culturally competent communication for minority populations who receive mental health services [14]. Although not all medical databases were searched, PubMed is the most widely accessed medical database in the world among psychiatrists [34]. Articles of interest were included by screening titles and abstracts according to whether they reported any content on cultural competence strategies with Muslim patients in mental health settings.

The initial search retrieved only 11 results, demonstrating a dearth of literature relative to the size of the world's Muslim population: as of 2010, there were an estimated 1.6 billion Muslims, with Islam comprising the second largest faith tradition after Christianity, and projections suggest that the number will grow to 2.76 billion (29.7% of the world's population) by 2050 [18]. Of these 11, 6 results were excluded for irrelevance; their topics covered various aspects of mental health in Arab countries, cross-cultural parenting styles, occupational therapy among Afghan clients in Australia, cultural competence for medical students through online simulations, the need for secularism in hospital practice, and concepts of mental health in Islamic law. Of the five remaining articles that were retrieved, one pointed out that there are no actual scientific studies on cultural competence with Muslim patients [8]. Notably, the remaining four articles suggested that clinicians could use the DSM-IV version of the OCF as a tool for cultural competence among Muslim patients. One article recommended adaptations to the OCF for nurses [38], and the other three articles discussed using DSM-IV OCF-based interviews in individual

Table 11.1 Cultural competence recommendations for Muslim patients in mental health settings

Reference	Cultural competence recommendation
Bäärnhielm and Scarpinati Rosso [13]	"In the two cases described here, we have exemplified how the cultural formulation can be valuable in increasing the validity of nosological categorization and in enhancing the overall understanding of patients' situation and perspective. The narrative approach to data collection encourages patients to talk about suffering and distress on the basis of their daily life activities and from their own frame of experience and meaning-making" (p. 423)
Groen [19]	"It was through his self-representation that the patient engaged the world around him and addressed questions about what had happened to him. Speaking about his cultural identity for the first time in 16 years allowed him to open up his isolated position and make room for change. This would likely have not come about had the intervention focused solely on the cultural explanations of his illness, rather than examining his identity and his relationship to cultural norms and expectations. In this respect, cultural identity in the CF is more than just the background to cultural explanations of the illness of the individual" (p. 461)
Rohlof et al. [40]	"The CF [cultural formulation] is [a] useful method in mental health care and produces information that challenges the stereotypes of both clinicians and patients. Working with the CF stimulates clinicians to ask questions beyond than those included in the usual assessment procedures" (p. 502)
Rassool [38]	"When assessing a Muslim patient and constructing a cultural formulation, it is important to examine the patient's cultural and religious identity, patient's explanatory model of their problem or illness, cultural factors related to the psychosocial environment, nurse–patient therapeutic relationship, and treatment interventions" (p. 322)

case studies with Muslim patients [13, 19, 40]. By way of illustration, Table 11.1 lists recommendations for clinicians on how to achieve cultural competence with Muslim patients in these four publications.

Four publications named the OCF as a useful assessment tool to evaluate Muslim patients in a culturally competent manner. Two articles came from the Netherlands [19, 40], the third came from Sweden [13], and the fourth came from Mauritius [38], suggesting the OCF's growing international importance. Notably, *none* of the articles made broad, sweeping generalizations about "dos and don'ts" for Muslim patients, revealing that this scholarship may be nascent but falls in line with greater trends to not stereotype patients based on group affiliations. The next session provides a brief history of the OCF and its revision for DSM-5 so that clinicians can use the current version with Muslim patients. I draw on my experiences as an advisor to the DSM-5's Cross-Cultural Issues Subgroup (DCCIS) [4].

The OCF in DSM-IV and DSM-5 and the CFI

The publication of the OCF in DSM-IV has been considered a landmark moment for cultural psychiatry, an acknowledgement that the assessment of cultural factors is relevant to the practice of all psychiatrists and not just those interested in culture

and mental health [35]. Developed through a series of literature reviews conducted by a Group on Culture and Diagnosis from 1991 to 1993 that was sponsored by the National Institute of Mental Health, the OCF consisted of a list of cultural topics that were organized under four domains for clinicians to evaluate [30]. The four domains were the (1) cultural identity of the individual; (2) cultural explanations of illness: (3) cultural interpretation of psychosocial stressors, supports, and levels of functioning: and (4) cultural elements of the patient-clinician relationship; a fifth domain encouraged clinicians to summarize information that could be pertinent to diagnostic assessment and treatment planning [10]. Cultural psychiatry has historically developed through an interdisciplinary exchange among anthropologists, psychologists, and psychiatrists [23], and theories from these fields influenced the development of all four domains, such as differentiating between inherited and ascribed personal identities (domain one), eliciting explanatory models of illness and treatment (domain two), examining the role of social networks such as family or friends in providing support or stress throughout the duration of the illness (domain three), and scrutinizing the role of bias and power differentials in the patient-clinician relationship (domain four) [3]. A review of all OCF studies from when it was first published in 1994 until 2014 found that educators have used the OCF for training in Canada, Denmark, India, the Netherlands, Norway, Spain, Sweden, the United Kingdom, and the United States [32].

Despite this international dissemination, case studies have identified problem with its actual implementation beyond the classroom into clinical settings. First, DSM-IV did not include guidance as to whether the OCF should be used with all individuals or only those for whom culture appears to be salient [17]. Second, some of the OCF's domains have been criticized for being repetitive: for example, domain two may rehash information from the history of present illness, and domain three may duplicate the social history [15]. Third, the literature reviews to develop the OCF for DSM-IV were not published, so it is unclear how the OCF acquired its current form as some topics seem to be missing, such as adaptations for immigrants and refugees, the elderly, and children [42]. Finally, the OCF's brief outline format has inspired multiple interview guides around the world, proving its popularity as a cultural assessment tool but also hindering generalizable research since there had been no consensus set of questions with implementation guidelines for clinicians [7].

In response to these criticisms, the DCCIS revised the OCF and developed a Cultural Formulation Interview (CFI) to provide concrete guidelines and discrete content domains for clinicians. The revision began with a literature review of all studies on the OCF or on any topics that were addressed in its individual domains in Danish, Dutch, English, French, Norwegian, Spanish, and Swedish [32]. The DCCIS conducted a search across these languages in recognition of the OCF's growing international uptake. Based on these findings, the DCCIS created a set of 14 questions through expert consensus that were field tested in a trial of 321 patients and 75 clinicians in six countries, showing that patients and clinicians rated the CFI as possessing high feasibility, acceptability, and utility [33]. The DCCIS took a subsample of interviews between patients and clinicians to revise the field trial questionnaire into the 16-item version that now appears in DSM-5 [11] based on perceptions of the field trial CFI's strengths [6] and weaknesses [5].

The DCCIS recommends that all clinicians begin every clinical assessment with the CFI. It was designed for use with patients who have any diagnosis in all inpatient, outpatient, emergency, and transitional settings. This general approach acknowledges that all patients and clinicians possess cultural backgrounds that can affect clinical care, countering an older generation of scholarship which assumed that clinicians only needed to assess cultural for patients from racial and ethnic minority backgrounds [1]. The DCCIS has also identified five situations when the CFI may be especially helpful: (1) difficulties in diagnostic assessment based on the clinician's unfamiliarity with the patient's background, (2) uncertainty about how DSM criteria relate to the patient's symptoms, (3) difficulties in judging illness severity or impairment, (4) disagreements between the patient and clinician over treatment planning and continuity or care, and (5) limited patient treatment adherence and engagement in services [11]. Apart from the CFI, the DCCIS has created an informant version and 12 supplementary modules that expand the number of questions for a cultural domain of interest (such as cultural identity or religion, spirituality, and moral traditions) or customize questions for certain populations (such as children and adolescents, immigrants, and refugees). To promote the CFI's dissemination, the APA has made these interviews available online, free of cost, which can be found by searching "APA CFI." The rest of this chapter explains the 16 items in the core CFI which consists of four domains and can be used with all patients. It avoids broad recommendations for "the Muslim patient" out of respect for the tremendous heterogeneity that characterizes 1.6 billion people, preferring instead to concentrate on how clinicians can use the questions with individual patients.

The first domain is known as the *Cultural Definition of the Problem* and consists of three questions. The first question – "What brings you here today?" – is designed to be open ended so that patients can share their views of the current experience. This question also includes a prompt in case clinicians wish to elicit more information: "People often understand their problems in their own way, which may be similar to or different from how doctors describe the problem. How would you describe your problem?" This prompt is intended to provide reassurance by acknowledging that a clinician's professional, biomedical system of knowledge is but one of many ways to make sense of the patient's experience. The second question – "Sometimes people have different ways of describing their problem to their family, friends, or others in their community. How would you describe your problem to them?" – further explores the circumstances of when, where, how, whom, and why patients narrate their experiences of health and illness outside of health settings. This question allows for the possibility that patients may use nonmedical descriptions when communicating with family and friends. The third question – "What troubles you most about your problem?" – helps clinicians understand what is at stake for patients in the current moment of distress [28]. DSM-5 frequently notes in the diagnostic criteria for disorders that symptoms must cause impairments in social, occupational, or other important areas of functioning, and the third question obtains a description of severity and functional impairment in the patient's own words.

The second domain of the CFI is known as *Cultural Perceptions of Cause, Context, and Support* and consists of questions four through ten. The fourth question – "Why do you think this is happening to you? What do you think are the causes of your

[PROBLEM]?" – reflects the long-standing professional interest in medical anthropology and cultural psychiatry on the patient's explanatory models of illness [29]. The placeholder "[PROBLEM]" can be substituted with the patient's cultural terms and phrases throughout the interview in order to build rapport, in recognition that patient linguistic registers may vary based on whom they are with and provide access to different types of knowledge when used respectfully [37]. A common example in the United States is the difference between a clinician's reference to "postpartum depression" and the more colloquial understanding of the same phenomenon as "the baby blues." The fifth question encourages patients to contemplate how family members or friends would name the cause of illness as a way of operationalizing DSM-5′s approach to culture as systems of knowledge and concepts that are socially learned and transmitted. The sixth and seventh questions – "Are there any kinds of support that make your [PROBLEM] better, such as support from family, friends, or others?" and "Are there any kinds of stresses that make your [PROBLEM] worse, such as difficulties with money, or family problems?" – attempt to situate the patient's experiences within interpersonal relationships, especially family structures.

The eighth, ninth, and tenth questions also belong to this domain but transition the interview toward a discussion of the patient's identity. The questions in this series begin with a prompt that clinicians can use to clarify the meaning of cultural identity in mental health settings without making any assumptions of how patients will respond: "Sometimes, aspects of people's background or identity can make their [PROBLEM] better or worse. By background or identity, I mean, for example, the communities you belong to, the languages you speak, where you or your family are from, your race or ethnic background, your gender or sexual orientation, or your faith or religion." This prompt recognizes that individuals are exposed to multiple cultural affiliations from which they construct personal identities and make sense of their experiences. The eighth question asks patients: "For you, what are the most important aspects of your background or identity?" This question helps clinicians avoid overgeneralizing cultural information or inadvertently stereotyping patients based on perceptions of a patient's demographic traits. For Muslim patients, it is important to not overemphasize the role of religious scriptures (such as the Quran and Hadith) in influencing everyday life practices or to conversely assume that religious beliefs and practices are irrelevant, particularly for those living in secular multicultural societies in North American and Europe. The ninth question links cultural identity to the presenting problem: "Are there any aspects of your background or identity that make a difference to your [PROBLEM]?" This question avoids the "clinical anthropologist syndrome" of clinicians demonstrating irrelevant and exaggerated curiosity about a patient's identity [16]. In this way, the CFI responds to the National Academies of Sciences, Engineering, and Medicine definition of cultural competence by helping clinicians become responsive to diverse cultural health beliefs and practices. The tenth question encourages patients to consider how their identities may impact other aspects of their lives such as post-migration acculturation for immigrants and refugees, gender expectations, or intergenerational conflicts: "Are there any aspects of your background or identity that are causing other concerns or difficulties for you?" This additional information may help clinicians locate patients in their life contexts outside of health settings.

The third domain is known as *Cultural Factors Affecting Self-Coping and Past Help-Seeking* and consists of the 11th through 13th questions. These questions clarify how patients have sought care for the illness within and outside of the biomedical system [39]. The 11th question asks how patients have handled their current problem: "Sometimes people have various ways of dealing with problems like [PROBLEM]. What have you done on your own to cope with your [PROBLEM]?" The 12th question expands this inquiry to include various sources of treatment: "Often, people look for help from many different sources, including different kinds of doctors, helpers, or healers. In the past, what kinds of treatment, help, advice, or healing have you sought for your [PROBLEM]?" A probe question asks patients to rank these sources of treatment: "What types of help or treatment were most useful? Not useful?" The clinician can use this information to develop a treatment plan that reflects the patient's positive experiences of past care. The 13th question asks about past barriers to treatment: "Has anything prevented you from getting the help you need?" A prompt lists common barriers to care so that clinicians can appraise and work with a patient's current resources: "For example, money, work or family commitments, stigma or discrimination, or lack of services that understand your language or background?" By taking such barriers into consideration, patients and clinicians may be able to negotiate a treatment plan that anticipates past problems with treatment engagement in the hope of optimizing recovery.

The final three questions comprise the last domain of the CFI, *Cultural Factors Affecting Current Help Seeking*. These questions shift the interview from a discussion of the past to the present. The 14th question clarifies perceived needs and expectations of help: "What kinds of help do you think would be most useful to you at this time for your [PROBLEM]?" The 15th question considers the role of a patient's social network in shaping treatment expectations: "What kinds of help do you think would be most useful to you at this time for your [PROBLEM]?" The final question addresses possible clinician-level barriers by patient concerns such as perceived racism, language differences, or cultural differences that could endanger rapport: "Sometimes doctors and patients misunderstand each other because they come from different backgrounds or have different expectations. Have you been concerned about this and is there anything that we can do to provide you with the care you need?" The intention is to validate patient concerns and resolve such differences. The clinician's directness may reassure patients that differences of opinion can be openly discussed, a way for clinicians to model the resolution of potential conflicts without the presence of antagonism.

Conclusion

This chapter has discussed the DSM-5 OCF and CFI as clinical tools that can advance culturally competent treatment among Muslim patients. These tools depart from older models of cultural competence based on race or ethnicity by eliciting cultural health beliefs and practices in an individualized patient-centered way. Clinicians now have a standardized series of guidelines and questions to complete

cultural assessments with patients, raising hopes that the next round of DSM revisions can incorporate the experiences of those working with the world's second largest faith tradition. In my other chapter, I address how clinicians can address Islamophobia through clinical vignettes, some of which draw upon information elicited through the CFI.

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Part II

Psychiatric Implications of Islamophobia

12 Transference and Countertransference in Addressing Islamophobia in Clinical Practice

Neil Krishan Aggarwal

Introduction: Defining Islamophobia and Its Effects on General Mental Health

This chapter discusses the clinical manifestations of Islamophobia within mental health settings and how clinicians can transform awkward or even negative encounters into opportunities for therapeutic advancement. Islamophobia has been defined as "indiscriminate negative attitudes or emotions directed at Islam or Muslims" ([10], p. 1581). Negative attitudes and emotions directed toward Islam and Muslims have long existed throughout European scholarship – across the gamut of the behavioral, human, social, and natural sciences – since the eighteenth century, mirroring the global competition between the Muslim Ottoman Empire and the Christian British and French Empires for control over Asia, Africa, and the Middle East [24]. In its current form, the term Islamophobia appeared in the 1990s to characterize the experiences of social discrimination and marginalization of the Muslim diaspora, specifically in the United Kingdom [20]. After the terrorist attacks of September 11, 2001, interest in Muslim communities grew rapidly, as evidenced by a 900% increase in the annual number of academic publications indexed in the psychological database PsycINFO in the decade after the attacks compared to the decade before [7]. However, systematic reviews of this mental health scholarship have shown that this interest in Islam disproportionately relates to the psychology of terrorism, with authors relying on personal anecdotes or theoretical arguments to explain violence committed by extremists against civilians as the result of literalist interpretations of religious texts, rage against Euro-American geopolitical dominance, or pathologies inherent to Muslim families [2]. This publication bias is not isolated to scholarly communities and reflects negative attitudes and emotions

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toward Muslims within society: in a 2015 online survey, only 33% of 1001 Americans expressed favorable attitudes toward American Muslims, a drop from 48% compared to a poll conducted in 2010 [9].

A nascent line of scholarship that has been conducted with actual human subjects has documented Islamophobia's damaging psychological effects on Muslim populations around the world. In a sample of 222 British Muslims, 76.3% of respondents reported an overall increase in facing discriminatory experiences, and more than a third ($n = 70$, 35.6%) met cutoff scores on the 12-item General Health Questionnaire for common mental disorders [26]. During surveys with 152 Muslim Americans (92 males, 60 females), of whom three-quarters were educated with at least a college degree, 53% reported personal experiences with discrimination or hate crimes since the 9/11 attacks, and men who reported experiences of discrimination also showed higher levels of subclinical paranoid ideation on the Perceived Religious Discrimination Scale [23]. Muslim Americans who participated in a focus group discussion identified major types of Islamophobia that they confronted in everyday life: (1) religious stereotypes against Muslims, who were often ridiculed as terrorists; (2) the "exoticization" of Muslim apparel such as headscarves, leading to negative comments or inappropriate responses from strangers such as touching clothes; (3) statements about the pathological nature of Muslim beliefs of practices; (4) assumptions that all Muslims held the same beliefs and practices without recognizing the plurality within Islam; and (5) denials of prejudice even though perpetrators' speech or actions suggested otherwise [21]. Negative portrayals of Muslims in the news media have been implicated in fueling Islamophobia, as greater news exposure was associated with increased anger and reduced positive affect toward Muslims, irrespective of which political ideology the respondent belonged to [25]. The spread of Islamophobic attitudes in European and North American societies suggests that clinicians would benefit from understanding its manifestations in clinical practice, especially since Muslims have traditionally been reluctant to access mental health services due to stigma and the perception that mental disorders stem from personal moral failings, at least as has been reported in studies from the United States [16], the Arab Middle East [5], and South Asia [14]. A core concern in cultural psychiatry has been the improvement of services for minority populations [17], which also includes Muslim patients living in societies that are increasingly marked by widespread Islamophobia. The next section describes various types of Islamophobic transference and countertransference reactions so that clinicians can recognize their manifestations.

Islamophobia Within the Therapeutic Dyad

In an article that is now considered a classic in the field of cultural psychiatry, Comas-Diaz and Jacobsen [11] noted that demographic traits such as culture, race, and ethnicity "can touch deep unconscious feelings in most individuals and may become targets for projection by both patient and therapist" (p. 392). Writing against a traditional psychoanalytical orientation that deemed patients' remarks about cultural

differences with their clinicians as defensive shifts away from investigating underlying conflicts [12], Comas-Diaz and Jacobsen [11] have suggested instead that "by encouraging the elaboration of ethnoculturally-focused devaluing concepts and feelings, the therapist can offer patients a richer opportunity to know and resolve their own ethnocultural and racial conflicts" (p. 392–393). If explicit utterances related to social differences based on race, ethnicity, religion or culture are the first sign of a developing transference relationship [30], then it stands to reason that the clinician's own awareness of social differences with patients can signify the start of a countertransference relationship. Comas-Diaz and Jacobsen [11] described several patterns of ethnocultural transference and countertransference through case vignettes, and this method is adopted here to discuss inter- and intra-religious forms of Islamophobia.

Transference Reactions

Denial of a Religious or Cultural Identity In this transference reaction, patients refuse to identify themselves as Muslim. Such denial may emerge from the desire to anticipate and avoid any experiences of discrimination by concealing one's identity [27]. The vignette below illustrates this kind of transference:

> A 20-year old undergraduate woman presented to university student services for the treatment of acute depression following the abrupt end of a romantic relationship. Her clinician, a White male resident in psychiatry, conducted the intake. As part of the social history, he included questions eight through ten from the DSM-5 Cultural Formulation Interview [CFI]. In response to the question, "For you, what are the most important aspects of your background or identity?" she replied, "I'm a Lebanese-American." When asked if there were any aspects of her background that have impacted her depression, she replied, "My parents are strict Muslims and don't believe in dating. They only believe in arranged marriage and don't understand that we marry who we love in America. It was really hard with this guy because I always kept fighting with them." When asked if there were other aspects of her background that have caused concerns for her, she answered, "I know that I'm supposed to say I'm Muslim, but I'm not practicing. After 9/11, I got made so much fun of in school that it totally turned me off religion. Any religion. My brother was in middle school and got it much worse since he wanted to grow out his beard like my father. He finally gave up. Now in college, a lot of my friends are into wearing hijab and are part of the Muslim Students Association, but all of those Friday prayers are just not for me."

The resident's inquiry into the patient's cultural identity revealed a complicated relationship with her sense of self and others. She opted for an identity based on her parents' country of origin, not religion, due to direct experiences of Islamophobia. Nonetheless, religion informed her parents' attitudes of acceptable and unacceptable forms of intimacy, and her depression emerged after a romantic relationship ended for which she fought hard against them. The negotiation of her personal identity continued into college as she found herself occasionally at odds with friends who identified as Muslims.

Mistrust, Suspicion, and Hostility Comas-Diaz and Jacobsen [11] describe this reaction as beginning with the patient's doubt aboutthe clinician's intentions, which

ultimately boils down to the question of “How can this person understand me?” (p. 394). Mistrust can escalate into outright aggression, as in this example:

> A former Marine in his thirties was brought to the local Veterans Affairs Hospital for making threats about wanting to hurt himself after ingesting twelve cans of beer during an annual celebration to commemorate the return of his military unit from the Iraq war. After a period of detoxification, the emergency room attending physician called the psychiatric consult-liaison service to provide recommendations. A Bangladeshi psychiatrist knocked on the door and introduced himself. “Come in,” the patient said. The patient’s gaze fell to the psychiatrist’s beard, and he shook his head incredulously. He yelled, “Fuck! I’ve got a sand nigger for my doctor now?! Fuckin’ Osama, this guy.”

The patient’s conception of himself as a soldier – a marine visiting a military hospital after communing with other veterans of the Iraq war – predisposed him to viewing his clinician as a member of a hostile group. The psychiatrist’s beard, a symbol of religiosity for many observant Muslim men, became the focus of hostility even before he uttered a word. It did not matter that the slur “sand nigger” is used for Arabs even though the psychiatrist was South Asian. Islamophobia appeared in the patient’s ascription of an identity to the clinician.

The prior example portrays this dynamic between patients and clinicians belonging to different religions. However, the same transference dynamic can occur between patients and clinicians who belong to different sects of Islam. The following example exhibits how the patient-clinician relationship can become a site for reenacting geopolitical conflicts:

> A Syrian woman in her thirties was resettled with her two children in the United States through the United Nation’s Office of the High Commissioner for Refugees. She presented to an outpatient clinic in Michigan for post-partum depression. She specifically chose this clinic because she heard that it caters to a large Arabic-speaking population and she did not feel confident in her ability to speak English. She greeted her psychiatrist who identified herself as a naturalized American citizen and who migrated from Lebanon about a decade beforehand. As part of her standard intake, the psychiatrist began with the CFI. In response to the fourth question about explanatory models of illness, “Why do you think this is happening to you? What do you think are the causes of your problem?” the patient said, “Well, the Party of Satan [an insult against the Shia political group Hizbullah which means “Party of God”] worked with the bloodthirsty Assad regime to slaughter us Sunnis. If they didn’t kill my husband, then I would have more help with my newborn daughter.” The psychiatrist said, “I’m sorry to hear that.” The patient broke from her sobbing and said accusingly, “As a Lebanese, you don’t support them do you? You’re not Shia, are you?”

The patient’s grief over losing her husband to the Syrian civil war, coupled with the tribulations of raising two young children in a foreign country, led to an outburst of affect against her Arabic-speaking psychiatrist. Without waiting for the psychiatrist to answer, the patient doubted her intentions which manifested as outright aggression. The patient assumed that the psychiatrist could sympathize with aggressors against her family even though both women were living far away from a conflict zone that has been engulfed in sectarian differences.

Ambivalence Comas-Diaz and Jacobsen [11] describe this reaction as a response to two scenarios: (1) an external manifestation of negative feelings toward clinicians

while simultaneously experiencing true interpersonal attachments and (2) the patient's awareness of mixed feelings. This anecdote expresses one patient's ambivalence toward a clinician's religion:

> An African-American woman in her seventies attended a multidisciplinary neuropsychiatric clinic after experiencing her first stroke following a transient ischemic attack six months beforehand. Her daughter accompanied her to an outpatient specialty clinic where she met a geriatrician, a neurologist, and a psychiatric social worker who evaluated her for signs of depression. The social worker introduced himself as "Dr. Singh." The patient smiled, looked down, and shook his hand politely before asking, "What kind of Muslim are you?" The social worker, accustomed to this confusion, replied, "I'm actually not a Muslim, but a Sikh. We're a different religion." The patient nodded before gesturing to his turban. "I understand, but you look like them with that thing you're wearing on your head. I know it's none of my business, but I haven't ever met one of you." Embarrassed, her daughter apologized by saying, "Sorry. She hadn't really ever left the South[ern part of the United States] at all until she had to come stay with me. She's never been out of the country."

Perceptions of resemblance between Sikhs and Muslims based on apparel led this patient to inquire about the clinician's identity. Although the actual number of hate crimes against Sikhs is unknown, the US Department of Justice noted that its attorneys have investigated over 800 incidents of hate against Sikhs, Arabs, Muslims, and South Asians in general [29]. Islamophobia fuels these perceptions of mistaken identity because Sikhs, like Muslims, are assumed to be acting against national interests [4]. Here, the patient acknowledged her ambivalence by recognizing that she had no business asking her clinician about his identity. Even after he responded that he is not Muslim, she persisted by stating, "you look like them."

Islamophobia can also manifest as ambivalence between patients and clinicians who belong to different Muslim sects, as the following example demonstrates:

> At a clinic in Harlem, New York that caters predominantly to lower income families and those without health insurance, a Pakistani male taxi driver who is self-employed as an independent contractor greets an African-American psychiatrist with a Muslim last name by saying, "*Salaam aleikum*." The psychiatrist smiles and says, "*Wa'leikum salaam*." The Pakistani patient says, "Your last name sounds Arabic. Are you a Muslim?" to which the psychiatrist responds, "Yes." The patient asks, "How did you become Muslim?" and the psychiatrist asks, "I'm happy to answer that, but please tell me why it's important to you." The patient responds, "Well, in my country, we hear about how many African-Americans became Ahmadiyya Muslims after they were converted by missionaries, but our government banned them from calling themselves Muslim." The psychiatrist asks the sixteenth question of the CFI: "Sometimes doctors and patients can misunderstand each other because they have different backgrounds. Are you concerned about this?" The patient responds, "Not really. I'm here just for my anxiety medications. But I never thought an Ahmadiyya would be part of my social circle, let alone my doctor."

In 1974, the Government of Pakistan officially declared members of the Ahmadiyya sect as non-Muslims to the consternation of domestic and foreign civil rights groups [15]. In this example, a Pakistani man acknowledged his mixed feelings about the situation: he recognized his role as a patient who presents for medication management, especially in the context of limited financial resources where he could not choose his provider, but he also articulated his curiosity and slight

discomfort about his psychiatrist's identity. The psychiatrist used this opportunity to elicit possible concerns based on patient-clinician cultural differences that could have undermined clinical rapport.

Countertransference Reactions

Denial of Religious Differences Clinicians, like patients, candeny certain aspects of their identity based on perceptions of Islamophobia. Comas-Diaz and Jacobsen [11] attribute this tendency to a clinician's (perhaps erroneous) belief that one can or should be above cultural and political influences in society. The following case exemplifies this dynamic in practice:

> A Caucasian man in his thirties presented to an outpatient clinic in rural Florida for buprenorphine treatment after a ten-plus year history of opiate dependence. His illness began after he started to consume more oxycontins than prescribed to treat severe back pain following a steep fall at his construction site where he was working as a foreman. In the waiting room, a television was set to the channel CNN which played a news clip commemorating the 2016 Orlando nightclub shooting that killed 49 people and wounded 58 others in an attack claimed by the militant group the Islamic State, also known as the Islamic State of Iraq and Syria (ISIS). His psychiatrist, a Caucasian who converted to Islam after a profoundly formative, study-abroad experience in college, introduced himself as "Dr. Zakariya." The patient did not know that the name was an Arabic spelling for the English name "Zachary." The patient smiled and said, "Nice to meet you," before adding, "Kinda creepy that we're meeting on this date, huh? Those fuckin' ISIS guys have the balls to attack our country." Caught by surprise, the psychiatrist smiled politely and nodded his head as the patient said, "Everywhere you look – Syria, Iraq, Pakistan, Israel – these Muslims are always causing problems." The psychiatrist, aware that his religion could be a point of contention, chose not to comment, preferring instead to emphasize his racial similarity.

The psychiatrist wanted to believe that his patient's substance addiction, low socioeconomic status, or relative lack of education could explain his blatant Islamophobia. Rather than address the patient's strong affect or even declare his own religious identity, he thought it best to remain silent, especially since he did not want to threaten rapport during their first meeting. He took advantage of a shared racial background to deny demographic differences.

Aggression and Anger This countertransference reaction can result when clinicians identify with an aspect of their patients' lives to the point of hostility. The following example reveals how clinicians who are inexperienced with processing their emotions can erupt into anger:

> A Muslim-American female resident in her twenties who wears a head scarf known as the hijab was assigned a case on an inpatient eating disorders unit as part of her second-year rotation. She began to wear the hijab after a high school family trip to Iran where she met fashionable aunts who wore designer outfits and saw the scarf as an accessory that conveyed modesty with sophistication. She introduced herself to the patient, a graduate student at a prestigious Ivy League university who was pursuing her doctorate in the social sciences. Immediately upon seeing the resident's hijab, the patient rolled her eyes and remarked, "Oh God. Don't tell me you wear that noose of oppression around your head. Surely you must be educated if you're a physician?!" In response, the resident said heatedly, "Is that the best

you've got? You're the one in here, not me!" The patient immediately broke down in tears and the resident understood that the short-term satisfaction of revenge endangered long-term clinical rapport.

This case represents tensions that Muslim women may experience over their decision to wear the hijab. Although popular media in North America and Europe frequently features commentators who decry the hijab as symbol of female docility or inequality, many Muslim women wear it as a sign of identity in which they seek to accommodate religious expression with postmodern forms of feminism [6]. The patient's reaction comports with an established social fact that observers of the hijab may assign it different meanings than the people who actually wear it [19]. Had this junior physician understood this dichotomy, perhaps she could have intervened differently to this act of Islamophobia.

Ambivalence Just as patients may experience awareness of their mixedfeelings, so can clinicians. The following example illustrates this process:

An Orthodox Jewish woman in her late thirties brings her son with a history of Autism Spectrum Disorder to establish care at a multispecialty child and adolescent mental health clinic. The social worker, an Indonesian Muslim man who became a naturalized American citizen just a few years back, conducts a detailed social history. The woman informs him that she and her husband lived on a kibbutz in Israel with their children until it became too difficult for them to keep arranging for their son's mental health care. For this reason, they returned to the United States where they were originally from. As she spoke, the social worker found himself recalling how he heard about the Palestinian struggle during his early years in Indonesia, specifically how Arab Muslims were being suppressed by Jews and that Muslims worldwide had a duty to come to their aid. The woman, seeing that he was ethnically Chinese, did not censor herself in describing life in Israel as she did not think that he would have had such a negative reaction since he did not look Arab to her. Even though he maintained his composure, he found himself wondering whether he should ask to be recused when he presented the case to his clinical supervisor.

This vignette encapsulates why patients and clinicians cannot take each other's identities for granted. The Orthodox Jewish woman did not assume that her Indonesian social worker would feel any sort of attachment to Palestine since he did not physically appear to be ethnically Arab. The social worker himself did not imagine that he would feel enraged at this woman's settlement in Israel since he had not thought of the Palestinian cause in a personal way as an adult. Nonetheless, her narrative tapped into his wellspring of profound cultural memories. At the same time, he recognized his fiduciary responsibilities to her as a clinician and contemplated referring her case to someone who could provide more empathy.

Strategies to Recognize Islamophobia in Transference and Countertransference

For over 70 years, psychiatrists have recognized that patients can trigger ambivalence and even hatred among clinicians. In a widely cited article that has become a classic, Winnicott [31] acknowledged that patients with certain pathologies such as

psychosis or obsessions can challenge clinicians. Islamophobia does not fit this pattern of negative emotions expressed in clinical settings: people with any type of pathology or no pathology at all can direct negative attitudes and behaviors toward Muslims. Moreover, clinicians need concrete strategies to navigate such situations in actual practice.

Here, cultural competence efforts may offer a roadmap. The idea of "cultural humility" enjoins clinicians to adopt a stance of self-evaluation, primarily to redress power imbalances in the therapeutic relationship so that historically disadvantaged racial and ethnic minority patients do not experience discrimination in healthcare settings [13, 28]. As we have seen in the examples above, however, Islamophobia can create a power imbalance that is initiated either by the patient or the clinician. To retain this notion of self-evaluation, cultural psychiatrists have suggested three consecutive steps for clinicians to address negative experiences of cultural differences: (1) allowing oneself to experience strong emotions rather than assuming a clinical stance of neutrality or objectivity, (2) processing the resultant countertransference rather than reacting defensively, and (3) using one's reactions to engage with a patent's narrative through curiosity, even when it seems as if empathy is not possible [3, 18].

Each transference and countertransference reaction described above lends itself to these techniques. Clinicians may find questions from the Cultural Formulation Interview supplementary module on the patient-clinician relationship [8] to be helpful in engaging curiously with patients. Key questions that clinicians can ask themselves include:

- How did I feel about my relationship with this patient? Did cultural similarities and differences influence my relationship? In what way?
- What was the quality of communication with the patient? Did cultural similarities and differences influence my communication? In what way?
- How do the patient's cultural background or identity, life situation, and/or social context influence my understanding of his/her problem and my diagnostic assessment?
- How do the patient's cultural background or identity, life situation, and/or social context influence my treatment plan or recommendations?
- Did the clinical encounter confirm or call into question any of my prior ideas about the cultural background or identity of the patient? If so, in what way?
- Are there aspects of my own identity that may influence my attitudes toward this patient?

Although this supplementary module suggests that clinicians ask themselves these questions after the interview, clinicians can also deploy these questions as a form of internal dialogue during sessions. The ability to introspect during sessions by considering how one's "reveries" such as self-absorptive states, ruminations, daydreams, and fantasies reflect the clinician's receptivity to the patient constitutes an accepted form of psychodynamic therapy [22]. The cultural

psychiatry approach to transference and countertransference assumes that patients and clinicians respond to each other based on their experiences with identity, as it pertains to themselves and others, and clinicians can use cultural reveries to process the countertransference that results from developing strong emotions [1].

This supplementary module also includes questions to patients that clinicians can ask during sessions to process transference reactions [8]. Examples of such questions include:

- Have you had difficulties with clinicians in the past? What did you find difficult or unhelpful?
- Now let's talk about the help that you would like to get here. Some people prefer clinicians of a similar background (e.g., age, race, religion, or some other characteristic) because they think it may be easier to understand each other. Do you have any preference or ideas about what kind of clinician might understand you best?
- Sometimes differences among patients and clinicians make it difficult for them to understand each other. Do you have any concerns about this? If so, in what way?
- What patients expect from their clinicians is important. As we move forward in your care, how can we best work together?

Each of these questions is an open-ended query into the patient's experiences that exhibit curiosity rather than defensiveness. Just as the second question inquires about "What kind of clinician might understand you best?", we could also ask, "What kind of clinician might not understand you?" as a way of eliciting Islamophobic thoughts and emotions in the service of advancing treatment. The goal of such questions is not to legitimize negative attitudes but to model behaviors that negotiate and work through patient-clinician differences, stimulating the capacity for self-reflection among patients.

Conclusion

This chapter has defined and discussed Islamophobia, offering examples of its detrimental effects on mental health. The article has also presented case vignettes on how Islamophobia can manifest through common forms of transference and countertransference whenever a patient or clinician is perceived to be Muslim. Finally, the article has used the Cultural Formulation Interview supplementary module on the patient-clinician relationship to organize practical strategies for clinicians to respond to such psychological reactions constructively. Patients and clinicians may walk into sessions with a predisposition toward Islamophobia, but the therapeutic encounter that sensitively confronts interpersonal differences in identity can become a forum of personal transformation for both parties.

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Islamophobia: A Jungian Analytical Perspective

13

Ashok Bedi

Every individual, family, group, society, and race has a rational and irrational side. We all have a light and shadow, a numinous and demonic nature. The goal of psychological maturation and living at our higher threshold involves consciousness, transmutation, and integration of these parts in a meaningful narrative that serves our personal best potentials and puts these in service of our families, community, and higher good. Carl Jung termed this process individuation. Since the subject of our investigation is Islamophobia, let us put it in context of the history of human civilization. Every individual and culture has the potential for Eros and Thanatos, love and aggression. We may introject it or project these. For example, it could be said that the Jewish tradition introjected feelings that led to the Exodus, the Christian tradition had its crusades and inquisitions, the Muslim tradition has Jihad, and the Hindus have imploded their aggression onto some of their own people such as women and the untouchables in a caste system that has led to the abuse of a large sectors of its marginalized populace.

A Template with Which to Explore Islamophobia

Carl Jung's analytical psychology considers myths, fairytales, creative works of art, and literature as algorithms that have crystalized over time to guide us in the challenges of life such as crises, trauma, development, and initiations. For the purpose of exploring the dynamics of Islamophobia, Oscar Wilde's classic novel *The Picture of Dorian Gray* may be instructive [1]. In this novel, Dorian Gray was the subject of

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a full-length portrait in oil by Basil Hallward, an artist who is impressed and infatuated by Dorian's beauty; he believes that Dorian's beauty is responsible for the new mode in his art as a painter. Through Basil, Dorian meets Lord Henry Wotton, and he soon is enthralled by the aristocrat's hedonistic worldview: that beauty and sensual fulfillment are the only things worth pursuing in life. Aware that his beauty will fade, Dorian expresses the desire to sell his soul, to ensure that the picture, rather than he, will age and fade. The wish is granted, and Dorian pursues a life of debauchery, while his portrait ages and records every soul-corrupting sin.

This template is instructive in unpacking the dynamics of the individual and collective projection of our dark side or shadow onto another individual or groups. This is the central theme of Islamophobia in that our collective woes as a society are now clumped and projected onto our Muslim citizens and society. While we may remain oblivious of our own contribution to our problems, the chosen victim must now carry all the responsibility of our problems.

The Shadow

Jung defined the shadow [2] as the negative side of the personality, the sum of all those unpleasant qualities we like to hide, together with the insufficiently developed functions and the contents of the personal unconscious. These inferior and undeveloped aspects of our personality are usually projected onto another individual or group that we consider inferior. The shadow of individuals coalesces into the shadow of the masses, communities, cultures, and nations. When the shadow becomes a collective phenomenon, it is projected onto another group, community, or race. The shadow phenomenon in individuals and groups is mediated via the archetype of the shadow. The archetypes are the timeless wisdom templates which are crystallized in the human psyche over last 2 million years to guide our development and growth in typical life situations like parenting, birth, death, marriage, and relationships [3]. Jung evolved the theme of the archetypal shadow based on his extensive exploration of Goethe's Faust [4]. In this German classic by Goethe, the protagonist Faust makes a deal with Mephistopheles the devil to claim love, power, and prestige but in return sells his soul to the devil, once he receives total satisfaction. Jung studied the phenomenon of the archetypal shadow in his essays on Nazi Germany [5]. Oscar Wilde's novel – *The Picture of Dorian Gray* – is a more accessible rendering of this process.

Jung described Wotan [5] as the ancient god of stone and frenzy as well as of power and fury. He lies dormant during times of civility in society but like a restless warrior creates unrest and stirs up strife during times of unrest and chaos. Wotan came to life in the German youth movement, eventually culminating into the Nazi movement with Hitler as its leader, himself an embodiment of the collective shadow of the German psyche. However, when society sinks into chaos, then brought to the depths of darkness by the unconscious forces of compensation, the archetype of order emerges. After this a new and just society is established. This cycle of creation, consolidation, and destruction is the eternal cycle of the human condition. In

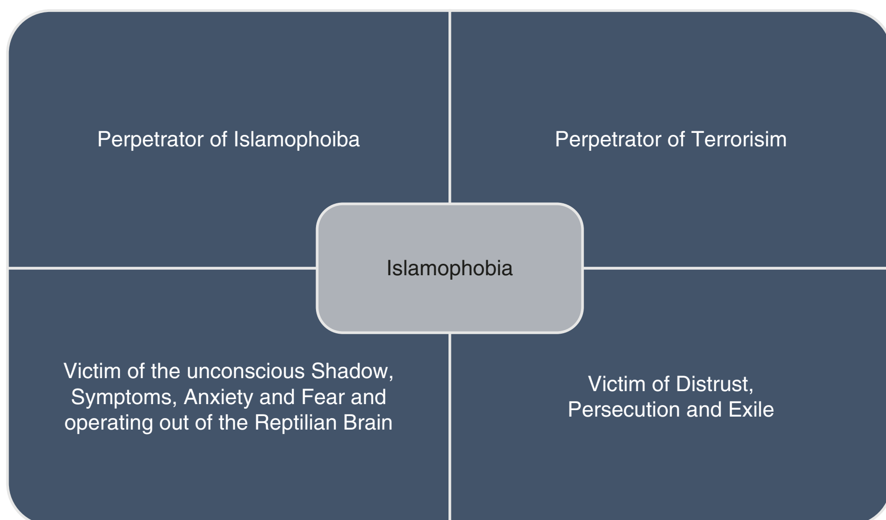
Hindu psychology, this is embodied in the archetype of the Hindu trinity [6] – Shiva being the archetype of destruction, Brahma the archetype of new creation, and Vishnu the archetype of order and consolidation.

Shadow Consciousness

The shadow is for each individual what the individual might have been, but has not had the chance to be. It is represented in dreams as the same sex figure. Shadow embodies not only repressed drives but also values that consciousness rejects. It is our unlived potential. The shadow of a restrained lady may be a flamenco dancer. Shadow is the dark side of the psyche which inevitably accompanies the illumination of another part. Shadow is the dormant aspect of the psyche. Shadow is very close to ego in the personal unconscious and always lurking about. Shadow is often projected onto people around us who intrigue or irritate us.

To take ownership of one's shadow is first step in assimilating it into consciousness. If one denies, disregards, or represses it, it may be projected, go unconscious and erupt as psychosis, or merge with collective shadow like Nazism or Islamophobia. When we accept our shadow, we have the opportunity to transmute it and to reclaim it as an integral part of our own underdeveloped personality. We can then harvest its potential rather than project it onto our victim.

The Victim: Perpetrator Dyad



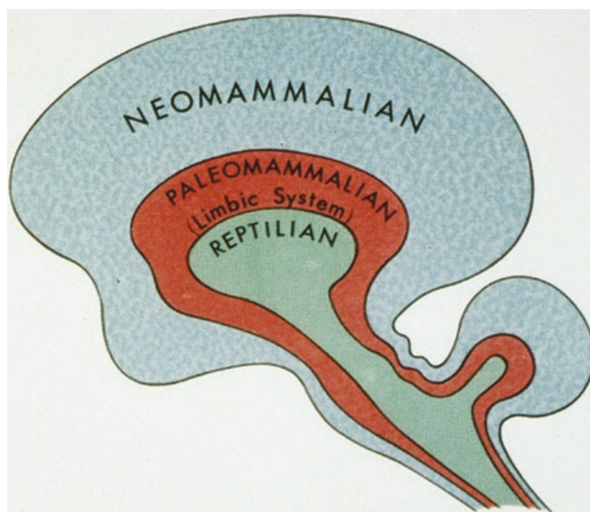
Xenophobia in general and Islamophobia in particular is a lose-lose equation rather than a win-win situation. The perpetrator of Islamophobia is oneself a victim of his

or her unconscious shadow and struggle with symptoms of anxiety and fear and operates out of reptilian survival consciousness of fight, flight, or freeze rather than more evolved limbic or neocortical higher ego adaptive responses to unconscious fears. Such individuals manifest minimally adaptive responses rather than limbic and neocortical choices of more evolved consciousness. The perpetrators of terrorism are also victims of distrust, persecution, and self-imposed exile from their community of peers.

Each one of us has a triune brain [7]. Each of our three brains exerts an influence on our response to stress. The reptilian brain is our survival mechanism. When we are in danger, it mediates our fight and flight responses; when we feel safe, it mediates our restoration and relaxation responses [8]. The fight or flight mode is operated by our autonomic nervous system's sympathetic section, while restoration, rejuvenation, and healing are managed by the parasympathetic section. The sympathetic nervous system is like the gas pedal in our car, while the parasympathetic system is like the brake.

The limbic brain stands at the border between 2 million years of cumulative ancestral wisdom and the management of our individual lives. The Jungian school of analytical psychology has evolved sophisticated paradigms for accessing this archetypal wisdom in ways that enhance our life management and align us with our spiritual purpose and destiny. This is done via attention to the unconscious material, e.g., dreams, complexes, synchronistic events, relationship tangles, and medical and psychiatric symptoms that are manifestation of our limbic psyche.

The neocortical brain is responsible for higher levels of cognitive processing and the potential for rational thought and choice that characterize human civilization. All three brains operate in tandem and are necessary for a total and informed response to our life issues, crisis, and opportunities. Our present challenge in the era of global turmoil and terrorism is to balance our reptilian proclivity with limbic memory and cognitive discernment to achieve higher human consciousness.



In the Consulting Room

Often what we fear or hate is projected onto an individual or a group. The task of our inner work is to transform the shadow into light, since there cannot be a shadow without a light source casting it. With patients and individuals struggling with Islamophobia, such an approach may yield therapeutic dividends rather than subjective distress when such fears are understood and harvested.

Virgo's Story

Virgo, a recovering alcoholic, was dry but not sober when he consulted me for his relationship tangles with women. He was afraid of dealing with women, a derivative of his negative mother introjects. He was charming but extremely exploitive of women in his life and had numerous affairs and failed marriages. He had sought therapy because of a deepening relationship with a woman that he was very sincere about to the degree that he was capable. He did not want to sabotage this relationship. We struggled with this problem in his therapy – how could he contain his compulsive exploitation of women? In desperation, I suggested that since he is addicted to this dysfunctional paradigm with women, let us accept this as a baseline, with one caveat: instead of exploiting them, he must strive to serve these women in some way. Gradually, he became caught up in this new paradigm and eventually became a fierce advocate of women's rights, advocacy, and activism in our community in his chosen profession. He is now in a stable relationship, still entangled with many women but as their advocate, not their abuser.

Destruction, Creation, and Consolidation of Societal Trauma

The sun always sets on every empire and movement in the history of civilization only to emerge at a higher threshold of adaptation. This phenomenon is best understood under the auspices of the archetype of the Hindu trinity [6]. Whenever an individual or societal consciousness is caught in the shadow or darkness, it activates the archetype of Shiva the destroyer. It is a response to extremism. Forces in society and global community coalesce to counter this extremism through collective action and corrective measures, e.g., the NATO alliance. When enough of shadow has been surgically excised, the destructive forces of Shiva are balanced by the feminine principle of Shakti, his consort. This may manifest in terms of voices of moderation in a society once the threat of extremism and terrorism has been substantially contained and shared democratic and human values reassert themselves. This ushers in a new era of creation of new consciousness under the auspices of the archetype of Brahma the creator.

These are epicycles of society, empires, and movements. Whenever the global spiritual order is out of balance, these Trinitarian forces are activated to assert balance and eventually higher order. As we respond to the present global threat of

terrorism and consequent Islamophobic responses by certain sectors of Western society, we must stay open to these underlying collective and archetypal forces to activate restorative and collaborative global responses. We must craft our response to global terrorism within the boundaries respecting basic human rights of all of her global citizens and with guidance of our Muslim brothers and sisters. Carl Jung would characterize this balancing act of the opposites as the "Complexio Oppositorum." This is consistent with the Hindu philosophy that when each one of us is guided by our inner moral compass or Atman (the soul), then we are aligned with the flow of the universe or the Brahman consciousness. This creates a just and orderly world order.

Psychological Impact on the Islamophobic Individual

Islamophobia is a lose-lose proposition. The Islamophobic individual endures the phobia, while the victim of Islamophobia suffers psychological violence. Both must bear the impact of psychic numbing, a sort of depersonalization that leads to a generalized blunting of affect and core attachments. It carries its own Karmic consequences in terms of the long-term stigmata of the stress on the psyche and its somatic consequences.

Sara's Scary Neighbors

Sara is a soulfulwoman in her 50s, who has been in therapy for depression and anxiety. She was divorced following her husband's affair and carries a deep wound of betrayal which further exacerbated the chronic feelings of abandonment by a workaholic father and an emotionally distant and depressed mother. She was particularly perturbed by the events of 9/11 as her adult son would often travel to New York on his business trips and was in the vicinity of the World Trade Center on 9/11, though unhurt. She has Islamophobic proclivities and avoids her Muslim neighbors. Paradoxically, I am an Indian American, and she worries about me being mistaken for a Muslim and being in harm's way.

Her specific fears included her perception that Muslims are aggressive, unpredictable, and volatile, driven by misguided ideology. She took particular umbrage at their mistreatment and suppression of women. In therapy, she was able to transmute these shadow projections and to claim her derivatives of these shadow projections: from aggression to optimal self-assertion, from unpredictability to spontaneity, from volatility to honoring her creativity as a jewelry designer, and from suppression of women to an advocate of women's rights in her community. She was also able to work through the betrayal and abandonment by her ex-husband. Once she reclaimed her shadow projections, her fear of Muslim neighbors abated, and she was able to return to her baseline as a fair, just, and empathic individual.

Cultural Formulation

America is a diverse society, and in the present chaotic post 9/11 environment, it is crucial that healthcare providers undertake cultural competency and diversity training. The opportunities for such training in health care and educational settings are still evolving. However, the American Psychiatric Association has been proactive in this regard, and the DSM 5 has a useful section on Cultural Formulation Interview [9]. It is a 16-item interview that explores the cultural context of their problems and suggests ways to make more refined interventions factoring in the patient's culture, race, ethnicity, and religious belief systems. Cultural sensitivities are amplified in mental healthcare settings as exemplified in the following case vignette.

Farida's Exile

Farida is a Pakistani immigrant settled in Milwaukee for a few years. She was an engineer in Pakistan and sought therapy from one of my white peers upon referral by her neighbor. She had started having panic attacks after an incident in which some white teenagers rolled down their car windows as she was driving home from a local shopping mall and made rude gestures toward her and her two young daughters and screamed, "Go home." My white peer referred her to me since I was brown and from the Indian subcontinent like the patient and thought she would feel more comfortable with me.

While we connected and made good progress in therapy, Farida brought up the issue of why the white doctor had "refused" to see her. While I explained his logic, she had felt re-traumatized by his refusal to engage with her. She perceived it as symbolic of the refusal of her white host culture to welcome and assimilate her in the cultural matrix of America. In retrospect, I wonder if it would have been more therapeutic for my colleague to see her and work through issues across the perceived cultural divide.

Later, I discussed the matter with my white colleague, who admitted that he was uncomfortable dealing with the Pakistani patient as he had struggled with his ambivalence about immigrants in general and Muslim immigrants in particular after 9/11. To his credit, he sought time-limited consultation with me to work through his countertransference issues invoked by this patient and agreed to seek ongoing analytic consultation as needed to deal with his ambivalence.

Healing the Healers Who Deal with Victims and Perpetrators of Islamophobia

When psychotherapists treat individuals who are victims or perpetrators of Islamophobia or any cultural trauma, it may provoke unique countertransference reactions depending upon their own personal context. Do they identify with the victim or the perpetrator? In any case it is a de-centering experience.

The therapist must introject the dysfunction in the other or the culture and transmute this experience within their own psyche. Once this is accomplished, the therapist is in Tao or balance, in a state of adaptation. This resonates with the patient and gradually with the culture in which they are embedded in and sends a transformational ripple effect, a sort of butterfly effect. In my own clinical experience, in times of the current post 9/11 cultural trauma, we as therapists must maintain our Tao or balance by self-reflection, self-care, peer consultation, and supervision if necessary to stay centered and be optimally available to our patients and our communities.

Maintaining life-work balance is essential for therapists in general and crucial for those working with trauma victims, both the victims of terrorism and recipients of Islamophobic projections. Each of us works out our personal program to maintain such balance. In an earlier publication [10], I have outlined some contemplative methods to foster such balance using pranayama, yoga, meditation, mindfulness, attending to play and creativity, music, biofeedback, neurofeedback, journaling, dream recording, active imagination, prayer, etc.

Microaggression in the Therapeutic Vessel

Usually, the victims of Islamophobia are people of color. This may subject them to subtle microaggression in the community as well as the therapeutic vessel. Microaggression is defined as, "a comment or action that subtly and often unconsciously or unintentionally expresses a prejudiced attitude toward a member of a

marginalized group such as a racial minority" [11]. When working with clients who have endured Islamophobia, the therapist needs to stay vigilant to work through their patient's experiences of racial and ethnic microaggression in the community and healthcare settings. Also, the therapist must stay attuned to microaggression as manifest in transference/countertransference matrix. Often, the patients have been victims of microaggression, but sometimes it is the therapist who must endure, confront, and explore microaggression transference in therapy sessions.

The Flamboyant Salesman

John is a flamboyant salesman with narcissistic traits in psychotherapy for depression. He struggled with self-esteem regulation issues as manifest in his professional missteps and relationship failures. He reclaimed solid ground in his professional life but continues to struggle with relational issues. As he entertained a new relationship, he started to struggle with an exacerbation of anxiety symptoms. He is a white individual in therapy with myself, an Asian Indian psychiatrist. I noticed that at the end of some recent sessions, he would entertain a monologue about his conservative political views about unfettered immigration policies and their impact on employment rates among Americans. While extremely respectful toward me at a manifest level, I became aware of his unconscious microaggression toward his immigrant and colored therapist. I was able to understand this as his projective identification. We are starting to explore this in therapy as a manifestation of his self-state. He had felt like a marginalized, colored illegal immigrant in his professional and relational matrix.

Concluding Remarks

Xenophobia in general and Islamophobia in particular is a manifestation of the dark side – the shadow on the individual and cultural psyche. Shadow is an integral part of the human psyche. Shadow is the unconscious, inferior, and underdeveloped aspect of the human potential and is projected onto another individual, group, culture, or race that we may consider as inferior. This leads to acrimony but also to curiosity about the other. It may lead to a deeper understanding of the underdeveloped and inferior parts of our unintegrated potentials and thus facilitate their integration and enrichment of our personality. The archetype of the shadow leads to strife and discord, but in the very depth of darkness and chaos, the forces of compensation and enantiodromia – a return to the opposite – lead to the activation of the archetype of order, structure, and function. This is the eternal cycle of creation, consolidation, and destruction in the human psyche leading to a gradually higher degree of adaptation. It is my hope that this epicycle of Islamophobia in our society will be transmuted to cross-cultural appreciation of other traditions and enrich our collective human psyche. These cyclical patterns of the human psyche activate our darkest demons, but they also call upon our highest angels to claim our higher potentials.

The consequences of Islamophobia are significant for both the victims and the perpetrators of this dyad. Both groups are victims. The chronic suspiciousness of a large sector of citizens leads to lowering our sense of integrity and soulfulness. This may manifest in subtle ways like racial microaggression or macroaggressive outbursts of Islamophobic avoidance, demonization, and prejudicial behaviors against brown citizens. This in turn feeds the narrative of extremists on both sides of this divide. As Mahatma Gandhi famously said, "an eye for an eye makes the whole world blind." In this dilemma of our times, we will do well to subscribe to the axiom, "United we stand, divided we fall."

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14 The Islamophobic Normative Unconscious: Psychoanalytic Considerations

Lara Sheehi

I think Islam hates us. There's something there that—there's a tremendous hatred there. There's a tremendous hatred. We have to get to the bottom of it. There's an unbelievable hatred of us. – Donald Trump[1]

"I can't trust Obama, I have read about him, he's not, he's not, he's a, he's an Arab…no?"
"No ma'am, no. He's a decent, family man, citizen…he's not, he's not." – John McCain, Town Hall Meeting[2]

The question of Islamophobia as an insidious ideological formation has been recently studied [6, 8, 18] and articulated as a phenomenon that became internalized into the US political fabric post-Cold War and exacted through national and international policies, systemic abuses, and the mainstream. Indeed, while the more blatant and undeniable iterations of Islamophobia were on display post-9/11, in his landmark study of the intricacies of Islamophobia as an ideological formation, Sheehi [18] reminds us that the bedrock of American Islamophobia was formed the decade prior. Still others trace the roots of modern-day Islamophobia to Orientalism [17] and as far back as European conquest and colonialism [14]. Scholars agree that the Islamophobia of today is deeply rooted in racism and has become increasingly unabashed in its presence, most pronouncedly in the right-wing blogosphere and media as well as in the American mainstream [6, 18]. What I contend in this chapter is that a normative unconscious process [9]

[1] Found at: https://www.cnn.com/2016/03/09/politics/donald-trump-islam-hates-us/. Retrieved March 12, 2018.

[2] Found at: https://www.youtube.com/watch?v=3c-Ijky95dc. Retrieved March 18, 2018.

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undergirds Islamophobia, informing and saturating the therapist as readily as the patient. What I call the *Islamophobic normative unconscious*, therefore, is at once ever-present and, at times, difficult to detect.

While much has been written about Islamophobia in recent years, in the interest of scope, this chapter will primarily make reference to and expound on a divisive ideological profile that has the potential to be activated when we work with or think clinically about Muslims—or those thought to be so; the analysis is offered from a psychoanalytic perspective. It is imperative that I note, as many have done so before me, that Islam is not a homogenous and unidimensional entity [3, 16, 18, 21] and that the "collapsed Muslim identity" [16] is a stereotype from which we must steer clear. However, for the purpose of this chapter and in service of the divisive ideological profile to which I make reference, in many ways, the discussion of Muslims and Islam is inextricable from Arabs. This is even more the case against the backdrop of politics in Trump's Muslim-ban era, the rise of American ethnonationalism, and the continued American support of right-wing Zionism. The trends, therefore, often conflate the two and, together, aim to activate the terrorist/terror trope. Indeed, the conflation is a core facet of the divisive ideological profile that is activated to shore up the normative unconscious processes of Islamophobia. That is, the ideology itself is predicated on a conflation of the Arab-Islam trope so as to render the individual, the Muslim in this case, an amorphous (and nefarious) entity with expansive boundaries that are difficult to contain. More so, it allows for the indiscriminate targeting of all individuals who may "look" both Arab and Muslim.[3] This is even more glaring when we understand how Black American Muslims are often overlooked, the identity of Muslim being inextricably linked to (brown) immigrant communities.

This conflation calls to mind a sociopolitical and racial image, what I have referred to elsewhere [22] as an apparition, that is activated: one that implies an environment of racial profiling, of surveillance, and of a guilt-by-association verdict that is predicated on race [3, 11, 15, 18]. Indeed, the position of Muslims and Arabs with respect to discrimination in a post-9/11 United States is not unlike that of the Black community with respect to racial profiling that continues to occur, for example, reflected in the disturbing axiom "driving while black" [1, 4]. The mere act of existing as a Muslim in today's world engages the Muslim individual in a dialectical relationality, the reference point of which is 9/11, America's never-ending imperial wars in the Middle East and Afghanistan, and "radical Islam." That is, one, by projection, comes to have a Muslim self that is mediated through and by the multiple sociopolitical meanings to which today's Islam exists in relation. This fuels racial profiling and continued abuses, just like those against Black individuals by law enforcement in the United States as they "drive while black." This parallel is key as it allows us to appreciate the inherent racism involved in the Islamophobic normative unconscious, corroborating the cultural norming of race and raced individuals in the United States as dangerous, suspicious, and worthy of surveillance. Such cultural processes inevitably seep into and inform clinical spaces and practice.

[3] See, for example, Junaid Rana whose work is on South Asian Muslims.

Importantly, this chapter is not interested in taking up the "psyche" or "culture" of the Muslim as patient or clinician. Nor does it offer an analysis that arises out of a prevalent "clash of civilizations" paradigm that renders Islam (and Muslims as an extension) as a monolithic, archaic religion in need of modernization. Further, this chapter will not take up the question of pathology within Islam, especially in relation to political Islam and terror groups. Rather, it will attempt to address the unconscious profile of Islamophobia in North America that threatens to inform psychoanalytic (clinical) thinking, usually unconsciously. This profile is an apparition, a materialization that happens by way of projection when the prevailing ideological framework instigates anxiety (in this case, within clinicians or those who may view individuals in a clinical capacity) that has the potential to obfuscate clinically analyzable space.

Finally, this chapter emanates from a place of deep belief in psychoanalysis as a viable theory to metabolize, hold, and further the growing ability of ethical clinicians to name and address Islamophobia (much like other forms of sociopolitical systemic abuses), especially in previously unanalyzable spaces. The xenophobic and anti-Muslim atmosphere of the United States, especially under the Trump regime, but also under Bush Jr. and even Obama, demands our close attention as psychoanalytic theorists and clinicians. The ideological profile that is activated within this context creates anxiety because it is activated by a real, fear-mongering, fundamentally racist, and Islamophobic atmosphere that has led to witch-hunts and "setting an example" convictions, detailed at length in many scholarly works.[4] It is testament to what cultural historian Stephen Sheehi refers to as the way in which Muslims and Arab-Americans are enlisted personally and institutionally to police themselves, becoming actively complicit with a culture of political surveillance [19].

Normative Unconscious Processes and the Problem of Complicity

Layton [9] introduced the concept of the "normative unconscious" to illustrate the ways in which clinical modalities, technique, and theories may reify rather than dismantle "splits" that are imbricated in "dominant identity categories, by the racism, sexism, classism, and homophobia in which these categories are forged" (p. 203). Normative unconscious processes, according to Layton, therefore, though unconscious, undergird and fuel dominant ideology. In their material and psychic manifestations, they reproduce the oppressive structures in which they were conceived and ultimately maintain the hegemonic status quo. Layton warns us that normative unconscious processes function within what might be understood as unconscious "cultural norms"—largely unspoken, but very pronouncedly

[4] For specific examples, please see Stephen Sheehi's [18] *Islamophobia: The Ideological Campaign Against Muslims* or Deepa Kumar's [8] *Islamophobia and the Politics of Empire: The Cultural Logic of Empire*.

neoliberal, White and middle-class in nature—with which both therapist and patient alike may consciously and unconsciously identify. For Layton, the crux and very viability of normative unconscious processes lies in the fact that:

> These norms not only condition thought, feeling, and behavior, but create dynamic unconscious conflicts as well. Such unconscious conflict, in turn, can generate particular kinds of clinical enactments, ones in which therapist and patient unconsciously collude in upholding the very norms that might in fact contribute to ongoing psychic pain. ([10], p. 107)

From here we can come to understand the ways in which normative unconscious processes in the context of Islamophobia can in fact become *Islamophobic normative unconscious processes* in their own right. That is, we can appreciate the ways in which a mainstreamed, unconscious Islamophobia that has become woven into the fabric of the United States, a dominant ideological formation [18], can become activated clinically and otherwise. This activation, as Layton highlights, not only reinforces the binary category in which it was created but also simultaneously relieves the “dynamic unconscious conflict” ([10], p. 107), recalibrating the dominant ideology to its comfortable equilibrium.

Many of us may be quick to identify the present-day atmosphere and the cultural norming of the Islamophobic normative unconscious as a problem of the Right. However, psychoanalytic theory, and Layton’s very concept itself, provides us the textured space to question the ways in which prevailing ideological paradigms may unconsciously find themselves embedded in the fabric of *all* our beliefs and, in the most extreme cases, our actions. I am interested, then, in the question of how potentially progressive, democratic, liberal, and, yes, even psychoanalytic scholars and clinicians may unknowingly or unconsciously be complicit in perpetuating this ideological profile and summoning the apparition. Extrapolating from Layton’s theory and her discussion of enactments [10], we can assert that, indeed, the complicity of so-called allies, institutions, and otherwise progressive movements fuels Islamophobic normative unconscious processes.

What are the ways in which we perpetuate and stoke the Islamophobic normative unconscious? Even in an attempt to make our field and psychoanalysis, especially, inclusive and critical, do we unwittingly replicate the stereotypes we hope to overpower—what Noha Sadek [16] calls “identity-through-stereotype-negation” (p. 215)? These questions are an essential springboard, a necessary practice, the heart of which is embedded in psychoanalytic technique. That is, the task of the analyst to maintain “evenly hovering attention” to the process, the content, and the intersubjective space, as well as invite reflection on the unfolding (unconscious) dynamics within the therapeutic dyad, dovetails well with how I am proposing we engage in breaking our complicity. While many psychoanalysts have spoken to the importance of ideology in our practice [6, 10, 13], the question of how one exorcizes ideological apparitions, especially those of an Islamophobic nature, has largely remained unchartered in favor of explorations of patients recounting external Islamophobic experiences or their own internalized Islamophobia. My contention is that the Islamophobic normative unconscious cuts across these phenomena: external discrimination and internalized hate as well as countertransferential and transferential enactments.

I will offer two examples from within the field: one extreme, if not dangerous, and another more benign, each of which will explicate a facet of this unconscious phenomenon. While neither example is a clinical vignette, they offer us an illustration of how clinicians themselves are called to participate, validate, and reproduce Islamophobic normative unconscious processes.

Example 1

In May 2016, the International Federation of Psychoanalytic Societies held its XIX International Forum of Psychoanalysis in New York City under the theme "Violence, Terror, and Terrorism Today: Psychoanalytic Perspectives." In the context of our current world and in the context of Layton's normative unconscious theory, one can appreciate the anticipatory pit-in-the-stomach feeling that an Arab clinician such as myself may have had when realizing that the conference would most likely attempt to psychoanalyze "Islam." I could not have been prepared for the deeply (and willfully) Islamophobic, fetishizing, and vitriolic speech to which I was witness.

This speech was especially present in the first plenary, titled "The Psychology of Terrorism," headed by psychoanalyst Salman Akhtar (keynote), psychoanalyst Malcolm Slavin, the pseudo-"native informant" [18] and political opportunist Zuhdi Jasser—interestingly, not listed in the proceedings of the conference—and a moderator whose name was also not made available. The naming of these individuals is not pedantic nor intended as an ad hominem attack. Rather, identifying these figures highlights the ways in which the Islamophobic normative unconscious is insidiously embedded in even the most learned spaces, peddled by senior psychoanalysts who are perceived as credible and inscrutable. It also underscores the importance of psychoanalysis' increasing commitment to becoming accountable and outspoken in the face of injustices that, in the past, may have been carried out unwittingly (and, at times, purposefully, such as in the case of the atrocities of conversion therapy) in its name.

The content of the plenary was rife with problematic opinions largely by non-experts that belied the underpinning Islamophobic normative unconscious at play. To clarify, the danger in this type of apparition is that the plenary content and its speakers are imbued with credibility and therefore "psychological power…the power to name the psychology of another" ([5], p. 85): indeed, to name the psychology of the unmetabolizable Other. Further, the content that was presented was done so in a manner so as to normalize absolute truths about Islam. This is a basic tenet of reproducing normative unconscious processes, what Layton [9] refers to as "the unconscious support of what we think of as 'common sense'" (p. 204). Hollander [6] further highlights how these truths are disseminated when she reminds us that,

> Hegemony permits the most powerful groups to dominate the rest of society in their own interest through consent rather than coercion. Once hegemonic values are taken as natural, we believe them to be universally true and become habituated to them. (p. 75)

More specifically, the plenary regurgitated so-called axioms of Islam, locating an inherent backwardness in the religion itself and extending this to its adherents by

claiming that Muslims did not have the interiority necessary to engage in reflective work demanded by psychoanalytic treatment. In one paper, an experience from the 1970s in a rural Tunisian village was presented and spoken of as though the experience continued to apply to present-day Muslims. This assertion exposes the unconscious slip(s) at play: the Muslim has not progressed and does not engage in growth-inducing processes due to inherent limitations *within* Islam. Moreover, this slip suggests a collapse of time and geography, embodied in a singular, immutable Muslim. These are the inner workings of the Islamophobic normative unconscious process.

Yet another presentation indicated that the Muslim nuclear family is forever trapped within Oedipal configurations and archetypes, unable to traverse this primitive fixation because of its archaic tenets and primal drives. That is, according to the plenary, Islam will always foreground the father at the expense of the mother (and by extension daughter) and replicate patriarchy in a more exclusive and dangerous way than any other religion. The universalized problem, again, lies within Islam as a religion. Such analysis can be found virtually verbatim in Islamophobic and anti-Arab classics such as Raphael Patai's *The Arab Mind* [12].

Zuhdi Jasser, a non-expert with no formal clinical or Islamic scholarly training, presented, at best, an incoherent diatribe against Islam. Jasser, a self-proclaimed devout Muslim, denounced all Muslims that are not pro-American interventionism in the Middle East, as, at best, not "true" Muslims and, most dangerously, regurgitating the worst of American jingoistic and imperialistic ideology, anti-American. In one instance, he claimed that all Muslims—referring to those in Afghanistan as "desert rats"—who do not have allegiance to the United States are at risk of being radicalized. He shored up this point with personal experience, indicating that, as a Navy officer, he "was not susceptible to radicalism because [he] had a belief to serve the USA." This, again, helps us unpack the Islamophobic normative unconscious process, one that collapses, for example, critique of the American war machine with non-patriotism and, therefore, susceptibility to radicalism.

While no discussion space was made available (in fact, the organizers ignored raised hands and even turned off the microphones), the moderator ended the plenary with an impassioned plea that clinicians, and especially psychoanalysts, should do their best "to allow these boys to function as true individuals." This statement, yet again, not only collapses Islam into a monolithic entity with an essential potentiality for violence and radicalization but further eviscerates any texture of gender, here erasing female presence tout court. That is, Islam is only made up of "boys" with "oedipal issues" who, by virtue of an inherent backwardness within their religion, cannot access an interior world of individuality and therefore are in need of saving, lest they fulfill their natural destiny of radicalization.

We are clued into the normative unconscious process at work because these logical leaps, and egregious fallacies, are unlikely to have been as easily made (let alone spoken and accepted as truth) had the topic not been about Muslims and Islam, a ready-made boogeyman and unconscious trigger within North American cultural norms.

Example 2

This second example is far more benign, yet illustrates another facet of the Islamophobic normative unconscious process and how we may not be immune to the apparition's materialization, even as progressives and deeply reflective individuals. It demonstrates how a deep-seated ideological position can in fact create lapses in psychoanalytic technique and thinking and collapse analyzable space. This example examines a specific section of Melanie Suchet's article, "Face to Face" [20]. In this striking and beautifully written article, Suchet walks the reader through a very intimate self-reflection of herself as a Jewish, non-Zionist, analyst engaged in analytic work with a Lebanese woman who, in Suchet's words, was "strongly identified with the Palestinian cause." The article is rich in case material, allowing a glimpse into the transformative conflictual moments that make the case worth recounting.

I had long known of Suchet's own tradition of critical and ethical work regarding race in psychoanalysis, this article highly recommended by colleagues. As I read, however, I quickly found myself inwardly battling with the text, beginning to worry about the unwitting engagement in a normative unconscious process that felt familiar to me. Where otherwise Suchet's work is incisive and unabashed, here I was angered by what I interpreted as a forced "neutral" positioning that I felt freed Suchet of subjective complicity with the political entanglements with which she otherwise critically engages.[5]

My biggest struggle with Suchet's article, however, came after reading material where Suchet recounts an exchange in therapy in which her patient, Ara, discusses a dream:

> She brought me her first dream on our fourth session. "It's about terrorism," she said, watching me closely "Buildings are being blown up in New York City. I am watching the bombings from my window." She hesitated a moment, a smile crossing her face. "I feel very happy." … How would I react to her dream? Would I be horrified or repulsed?…How would I deal with the *terrorist* in her?" (italics my own, 2010, PAGE)

I have italicized the word terrorist, because that word is what drew my energy. Suchet, picking up on her patient's language, refers to part of her as a terrorist. While we consider dreams to be symbolic representations of the unconscious, in this vignette, the symbolic swiftly transforms, even if unconsciously, into the literal when discussing "the terrorist" in the patient. The unconscious ideological shift at play is signaled by the fact that psychoanalysis, in its practice and its theory, has the inbuilt words, concepts, and mechanisms to engage such an interaction like the one between Suchet and Ara in the symbolic. Today's anti-Muslim and anti-Arab ideology, certainly well at play in 2010 when the article was published (the dream itself an evocative nod to 9/11), seems to shut down the analyst's capacity to stay in the

[5] More specifically, she seemed to deploy excessive questions to deflect from the consequence of taking a decided stance about a politically complex issue, in this case, Palestine. I felt the same about the footnote that seemed to provide an "out" about how Palestinians left their homes in 1948, as well as her problematic overview of Lebanese history.

symbolic realm, instigating a panicked concretization that renders the space "unanalyzable." The specificity in which Arabs are singled out in this terrorism, as individuals with an essentialized potentiality for terrorism or a "terrorist inside them," is a key variable in the materialization of this particular type of ideological apparition. For example, we do not see the same apparition in the case of White "terrorism" as with Anders Breivik in Norway, neo-Nazi racist shooter Dylan Roof, fascist Charlottesville murder James Fields, or even sustained police shootings of unarmed children and adolescents of color in the United States. We do not see this apparition because "whiteness" is not seen or experienced as dangerous; White people, therefore, are not, consciously or unconsciously, thought to harbor a "terrorist" within them.

A parallel example might help highlight why I am contending that the Arab apparition (conflated with Muslim by design) collapsed analyzable space in Suchet's reading of her treatment: a patient describes a dream in which she kills her father, "It is about murder," she says, watching us closely. Would we label her a murderer? Or would we attribute symbolic value to her dream, probing for her aggression, perhaps displaced, perhaps externalized, and perhaps a myriad of psychoanalytically sound interpretations. Rarely do we attribute to her a true essence of murderer, a "murderer in her." It is curious, therefore, that the Arab—in this case, woman—that much more dangerous in today's world, comes to fundamentally harbor a terrorist within her. With the ideological activation of the Arab terrorist, the apparition, the Arab must be felt to be so much more dangerous, making the analyst afraid and therefore unable to remain in the symbolic and analyze. The personhood of the patient, of Ara, then, becomes that of terrorist.

Ara is in fact introduced to us as a Lebanese woman "heavily identified with the Palestinian cause." While Suchet makes mention of Ara's "blend" of religious identifications, the religious categorization is a very unlikely one given Lebanon's past as well as present demographic reality. The name Ara, while a pseudonym, is not only a male name, but also very traditionally Armenian—Middle Eastern, therefore, but not Arab. These are not meant to be pedantic comments, but are rather meant to help us unpack how ideology powerfully shapes and activates our internal world. This ideology, interestingly, even affects how we may disguise our patients, a particularly complex predicament if we are interested in the sociocultural and sociopolitical world of our patients. In this article, Ara's cultural/religious history is largely conflated, which has the effect of projecting onto her an identity that is undifferentiated from the multitude of identities that a Lebanese woman may have, let alone an Arab woman. While Lebanon's demographic make-up would categorize her as an Armenian Christian, Ara becomes the archetypal Arab, the Terrorist Apparition, and the pro-Palestinian voice that ultimately activates a normative unconscious process due to prevailing cultural norms.

This example helps us illuminate how a dominantly entrenched ideological formation has the potential, as happened with Suchet, to hamper psychoanalytic technique. The way this happens is through an unconscious internalization of ideology that demands a splitting off of one's other identifications in a bid to maintain its structural coherence. This then instigates an expression of, in this

case, an Islamophobic normative unconscious process that disavows potentials that may contradict or threaten the integrity of the ideological formation. The anxiety of deviation, therefore, is so pronounced, though perhaps not conscious, that all attempts to hold true to the position are made. The apparition, therefore, is at once all-encompassing and can go on virtually undetected if not acknowledged and unpacked.

Here, the apparition of the Muslim/Arab terrorist prevented Suchet's ability to move beyond what Layton [9] calls "the status quo" of the normative unconscious, into other potentially more meaningful apparitions. This is especially glaring, as Ara is explicitly presented as non-Muslim and "Lebanese" vs. Arab or, more suitably, Armenian. Had we (and Suchet) met Ara as a more sociopolitically and culturally specific patient, or had the apparition not been so suffocating, an "easier" association would be of a mirrored history of persecution and genocide given Suchet and Aras's respective history, namely, the Armenian Genocide and the Holocaust. We are alerted, therefore, to the potential pitfalls of calling up and upon the wrong apparitions in the name of preserving confidentiality. It also alerts us to the danger of prevalent ideological structures in our world, the Arab terrorist, for example, the potential terrorist in all Muslims, obfuscating otherwise meaningful analytic treatment.

Enactments Are Inevitable, Collusion Is Not

As we have seen, normative unconscious processes are infused into the North American cultural ethos, highlighting, in the case of this chapter, how Islamophobic tropes are readily available and accessed by therapist and patient alike in the therapeutic space and dyad. This is what I refer to as the "apparition," an ideological activation that is instigated by anxiety—what Layton might call "unconscious dynamic conflicts" ([10], p. 107). This apparition, then, affects the treatment and, at its worst, interferes with clinically analyzable space. The mechanism by which this happens is an enactment in the intersubjective space of treatment.

The term "enactment" warrants attention. The word implies that both patient and clinician *together* are engaging in a pattern of behavior. Recognition of the therapist's role in this interaction is imperative. In the context of the Islamophobic normative unconscious process, this becomes even more vital. In other words, the therapist's own vulnerabilities to the "common sense" cultural norms that guide the Islamophobic normative unconscious may mobilize an enactment(s). The word "vulnerabilities" should not imply "impediment." Rather, in my experience, these vulnerabilities, if noted and attended to, rather than colluded with, have the potential to be the very mobilizing force for structural change. The clinic room, in this way, emerges as the breeding ground for both problem and cure. Indeed, in this framework, enactments are viewed as inevitable, but collusion is not.

I will use two clinical examples to further explicate this in the context of what could have potentially been the breeding ground of a dangerous Islamophobic normative unconscious process.

Clinical Vignette 1

I met Mr. A through my capacity as on-call clinician at a major state school at which I worked as a psychologist. While the role I occupied primarily involved my being the first-responder to mental health crises on campus, and in specific within University Housing, I also interfaced with the Office of Student Judicial Services as well as with the University Police Department. I often found myself deeply struggling with theoretically limiting situations, especially when I was expected to eschew clinical and psychoanalytic readings of a situation in service of protocol and procedure. Such was the case when I was called to accompany the police on a house visit to a graduate student who had allegedly stated, “I want to hurt someone” after performing poorly on an exam. While no report of intent or plan of homicidality was given, my presence, as explained by the Police Department, would be helpful in that the student had a prior mental health history; I surmised that they hoped I might lend my clinical skills to diffuse a possibly enflamed interaction.

The only other identifying information I received was through deduction: I was introduced to a Black officer with the explanation that his presence would help the student feel less defensive—weary of this causal link, I deduced that the student I would be meeting was also Black. In this moment, I became acutely aware of an a priori activation of a normative unconscious process, given the context of a discriminatory and punitive history between law enforcement and Black men in the United States. It was not until we approached his house in two unmarked police vehicles with a total of four officers in protective vests that the full gravity of the situation materialized. The house we approached was in a very gentrified area of the city in which I worked, a city with a segregated history and an equally segregated present. Immediately, the intersectional nature of the power dynamic at play [2] became apparent: the bumper stickers on the student’s car read: “Islam in the Bible,” “Islam is not violent.” It was painstakingly obvious to me that I had become, even unwittingly, complicit within an Islamophobic normative unconscious process, as we were responding to an alleged threat made by a Black American Muslim male. This was made even more clear when one of the accompanying officers stated, “Ahhh, he’s a Muslim.” We spent 3 hours outside the student’s home as he—in his full right—refused to let us in, refused to come out of his house, and refused to comply with “encouragements” to accompany me to campus.

I could not but ask myself, all the while feeling the weight of my betrayal, my undeniable complicity in what was effectively a stake out of a fellow person of color: would the student have been reported had he been a White fraternity brother, for example—a trope that was not hard to come by at the school at which I worked? Would the Police Department have taken an explicit nonaction statement this seriously had they not been aware of the student’s racial and religious identifications? Would we be “smoking him out,” as one of the officer’s stated, had the profile not fit one identical to the ideological boogeyman espoused by the United States government and mainstream, one that activated the Islamophobic normative unconscious process with such ease?

While many may protest that the Police Department was merely following protocol and that my presence was defined by my professional role, psychoanalytic theory equips us with the tools and method by which we can move beyond the surface and become curious about the meanings of even a seemingly standard procedure. This is especially true when understood within the racial/political/cultural context in which an event occurs and, what I suggest here, is the overarching ideological profile in which it was created. In fact, Sheehi [18] demonstrates that this ideological formation works in tandem with dissent-crushing and xenophobic state and federal policies, and, therefore, more than mere procedure is implicated.[6]

In this instance, registering the Islamophobic normative unconscious process became a centering tool, a lens through which I could focus my work. I do believe that my own identity as an Arab Druze woman, with my own Othered experience in the United States, helped anchor me in this reality. However, one's own Otherness is not a precursor to sensing the presence of an apparition, especially if one is inoculated prior to the interaction, i.e., understand the prevailing cultural norms as the bedrock on which any therapeutic interaction occurs.

This sociopolitical understanding seemed all the more important as I became aware of the seeming split: identify with the Other and risk underpathologizing in the face of what could have been a genuine clinical risk or identify with the aggressor and, yet again, overpathologize a Black Muslim male. What I offer in the recognition and naming of an Islamophobic normative unconscious process is the ability to move beyond the split and engage in a both/and possibility. More specifically, moving out of the entrapments of the normative unconscious process provides psychic space and fluidity to engage with psychoanalytic theory and technique such that *curiosity* and *alternative interpretations* may become available. The analytic reading, therefore, moves beyond the potentiality of a Black Muslim male to become violent or disproportionately likely to commit acts of terror, but rather the ways in which these identity markers and assumptions within a fundamentally racist and oppressive system may instigate and/or contribute to pathology.

Clinical Vignette 2

Mr. B, a 35-year-old Muslim from Iraq, presented to my office for psychotherapy following an intimate partner violence incident in which he had repeatedly struck his wife out of frustration. Mr. B and his wife were in the United States on a student visa while he completed his doctoral work. Following the violent incident, Mr. B's wife had fled back to Iraq with the aid of her family. Consequently, Mr. B's wife, again with the aid of her family and social network, had refused to return to Mr. B, asking him for a divorce on the grounds that she could not tolerate

[6] This is especially the case in incidents involving anti-Black Muslim violence. For example, see Stephen Sheehi's account of the murder of Black Muslim Imam Luqman Ameen Abdullah in Detroit, MI ([18], p. 163).

physical abuse and her lack of ability to trust that he would not engage in such boundary crossings in the future.

Mr. B was earnest in his attempts to engage therapeutically, despite his deep shame in his actions as well as his need to ask for professional help. The therapy was conducted in Arabic, and while at times Mr. B expressed appreciation that I could understand his culture and the norms in which he was used to operating, still at others he found himself frustrated at the hard-line boundary I set in reflecting back to him the problematic nature of his actions.

We spent many sessions revisiting the incident, what had triggered him, and in keeping with my own theoretical position, explored with him the underlying feelings, associations, and larger sociopolitical factors at play. For example, we discussed the "wrecking effects" [7] of immigration, the humiliation of not knowing what he felt were basic functional skills in the United States (e.g., where to file for a Social Security Card, how to navigate public transportation, etc.), and feeling at the mercy of a system that viewed him as a danger. Mr. B described himself as having had a prominent career and being very well respected in his community prior to coming to the United States. He experienced his difficulty transitioning into this new role and environment as a deep ego wound, and he described feeling "out of control" and, most of all, missing his family and social network. In addition to these facts, Mr. B expressed pointedly misogynistic views, especially on women's roles in society and expressed rage at his wife's having defied these roles by fleeing the country and refusing to respond to his overtures—he firmly believed that in doing so, she was not fulfilling her duties as a wife. He further discussed the ways in which Islam frowned upon divorce and how he felt his wife had betrayed him religiously, as well.

This is the space in which, as with Mr. A, I was alerted to the dangers of acting upon an Islamophobic normative unconscious process—one in which Mr. B reportedly had already been embroiled by virtue of his immigration experience. It would be easy within the context of present-day cultural norms to, even unconsciously, attribute Mr. B's behavior and actions, especially that involving physical abuse, to his being a Muslim. That leap may be difficult to make on the surface, and, indeed, I contend that many of us would be self-policing in our tendencies to make this assertion even internally. However, it is imperative that we reflect on whether the "common sense" factor in the Islamophobic normative unconscious may have already been activated. That is, how likely is it that we may wonder, even casually, at how Islam may have played a role in his violence? Might we wonder about the rates of intimate partner violence in the Middle East, maybe even ask bolder questions about why the incident rates seem to be "so much higher" in those societies? Indeed, Sadek [16] provides a jarring incident in which a Lebanese patient shares how a colleague, upon first meeting her, asks her "why do Lebanese men beat their wives?" (p. 212), as though this were a given as true as the rising sun.

As we zoom out the lens further, what associations do we have when we learn Mr. B is Iraqi, especially in the context of the American invasion and occupation of Iraq and its continued presence there? What has the cultural reading of Muslim Iraqi men been—how "modern" are they, how do they treat their wives, how do they relate to "our" freedoms and the norms in which they must function when they are living in the United States? Had I not shared explicitly that Mr. B was Muslim,

would our unconscious assumption have been that he was? How does Islam dictate the workings of Mr. B's marriage, his ability to cross the boundaries into physical abuse? These are the inner workings of an Islamophobic normative unconscious process. It is a process that normalizes essentializing and racist questions—questions that collapse the texture and practice of Islam into a monolithic preconception (one of backwardness, inherent patriarchy, conservativism) and locate the pathology, even indirectly, within Islam per se.

In doing so, we would miss the "diversity and historicity of Islamic, religious, and cultural, identities [that] challenge the monovalent and ahistorical narrative of Islamophobia…" ([16], p. 209). Further, we would attribute the ills and downfalls of toxic masculinity and patriarchy exclusively to Islam, rather than to the systems that cut across all religions and races and work to perpetuate these phenomena. Indeed, it is these very systems that call on us to contain Mr. B's violence, for example, within Islam, rather than contend with the more challenging notion that violence exists in all power hierarchies, whether in the name of White supremacy, capitalism, or any other perverse and inherently oppressive structure. It is also these systems that call on us to conveniently overlook how his wife's family was instrumental in protecting her, encouraging and making space for a divorce, and eschewing religious "norms" for the safety of their daughter.

With the case of Mr. B, as with Mr. A, we are able to move beyond the trappings of an Islamophobic normative unconscious when we allow for (a) the naming of the normative unconscious process and (b) the exorcism of the apparition such that it creates space for other more nuanced and intersectional possibilities to emerge.

Conclusion

In the four vignettes presented in this chapter, the Islamophobic normative unconscious emerges as a formidable apparition that has the potential to cloud psychoanalytic theory and technique and unwittingly create hegemonic collusion within the therapeutic space. Further, because this phenomenon is deeply entrenched in the sociopolitical norms of North American culture, it has the potential to materialize in both benign and egregious ways, all of which serve to further replicate the normative societal structures that work to oppress. Psychoanalytic theory, as a process and collection of techniques, provides the space for clinicians to be curious as to the presence of the Islamophobic normative unconscious as well as the tools to explore alternative potentials.

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Challenges of Islamophobia: Psychiatric Considerations for Effectively Working with Muslim Patients

15

Fahad Khan

Muslim Americans

Each of the ethnic subgroups of American Muslims carries its own social and cultural histories and norms. While socially, culturally, and economically diverse, the Muslim American community shares a religious worldview that shapes all areas of life [30].

This integrated and enmeshed system of values sometimes creates complications for the individual, when there is a dilemma created by the need to balance the preservation of their religious and cultural identities with integration into mainstream American culture. As such, both culture and religion, individually and collectively, affect the cognitive and behavioral understandings and practices of Muslim Americans.

In the United States, most immigrant Muslims come from theocratic countries. Since Islam plays a significant role in their lives, it sometimes becomes challenging to differentiate whether issues are primarily linked to acculturation or religiosity. Historically, Muslims have integrated well with American society. Muslim Americans are second with regard to level of education compared to other major religious groups [18]. Muslim Americans have been found to be more educated and affluent than Muslim Europeans [33]. But even with this level of financial and educational integration, Muslim Americans often feel alienated and singled out [24].

Barriers Related to Treatment

Studies have assessed factors that affect help-seeking attitudes and behaviors of Muslims [7, 9, 23]. The author has proposed a summary of these barriers related to (a) the patient, (b) the clinician, and (c) the culture (Fig. 15.1).

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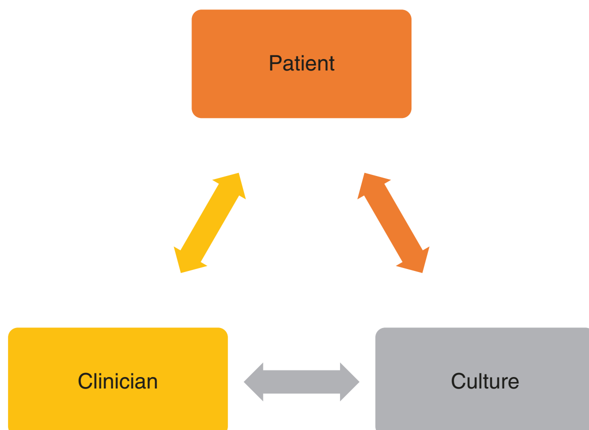

Fig. 15.1 Contextual categories of barriers related to treatment of Muslims

As seen in the table below, some of these barriers relate only to the patient, the clinician, or the culture, and others relate to the relationship among the three. The table summarizes the barriers related to Muslim Americans found in psychological literature (Table 15.1).

Attitudes and Beliefs

Muslims tend to conceptualize mental illnesses from a cultural as well as religious point of view. Some traditional understandings of mental illnesses link it to spiritual causes or a lack of God consciousness or awareness [21]. Psychosocial illnesses are often referred to as "diseases" of the heart (*amraad al-qalb*). Some Muslims also attribute mental illnesses to demons (*jinn*), an evil eye (*al-ayn*), and black magic (*seher*) [17]. This may lead to formulating negative attitudes toward mental health professionals and relying on faith healers rather than seeking formal professional services.

Stigma

Stigma has been defined as a condition in which a member of the society is barred from acceptance from their social environment [20]. It is affected by a person's attitudes, stereotypes, prejudice, and discrimination [15]. Self-stigma is a concept that occurs after a person internalizes prejudices that exist in the public toward his/her minority group [16].

Very few studies have assessed stigma within Muslims. Shibre et al. found that three quarters of families studied reported the presence of stigma due to mental illness among relatives, along with more than one-third reporting that they would not marry into a family that has a mental illness [38]. Abu-Ras found domestically abused women avoided sharing personal facts and going to a therapist due to fears

Table 15.1 Barriers related to Muslim Americans

Category of barrier	Dynamics of the barrier	Examples
Attitudes and beliefs	*Patient's attitudes and beliefs toward the clinician*	Gender differences
		Clinician's culture and religion
		Mistrust of service providers
		Fear of treatment
	Clinician's attitudes and beliefs toward the patient	Preconceived notions regarding the patient's gender, age, race, etc.
	Attitudes and beliefs related to the cultures of patient and clinician	Negative attitudes stemming from cultures of patient and clinician
		General fear of racism and discrimination by the patient
Knowledge and familiarity	*Patient's knowledge and familiarity of clinician*	Questions about psychotherapy
		Psychiatrist vs psychologist
	Clinician's knowledge and familiarity of patient	Patient's perceived fears
	Culture-related	Cultural/religious understanding of illness
		Patient's unfamiliarity with types of services available
Stigma	*Patient-related*	Having a mental illness
		Going to a professional
		Following treatment plan (using medications)
	Clinician's stigma toward the patient	Feelings of disgrace related to treating the patient
	Culture-related	Societal stigma related to mental illnesses
		Societal stigma related to patient's gender, race, or religion
Other factors	*Patient-clinician*	Language barriers
		Differences in communication

related to negative consequences that may affect their marriage; 70% reported feeling shameful; and 62% reported feeling embarrassed with regard to obtaining formal psychological services [4]. A 2006 study found that 16% of the respondents reported a need for counseling but only about 11% sought it. The results also indicated that Muslim men had more negative attitudes and that Muslim women reported having a need for such services more often than men [25].

The shame felt by Muslims often causes them to deal with their own problems themselves instead of seeking professional services [3, 4] or, worse, postponing doing so [5]. Muslims are also often concerned with reputation within the community, and mental illness is thought to affect this reputation [7, 8]. Arabs have been linked with denying the existence of psychological problems due to fears of bringing shame and guilt to themselves and their families within their communities [8].

Overcoming the Barriers: Recommendations for Clinicians

With the aim of the chapter in mind, the author humbly offers the following recommendations to help address the barriers addressed above.

Initial Intake and Assessment

First impressions can be lasting and set the stage for the professional relationship and therapeutic alliance. The initial visit is perhaps the most important session for a patient and the doctor. After introductions, it is helpful to inquire about the patient's previous experiences with psychiatric and psychological treatments. If the patient is new to the process, it will be necessary to provide the patient with psychoeducation related to the overall process. Body language and facial expressions can often be helpful when assessing religion and culture of the individual. For example, if a patient begins to evade a question or presents in a defensive stance, this may signify lack of comfort related to the topic.

Comprehensive assessment is not only essential for the intake; it also serves as an intervention itself and determines the course of the treatment. Beyond the medical components, a thorough assessment of the patient will include psychological functioning, level of acculturation, and religious affiliation and coping.

Both acculturation and religiosity are important factors in the progression as well as in the treatment and prognosis of psychiatric disorders. Acculturation can be objectively measured by using a standardized assessment tool. The author recommends using the Vancouver Index of Acculturation (VIA). The VIA is a 20-item, self-report survey, based on Berry's bidimensional model of acculturation [11].

Religiosity is a complicated matter to assess. Recommended objective measures include the Muslim Experiential Religiousness or the Psychological Measure of Islamic Religiousness [2, 19].

However, the importance of Islam in the life of the patient can also be assessed by taking a closed-ended question from an assessment tool and asking it in an open-ended manner. This can help build the relationship and help the patient to process their thoughts more openly. If religion and/or culture has been found to be important, a patient may inform the clinician about their background and knowledge related to Islam or their culture. In most cases, patients are open to educating the practitioner, which grants them some power in the treatment process. A clinician may engage this by asking "I know that there are cultural and religious beliefs and practices that I am not aware of. However, I would be willing to learn and educate myself as we continue this relationship. Would you be willing to help educate me?" This may even lower the anxiety felt by the patient, especially if the clinician comes from a different religious or cultural background.

The formal assessment of acculturation and religiosity can sometimes create a level of hesitation within the patient. This is often true for the first-generation children. Clinicians need to engage a young patient in conversation and assess these factors informally along with possible intergenerational conflicts. If hesitation is

observed, the clinician may need to process it in future sessions. Muslim youth have had more difficulties negotiating their cultural and religious identities and therefore may be reluctant to talk about them [39].

After a comprehensive assessment has been conducted, a treatment plan can be created accordingly. A very religious patient may want to focus a lot on religion during the course of therapy, and religion may affect their adherence to treatment (e.g., openness to taking medications), requiring the involvement of clergy (see below). A highly cultural and/or religious individual will likely also seek support from family members. In that case, the clinician may have to consider the involvement of the family and obtaining the necessary permissions to do so.

Involvement of Clergy

Among Muslims, clergy are considered the experts in the domain of religion. They include imams, shaykhs, and community leaders. Clinicians in the field of psychiatry are typically more open to seeking consultation from other professionals such as lawyers and psychologists than from clergy, leading to members of the clergy feeling dismissed and disrespected [27].

In the United States, with over 1200 mosques, imams provide a variety of spiritual and non-spiritual services to their communities [10, 29]. If a practitioner has many Muslim patients, it may be very useful to have a good working relationship with a local imam. When compared to the general population, while processing their issues, a Muslim patient is more likely to present with a dilemma that will require consultation with the imam. Imams play a vital role in health-related issues of the community, and consultations with imams can enhance the health of community members, establish trust between professionals, and reduce healthcare disparities [32]. Khalil Center, an institute specializing in Traditional Islamically Integrated Psychotherapy, has partnered with the Institute of Muslim Mental Health and offered a certification course for imams and community leaders in an attempt to educate the clergy about how to recognize mental illness and clarify the scope of practice for clergy and mental health practitioners.

Guidelines for Therapy

Most Muslims come from collectivistic cultures where identity is developed through public interactions and where religious teachings are learned through the lens of culture and family dynamics [22].

Accordingly, Muslims sometimes prefer an authoritative therapeutic style, looking to their therapist for direction and even direct advice [22]. By contrast, in the West, authority is generally given to the individual, and emphasis placed on the autonomous self. Some specifically recommended styles of therapy in the literature include cognitive behavioral therapy; solution-focused therapy; modeling and behavioral techniques, including behavioral modification, behavioral activation,

systematic desensitization, and flooding; and nondirective Rogerian approach for nonimmigrant youth [14, 28]

Eye Contact and Other Gender-Related Issues Eye contact is seen as an important aspect of the therapeutic relationship. A patient who does not maintain eye contact may be considered defensive, evasive, or even psychotic. For Muslims, eye contact will vary depending on the level of acculturation, religiosity, and gender of the individual. For example, many Arab women presenting for services have avoided eye contact as it is seen as a sign of disrespect. From a religious perspective, eye contact between males and females is discouraged as it may provoke inappropriate feelings. Acts of physical touch (e.g., handshakes, hugs, etc.) are forbidden between males and females. The author recommends that the clinician follow the patient in this matter. If the patient reaches out to shake the clinician's hand, the clinician may do so accordingly.

In Islam, modesty is considered one of the most important ethical principles pertaining to cross-gender interactions [31]. This can be seen in practice in women wearing the head covering (*hijab*) and men lowering their gaze when interacting with women. Furthermore, Islam emphasizes the protection of individual dignity. *Khalwah* is defined as the situation in which a man and a woman are both located in a closed place alone and the possibility exists that sexual desire between them can occur, which can subsequently lead to committing the cardinal sins of fornication and adultery [35]. Therefore, this is prohibited in Islam. This may cause Muslims to feel anxious when in seclusion with a nonrelative. A clinician can overcome this by involving a family member in the treatment process. A Muslim woman will feel much safer if her father or husband is also part of the process as much as is feasible, especially with a male clinician. Some of the concerns can be dealt through psychoeducation on the roles, ethics, and legal aspects of the psychotherapeutic practice. Small practices, such as leaving the door propped open, may make it easier to overcome this issue.

Gender-related issues may also arise in working with couples. Muslim immigrant marriages tend to share some common characteristics such as arranged marriage, patriarchal leadership, distinct gender roles, conservative sexual standards, and an emphasis on honor and shame that regulates family interactions [1, 3]. If a clinician is conducting therapy from a client-centered approach, it is helpful to recognize how individuals view their gender roles. For example, majority of the immigrant Muslim women believe that their purpose in marriage is to manage the home sphere and assume this as their primary responsibility [1].

Other Issues Related to Couples It is often beneficial to become aware of one's own biases that may interfere with the patient-doctor relationship. Muslim couples may have distinct gender roles and patriarchal authority which a Western practitioner may see as oppressive. It is not recommended that a clinician challenge these roles as it may damage the therapeutic alliance. Abbot et al. have recommended inquiring from the couple how their roles in the relationship allow them to show one

another love, thereby allowing them to explain how their roles are important to their responsibility toward their family [1].

Men are considered the authority figures in most Muslim families. Al-Krenawi and Graham [6] have recommended assessing this from the initial session as this will determine who will lead the therapy process. Physical intimacy is also defined through religious principles [13]; however, sexual intimacy within a marriage is not only endorsed but encouraged. Some conservative Muslim couples may be very hesitant to discuss intimacy with someone outside of the marriage. If religious-related issues arise in the process, consultation with the clergy will become important.

One of the major causes of divorce among Muslims is in-law-related issues. This typically stems from the Islamic obligation of the child to take care of his/her parents. Since males usually bear this burden, husbands often neglect the rights of their wives while fulfilling their obligations to their parents. Furthermore, families of the couples are often heavily involved in their lives. As stated previously, Muslims show greater flexibility when addressing cultural issues than religious beliefs.

Muslim Youth In the United States, Muslim youth primarily consist of children to first-generation immigrants from Muslim countries. This often leads to a difference in acculturation and complicated effects. Often, the youth tend to develop a hybrid cultural identity that consists of aspects from the mainstream American culture as well as of their own culture of origin [14]. Therefore, mental health issues tend to be higher among second-generation immigrants. This has to be taken into consideration since all of the beliefs and practices do not follow one culture. As always, much benefit can be gained through a detailed assessment of the patient's acculturation and religiosity. For example, a man in his 20s was Islamically married to his wife. However, since she had not moved into his house, he was told by his parents that it is Islamically forbidden for them to spend time together.

If the parents are immigrants, language barrier may also become an issue. Clinicians must obtain translators from outside the family, especially when the child is the patient and acts as the translator for the parents [34]. Clinicians need to identify and process culture- and religious-specific stressors including discrimination, threats to safety, victimization, and trauma [14]. If the clinician approaches cultural or religious issues with the lack of care or humility, this can damage the therapeutic alliance. Muslims tend to look to religion for healing, and the therapist needs to be considerate of this [12].

In collectivistic cultures, family members tend to become involved in the treatment and care of a patient. Clinicians should be aware of interpersonal dynamics, especially among parent-child relationships, since these can serve as both strengths and challenges to the mental health of the patient. It is not unusual for multiple family members to attend therapy sessions to provide support [14]. This is often observed in Indo-Pakistani families.

Medication Use with Muslim Patients

Islam does not prohibit the use of medication, especially if it becomes necessary for the individual. On the contrary, Islam actually encourages the ingestion of medicines to expedite convalescence. Muslims often seek out naturally derived medicinal regimens including vitamins and other supplements, naturopathic or homeopathic medicine, or probiotics. If the hesitation to medication is due to religious reasons, imams may help clarify this. However, it may also be due to lack of knowledge. A religious issue may be that the medication may contain prohibited ingredients such as pork gelatin commonly used in capsules [36]. Adherence to medications will be affected while fasting, especially during the month of Ramadan. Muslims are obligated (with some exceptions) to fast in Ramadan by abstaining from food and water throughout the daylight time. If medication is required for psychological functioning, it may lead to some level of resistance. A clergy member may feel that fasting is more important, whereas a clinician may feel that medications are more important. A collaboration between the two can often help resolve this dilemma for the patient. In some situations, a different type of medication (e.g., extended release) or a different dosage may help accommodate fasting, leading to an increase in compliance by the patient [36]. A woman presented to Khalil Center with bipolar disorder. She was prescribed a strict regimen of mood stabilizers but was worried about missing her Ramadan fasts. A team consisting of her therapist, her psychiatrist, and an informed scholar consulted on the case and provided the recommendation that she should not fast as medications were more important for her.

Common Errors Made by Clinicians

As humans, it is often easy to become influenced by the social, cultural, and political climate in which we exist. This can lead to biases and heuristic tendencies. A clinician must be mindful not to overextend his or her expertise and to generalize within the therapeutic relationship. For example, if a cultural matter arises during therapy, it would be better to ask the patient for clarification. For religious matters, it is best to consult a religious scholar. It is wise to recognize patients' and clinician's indigenous cultural narratives and attend to how subjective experiences of social oppression and stereotypes of the other influence the clinician, the patient, the process, and the outcome [40]. Silence in the session may indicate resistance from a patient or a lack of understanding from clinician. This can be further exacerbated by patient's notion of being socially oppressed. Clinicians can expect scrutiny of stereotypes and biases and the possibility of being considered complicit in the patient's experience of social oppression [26].

If the relationship has been ruptured and the Muslim patient appears withdrawn, the clinician may seek surface-level clarifications and explore the topic in here and now terms [37]. For defensive patients who have felt criticized or judged, the clinician may respond nondefensively and acknowledge how the patient may have felt

this way. If the patient is late or misses a scheduled appointment, this should be discussed in the subsequent appointment.

Conclusions

Islam maintains a diverse sociocultural following as the second largest religion practiced in the world. The changes observed in the past two decades have significantly altered public perceptions of and behaviors toward Muslim Americans. This has led to a shift in the psychosocial challenges faced by this group. Even with a higher need for mental health services, Muslims tend to be reluctant to seek professional help for their individual or familial issues. Among the reasons for these attitudes and behaviors are stigma surrounding psychological illnesses, mistrust of clinicians, as well as shame incited by cultural politics of family honor.

In treating Muslim patients, practitioners need to be sensitive to cultural and religious aspects of their issues, with an understanding of the structure of Muslim households and communities. Having established trust, the clinician can further assess the role of religion and community violence, loss, or trauma in the patient's life. With increased religious affiliation and practice, patients may have reservations about cross-gender interactions, including handshaking or eye contact due to their understanding of modesty in Islam. In certain cases, it may be beneficial to seek involvement in treatment from family members or clergy to increase trust and comfort of the patient. Muslim American youth undergo a variety of challenges that affect their identity development as well as their religious family dynamics. Their level of religious affiliation and child-parent relationship should be considered when evaluating Muslim youth for religious-specific stressors such as victimization, threats to safety, and discrimination.

Even with a gap in the literature in this area, many resources are available for those who are treating Muslim patients including the Institute of Muslim Mental Health, the Khalil Center, the Stanford Muslims and Mental Health Lab, and local Muslim clinicians and imams. The strength of one's approach and the efficacy of the treatment may be increased by collaborating with these institutions and individuals to ensure appropriate and comprehensive care for Muslim American patients.

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Understanding Islamophobia and Its Effects on Clinicians

16

Samaiya Mushtaq and Saira Bhatti

Introduction

In this chapter, we address the importance of being aware of both the concept of "Islamophobia" as well as the implications it has for us as professionals in the field of psychiatry. We do this by proposing a discussion in three sections. In the first, we consider whether it is accurate to call Islamophobia a "phobia." Next, we discuss dealing with patients expressing anti-Muslim sentiment and the effects of these experiences on Muslim clinicians. Lastly, we explore whether there is a place to discuss anti-Muslim views with patients who hold these views in a clinical setting and whether this has the potential to be of therapeutic benefit.

Is It Accurate to Call Islamophobia a "Phobia"?

Users of the term "Islamophobia" attempt to define discriminatory attitudes toward Islam and the resulting negative effects on Muslims. In employing this term, we refer to Islamophobia as attitudes toward Islam and Muslims that are indiscriminately or uncritically negative, as opposed to carefully thought and researched critiques of the religion [1]. However, it can be argued that the term Islamophobia is a misnomer in that it is not a true phobia that would meet the DSM 5's diagnostic criteria for a phobia. It can instead be seen as more of a social term or "social phobia," arising from similar sociopolitical climates that brought about the terms "homophobia" or "xenophobia." Islamophobia, like many other social phobias, is an attempt to distinguish an in-group from an out-group. In the case of Islamophobia, members of the in-group are those who do not appear to be Muslim, and the

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members of the out-group are those who stereotypically appear Muslim (i.e., women who wear traditional Muslim garb like a headscarf [2] or men with darker skin complexion [3] and long facial hair [4]).

As the name would imply, Islamophobia can be seen as a form of religious-based discrimination but only partially so. Islamophobia, while based on a self-proclaimed identity manifested through wearing a headscarf or publicly identifying as Muslim in some other way, is socially centered more around an identity *perceived* to be a specific group of people. This is evidenced by events such as attacks on Sikhs (a non-Muslim group often of South Asian backgrounds) and the Muslim travel ban (which indiscriminately targets specific countries thought to be predominantly Muslim without taking into consideration the possibility of extremism and terrorists existing in other parts of the world).

As argued by renowned twentieth-century scholar Edward Said on Orientalism, Islamophobia is always inextricably linked with the idea of foreignness, non-White, or "other" and finds it roots in Orientalism [5]. Through Said's magnum opus *Orientalism*, it can be seen that the origins of Orientalism and anti-East sentiment began centuries ago and have since extended to those who *appear* to be "other," Muslim or not [6]. This, in addition to its past in the West, would suggest that Islamophobia may carry some racial component in its applications today.

Islamophobia, translating literally to "fear of Islam," indicates a fear of religion, and not race. This would make it seem as though racism is distinct from "Islamophobic" sentiments, but this is not entirely the case. In addition to religious discrimination, Islamophobia can be thought of as also combining cultural intolerance and racial discrimination [7]. This can be explained though exploring "race" as a concept, cultural intolerance or racism, and the racialization of Islam.

Race exists as a fluid concept, and racial discrimination in turn is a result of these socially constructed groupings. To define racial discrimination, we employ the definition as used by the US Equal Employment Opportunity Commission: "race discrimination involves treating someone unfavorably because he/she is of a certain race *or because of personal characteristics associated with race (such as hair texture, skin color, or certain facial features)*" [8]. Such personal characteristics are what we use to organize and create the social constructs of various "races." Research has long shown that the concept of race has no biological or scientific basis; this was announced in a statement issued as far back as 1950 by the United Nations Educational, Scientific and Cultural Organization (UNESCO) [9, 10]. Since then, statements from organizations such as the American Anthropological Association and the American Association of Physical Anthropologists have echoed these sentiments [11, 12]. Therefore, race as the term exists in the USA is a "floating signifier" [13] and a socially created construct [14] used to denote certain connotations of groups of people based on appearances.

If Islamophobia is based partly on the appearances of those on the receiving end of it, and race is a social construct based on appearances, it can be concluded that part of Islamophobia is racial discrimination, as multiple organizations and scholars also contend. An international organization for racism and intolerance (ECRI) conceptualizes Islamophobia as including "forms of racism and discrimination or more

violent forms" [15]. The Swedish National Encyclopedia draws parallels between Islamophobia and anti-Semitism, stating "Islamophobia is fear of Islam, exaggerated notions that Islam is a religion that leads to negative behaviors and that Muslims' presence in a society is a danger. Islamophobia is often combined with ideas of a major Muslim conspiracy aimed at overthrowing Western society, as compared to anti-Semitism" [15]. The Swedish Integration Board has described Islamophobia as expressions that are racist, discriminatory, and directed against Muslims [15]. Chris Allen, a British researcher, has proposed that Islamophobia be defined as an ideology comparable to racism [15]; Professor Sayyid of the University of South Australia has backed this sentiment, expressing that the concept of racism does not depend on the existence of races but on physical appearance [16].

By conceptualizing Islamophobia as a form of both religious and racial discrimination, we can then begin to explore reasons for why it is detrimental to continue to refer to it as a phobia (see Fig. 16.1). This is especially applicable to those of us in the field of psychiatry, where understanding this term as distinct from a true clinical phobia is critical.

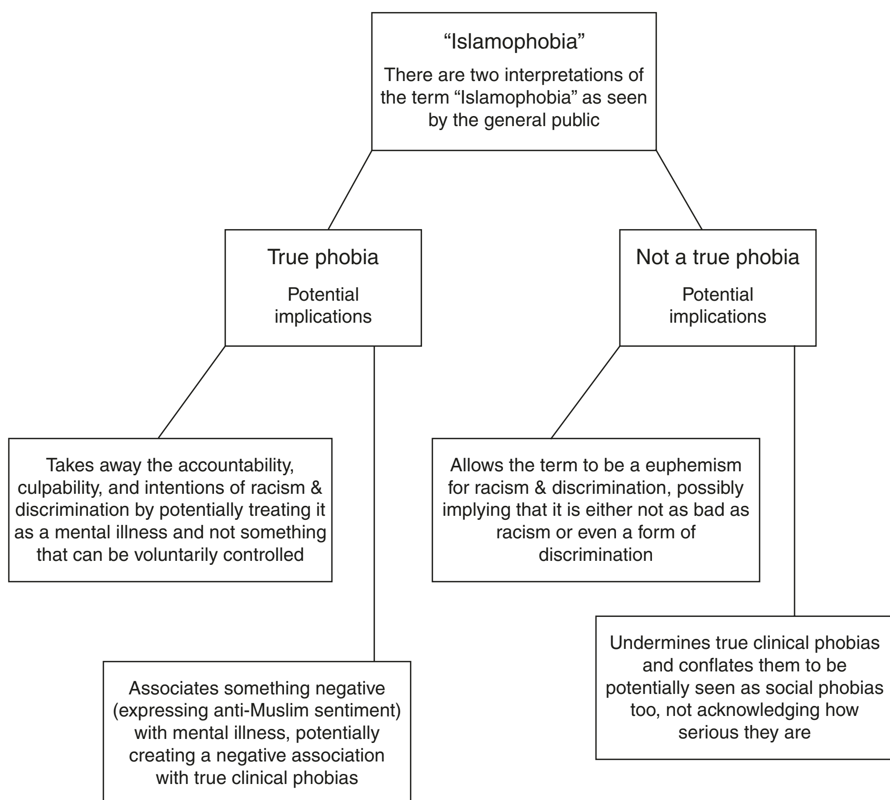

Fig. 16.1 The implications of the term "Islamophobia"

First, the term “Islamophobia” can unintentionally serve to take away the accountability, culpability, and intentions of discrimination by using the same terminology as is used in addressing psychiatric illness. This can occur through the association of the term “phobia” succeeding “Islam,” which can also imply that being Islamophobic or exhibiting Islamophobia is something that cannot be voluntarily controlled, as is in the case of psychiatric illness. It can subsequently be a way to defend negative sentiments about those practicing Islam [6].

Second, when conceptualizing Islamophobia as discrimination and using the term “Islamophobia” in public discourse, the term’s existing negative connotation could extend into the public’s understanding of psychiatric illness. While this misinterpretation and misunderstanding of a phobia may be difficult to imagine as potentially occurring, it is imperative to remember who the audience is in public discourse – the general public, many of whom are not very familiar with psychiatric illness or lack mental health literacy. Again, using the word “phobia” relates the term to psychiatric illness, potentially encouraging the illogical relationship between anti-Muslim views and true phobias. This ultimately serves to create a negative connotation with true clinical phobias, further stigmatizing psychiatric illness. Consequently, by referring to something that is not a true clinical phobia as a “phobia,” we risk undermining true clinical phobias and conflating them with social phobias too, thereby inadvertently undermining how serious and debilitating a true psychiatric illness can be. Overall, this has the potential to create a confusing exchange of terminology (see Fig. 16.2).

Lastly, perpetuation of the term “Islamophobia” could paradoxically create issues opposite to what the term was intended to help. As we have demonstrated above, not only is the term “Islamophobia” a misnomer in its application, but it arguably serves as a euphemism for discrimination, allowing it to be perceived as something less nefarious. The term’s allusion to mental illness, which has nothing to do with intentional discrimination toward a specific group, also disconnects the term from other terms describing types of discrimination and, as a result, dilutes its meaning. In contrast, terms such as “anti-Semitism,” “bigotry,” and “racism” each

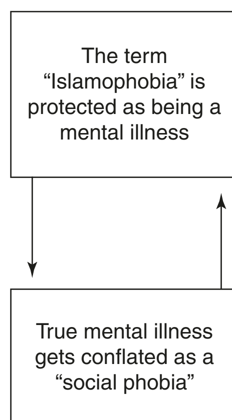

Fig. 16.2 “Islamophobia” and mental illness

clearly define a type of discrimination without alluding to words that connote a lack of agency and intentionality. Additionally, the “phobia” in “Islamophobia” distracts from the true purpose behind the use of the term: to define a type of discrimination rampant and overt around the world, today.

It is important to examine the potential negative implications of the term “Islamophobia” to address anti-Muslim sentiment, as its continued use may be a disservice to those suffering from religious and racial discrimination as well as psychiatric illness. As professionals in the field of psychiatry, we must constantly be cognizant of the consequences that misnomers can unintentionally have on both patients and the general public.

The Effect of Islamophobia on Muslim Clinicians

Anti-Muslim sentiment toward Muslim physicians has become a more pervasive phenomenon since 2001 and can manifest in multiple ways within institutions or by patients or colleagues. In 2008, JAMA published a book review on anesthesiologist Dr. Adam Dorin’s book, *Jihad and American Medicine*, a manual of sorts for counter-terrorism techniques against an anticipated attack of the US healthcare system [17]. The book review described Americans as “naïve and in denial” about their own vulnerability and assumptions of trust toward their clinicians. Despite this, in a review of 154 hospital-based shootings from 2000 to 2011, none were carried out by jihadists [18]. Nonetheless, the book and its review continue to exemplify how Muslim physicians may be uniquely cast as others, terrorist-sympathizers, or would-be-perpetrators themselves.

About 5–10% of the physician workforce identifies as Muslim [19, 20], a significant proportion when considering that only 1% of the US population is part of the Islamic faith. Results published in 2015 from a nationwide survey of 255 Muslim clinicians found that 24% of respondents reported workplace discrimination occurring “sometimes” or “often” over the course of their career, and 14% reported that they were experiencing discrimination in their current job [19]. Nine percent of the 255 respondents agreed that patients had refused their care because of discrimination. The experience of patient discrimination toward Muslim clinicians can be especially demoralizing for physicians for whom Islam is central to their vocational calling. In an opinion-piece published in the *Washington Post* in 2016, Dr. Jalal Baig, then an oncology fellow in Chicago, reflected upon the experience of having a patient refuse his care [21]. His commitment to both the Hippocratic Oath of his profession and the principle of justice within his faith tradition mitigated the anger he might otherwise have felt, but his experience speaks to the dissonance between Muslim physicians’ practice of Islam and the unfortunate perception of the very same by many of their own patients. That the devoutness of faith is what often inspires the values of compassion and beneficence espoused by their clinicians is often lost on patients who discriminate on the basis of their clinicians’ religion.

Incidents of discrimination are particularly jarring when displayed by clinicians’ fellow physicians and staff, likely given the expectation of colleagues to have

similar levels of education and by proxy broader perspectives and deeper understanding about different religious beliefs and practices. During a small focus group at the institution of these authors on workplace discrimination, five resident physicians recalled incidents of offhand comments about religious attire or practices directed toward them by colleagues or superiors, including but not limited to disdainful jokes about the headscarf and religious practices such as prayer and fasting. Trainees, in particular, may be susceptible to such comments due to the existing hierarchy within medicine and less likely to address them due to fear of retaliation. In the previous study, only 4% of attending clinicians had reported discrimination to their employer. Such encounters can also have potential implications for future employment: in the previously cited study, 12% of physicians felt that they had been passed over for professional advancement because of their religion, and 7% left a job due to workplace discrimination [19].

From a psychiatric perspective, in the absence of any large-scale studies exploring further outcomes unique to Muslim physicians, one could extrapolate that the effect of bigotry on Muslims in the general population also includes Muslim physicians. Within a clinical context, Muslim physicians may find it difficult to receive the trust of their patients when there exists suspicion toward their religious identity. Additionally, given higher patient satisfaction scores in religiously-concordant dyads, it is worthwhile to consider the potential for lower scores for Muslim physicians, especially when taking into account that Muslims are the least-accepted religious group, just behind atheists [22]. That these scores can then affect compensation bonuses and promotion again reflects how the experience of discrimination affects professional development and advancement. This may be particularly true of visibly Muslim clinicians, such as women physicians who wear the headscarf. Finally, experiencing routine discrimination often results in the same symptoms that comprise the syndrome of burnout: emotional exhaustion, depersonalization, and a low sense of personal accomplishment, to which physicians are already more susceptible than the general population [23]. Thus, given that a number of Muslim physicians currently experience discrimination in their workplace, it is important to consider the potential for loss of agency in the clinician-patient relationship and a sense of burnout in this population.

Aside from these broader consequences, the experience of patient and colleague discrimination can simply be isolating and painful for Muslim physicians. Nonetheless, in the previously cited survey, only 9% felt that their religion had a negative influence on their relationship with their colleagues, compared to 66% finding it a positive influence, suggesting that while these incidents do occur, there are also instances of support that Muslim clinicians experience in their place of employment. A potential option for employers to consider in engaging this population involves wellness initiatives directed toward Muslim residents and faculty to provide support and engagement at the institutional level, to prevent isolation and burnout, and to foster an environment of understanding and acceptance. For example, the authors' institution has accomplished this by hosting an annual Ramadan dinner (*iftar*) for Muslim house staff as well as by developing a support group for Muslim residents with quarterly meetings on-campus to discuss issues relevant to Muslim clinicians, including campus prayer space and the experience of discrimination.

Addressing Islamophobia in the Clinical Setting

One manifestation of bigotry in the clinical setting is patients requesting that specific clinicians be excluded from their treatment team, as mentioned previously in the case of Dr. Baig in Chicago [21]. A 2016 Perspective piece in NEJM provided a suggested algorithm for physicians experiencing such a situation, which included the consideration of such factors as the patient's condition and capacity, the reason for the request, and the effect on the physician [24]. Ethico-legal dimensions of such a dilemma involve a physician's employment rights against discrimination and the patient's right to autonomy and refusal of care. Recommendations offered for navigating such a situation include reasoning with the patient or family, reallocating patients to another physician if feasible, or allowing a nurse or resident to conduct the evaluation. The article does note that the reason behind such requests is an important point of consideration, given that patients who are racial or religious minorities may seek out concordant clinicians to mitigate cultural barriers such as language or gender segregation. Ultimately, the article proposes that while institutions should not accommodate requests based on discrimination in stable patients, the personal decision to accommodate such a request may be under the purview of the individual physician [24].

In making the decision of whether or not to acquiesce to a patient's bigoted demands, an individual physician may find him or herself in the unfavorable position of having to consider their own self-interest against that of his or her patient. This self-interest includes not only one's own dignity but also that of security: patients, particularly those whose requests are refused, could potentially escalate to being verbally threatening or abusive, in which case patient, clinician, and staff safety is of the foremost concern. Trainees may again be particularly vulnerable in such situations; when this is the case, attending assistance in management of the situation and subsequent processing of it can be helpful, whether at the bedside or in a formal setting such as the authors' institution's network for Muslim housestaff discussed earlier. To that end, it may also be prudent for institutions to develop center-wide policies and training programs for navigating such instances, akin to how dozens of academic institutions voiced opposition to the presidential travel ban [25]. One such statement was drafted at Penn State Health Milton S. Hershey Medical Center, where it is used in the patient's rights and responsibilities contract. The policy cites zero tolerance for "threats, violence, disrespectful communication or harassment" of other patients or staff and explicitly states that "requests for changes of provider or other medical staff based on the provider's race, ethnicity, religion, sexual orientation or gender identity will not be honored" [26].

While clinicians can look to such perspectives on how physicians and institutions have responded to bigotry in the form of patient requests based in discrimination toward clinicians, psychiatrists are in the unique position of being able to explore and potentially challenge patients' anti-Muslim views as they would any other distorted thought process in the course of treatment. There are multiple factors to consider in how psychiatrists in particular can respond to patients with these xenophobic thoughts, including the patient's illness, the clinical setting, the continuity of care,

the patient's ego strength and willingness to change, and the clinician's own background. In psychotic patients, it is possible that anti-Muslim thoughts and expressions may be attributable to hyperreligiosity or paranoia and needs to be treated accordingly, whether in the inpatient or outpatient setting. In organized, nonpsychotic patients, psychiatrists may find themselves hesitant to address patients' bigoted views in consult, inpatient, or outpatient settings in which there is limited continuity, as they may feel they do not have the resources of time or continuity to make a meaningful impact on a patient's perspectives. Additionally, psychiatrists who are not personally affected by bigotry may also find it unnecessary to express their disapproval of a patient's outward expressions of hostility toward other groups that the psychiatrist does not personally identify with or even consider it a threat to their own rapport with the patient. However, the technique of bystander intervention in sexual harassment [27] and the policy of "see something, say something" in homeland security [28] are models of encouraging unaffected individuals to assume part of the responsibility of addressing threats to the well-being of others; these could be considered by psychiatrists who are not personally affected by anti-Muslim sentiment as a means of sharing the burden of challenging it.

In the non-acute setting in which a clinician can form a longer-term relationship with a patient, anti-Muslim views could be explored in greater depth in order to invite patients to critically examine their biases. A clinician may respond to a patient's bigoted views by helping identify what experiences drive such thoughts and how pervasive they are in the patient's life. A clinician must be thoughtful about fostering an environment which gives a patient freedom to discuss such thoughts but also allows healthy challenging of them. Indeed, if a patient is able to tolerate a continued therapeutic alliance with a Muslim psychiatrist in particular, the transference within the therapy space could be particularly useful in challenging a patient's anti-Muslim thoughts. Any clinician may experience their own countertransference toward a patient expressing xenophobic thoughts or behaviors. This could be especially pronounced for a clinician who practices Islam or has experienced bigotry due to his or her own race, religion, or sexual orientation; therefore, clinicians working with such patients may benefit from their own supervision. Ultimately, psychiatrists ought to consider the possibility that it is very much in the realm of the professional scope to address Islamophobia as a distorted thought process, regardless of the clinical setting and the clinician's own background.

Conclusion

In conclusion, anti-Muslim rhetoric is a pervasive issue affecting patients and clinicians in multiple negative ways. By providing a framework for understanding what "Islamophobia" truly is and means and the effects of its prevalence, we as clinicians can aim to better advocate for our patients and one another, as well as develop a clearer and more empathetic understanding for what our Muslim patients and colleagues experience is in the current sociopolitical climate. Lastly, and more generally, we can provide greater support and voice to the often silenced and marginalized, whether or not they happen to be our patients.

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Muslim Psychiatrists in Training Address Islamophobia in Clinical Experiences

17

Salam El-Majzoub and Mim Fatmi

Introduction

The lives of Muslims in North America have been arguably forever changed by the events of September 11, 2001. Since then, a cultural and political climate shift has taken place that often pins Muslims at the centre of various controversies. The campaign of the current American president was largely founded on scapegoating the average Muslim American citizen. Media outlets grossly overemphasize crimes committed by Muslims by dedicating five times the amount of coverage to Muslim terrorist attacks compared to white terrorists [1]. This increased media exposure results in increased anger and reduced warmth towards Muslim, regardless of the viewers' political ideology [2]. In 2015, hate crimes against Muslims were the highest they have been since immediately post-9/11; yet this encompasses only a fraction of perceived anti-Muslim incidents [3]. For example, Craig Stephen Hicks, the culprit of the Chapel Hill shootings in which three Muslim university students were murdered, was not charged with a hate crime [3, 4]. Muslims have watched Western media and political influences essentially claim ownership over their narrative, such as completely redefining the word "Islamist" to refer almost exclusively to militants overseas claiming to be Muslim [5]. Instead, Muslims in the Western world are constantly expected to condemn acts of terrorism occurring across the globe that they took no part in, and a refusal to participate in this dialogue often leads to accusations of condoning these acts. This climate shift must be acknowledged and explored in order to garner an understanding of how Islamophobia has affected Muslims working in mental health and our Muslim patients.

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Islamophobia and Its Impact

For the purposes of this chapter, we must define Islamophobia and attempt to understand the fear and other emotions that underlie it. We will borrow the definition used in the 2011 report entitled "Fear, Inc.: The Roots of the Islamophobia Network in America" by the Center for American Progress:

> An exaggerated fear, hatred, and hostility toward Islam and Muslims that is perpetuated by negative stereotypes resulting in bias, discrimination, and the marginalization and exclusion of Muslims from America's social, political, and civic life [6].

One must wonder if the roots of Islamophobia are grounded in fear, malicious intent, mere ignorance, or some combination of the above. Indeed, the term "Islamophobia" can be problematic by implying that fear is its underlying emotion, when in fact individuals who despise Islam and its adherents may do so without experiencing fear of any sort. A term like "anti-Semitism" more accurately captures the hatred directed at a religion and its people, and the late Edward Said astutely notes that hostility to Islam in the modern Christian West has historically gone hand in hand with anti-Semitism, nourished by the same stream [7]. We discuss later in the chapter the emotional vulnerability that may exist at the root of Islamophobia.

While anti-Muslim sentiment existed prior to 9/11, it certainly became much more prominent after the attacks. If September 11, 2001, is taken to be the watershed moment before which time Muslims were generally viewed as any other visible minority in North America, what was required for the perception of Muslims to become what it is today?

In the immediate aftermath of 9/11, then President of the United States George W. Bush went to great lengths to assure Americans that Muslims and Islam were not the enemy. In a statement at the Islamic Center of Washington, DC, he said,

> The face of terror is not the true faith of Islam. That's not what Islam is all about. Islam is peace […] Those who feel like they can intimidate our fellow citizens to take out their anger don't represent the best of America, they represent the worst of humankind, and they should be ashamed of that kind of behavior. [8]

This is in stark contrast to the rhetoric that is being espoused in the political climate today. The report conducted by the Center for American Progress suggests that it was not until a year or two after 9/11 that this rhetoric was eclipsed by an orchestrated movement from what would become an Islamophobia network. Many of these sensationalist documentaries, websites and right-wing think tanks would not arise until 2010 (cf. Pamela Geller's Stop Islamization of America). An ABC News poll in 2006 indicated that the proportion of Americans who believe that Islam stokes violence against non-Muslims had more than doubled, from 14% in 2002 to 33% in 2006 [9].

What happened in the decade after 9/11 to shift the public perception of Muslims from victims of a religion hijacked by extremists to becoming directly associated with terrorism themselves? One can deduce from this delay that the answer is more

than a reaction to the attacks themselves but that a larger and more organized social and political movement must have occurred. Seven foundations contributed a combined $42.6 million over 10 years since 9/11 to fund organizations like Jihad Watch and Stop Islamization of America [6]. These groups directly inform media outlets such as the Fox News channel and the Washington Times, who go on to broadcast their own narratives about Islam and Muslim Americans [6].

The impact of this messaging reaches beyond social stigma and alienation, affecting both the mental and physical health of Muslims and visible minorities not only in the United States but in other countries in the West such as Canada, France, the United Kingdom and Australia [10]. In a survey of 1,016 Arab Americans in the Detroit area including Muslims and Christians, 25% reported personal abuse or abuse of a household member based on race, ethnicity or religion [11]. Psychological distress as measured by the Kessler Psychological Distress Scale was higher in respondents who reported personal or family abuse and personal bad experiences after 9/11, as well as those who perceived a lack of respect in US society for Arab Americans [11]. Reports of personal or familial abuse or personal bad experiences had stronger negative associations with one's level of happiness than did any of the socioeconomic or demographic factors assessed [11]. In self-reported health status, reported personal or familial abuse was associated with worse health after adjustment for sociodemographic characteristics. Perceived religious discrimination was shown to be associated with an increase in suspicion, vigilance and mistrust in Muslim American males compared to women in study of 152 Midwestern American Muslims [12]. The authors queried whether this subclinical paranoid ideation in Muslim men may be the direct effect of fear, suspicion and anger targeted at them in public places such as airports or the workplace [12].

Islamophobia is a force that seems to have only grown in size since the September 11 attacks, and its impact on Muslims living in the West must be recognized in order to gain insight on the current state of Muslims and their mental health at large. We go on to explore how Islamophobia has affected Muslim clinicians in their practice.

Otherizing the Muslim Clinician

Reporting on the religious backgrounds of physicians is limited, but the most recent available data suggest that Muslims make up 2.7% of American physicians yet only 0.5% of the US population [13]. Despite the fact that one is more likely to run into a Muslim at the doctor's office than at the grocery store, Muslim clinicians are, like all clinicians of visible minority status, subject to being treated as an "outsider" by their patients or colleagues. A study of 255 American Muslim physicians showed 25% reported experiencing religious discrimination in their career [14]. This can present in overt forms of racism but can also take the subtle form of microaggressions that may be harder to recognize. Microaggressions are comments or actions that subtly and often unintentionally express a prejudiced attitude towards a member of a marginalized group [15]. Examples of this include "Your English is so good—you don't

even have an accent!" or "How long have you been in Canada?" Even being asked "Where are you from?" can feel somewhat tiresome, especially when the questioner is unsatisfied with an answer suggesting the clinician is from a North American city or any place other than an "exotic" country the questioner might have had in mind. The difficulty with microaggressions is that if the subject confronts the perpetrator about their prejudiced nature, the subject risks being accused of hypersensitivity or paranoia; if the subject ignores the microaggressions, they risk becoming the target of future transgressions [16]. Just as a female physician is more likely to be mistaken for a nurse than a male physician, these microaggressions are more of a nuisance for the subjects than a display of true hostility on an individual level. However, in large numbers, they form the foundation of the Pyramid of Hate, a well-known idea in the social justice field demonstrating the steps from individual bias to institutionalised discrimination and, ultimately, socially accepted violence (Fig. 17.1) [17].

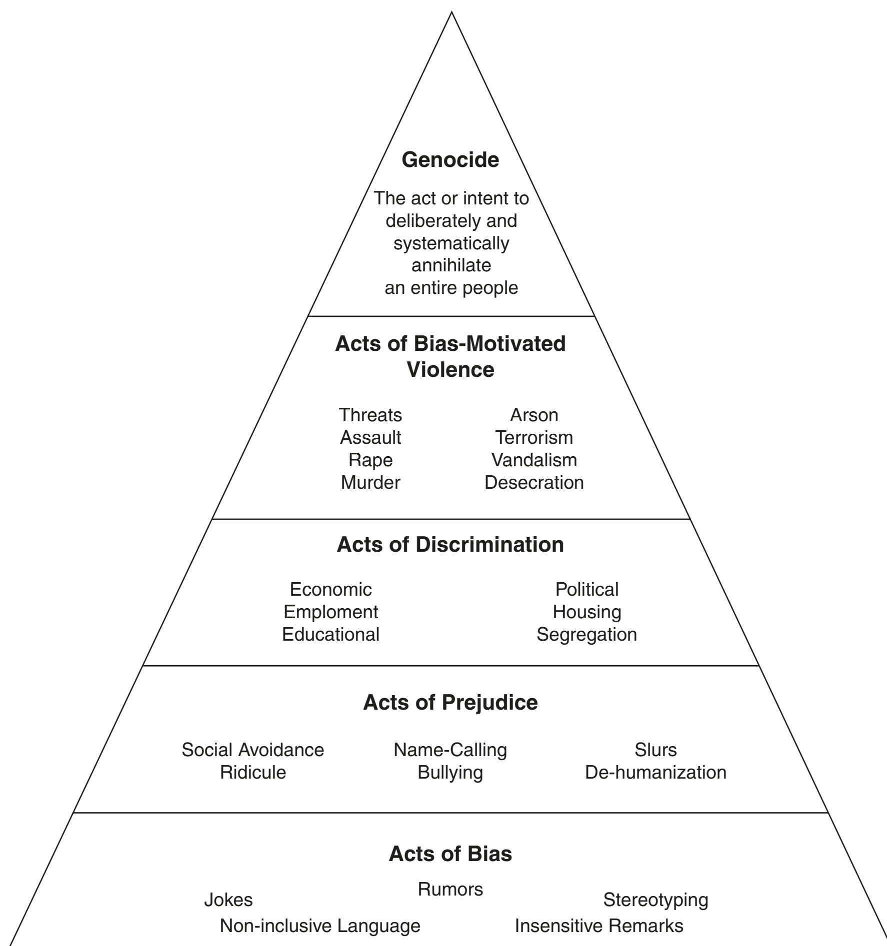

Fig. 17.1 The Pyramid of Hate

There are likely several root emotions or defence mechanisms that underlie these initial acts of bias that lead to violence or aggression. However, as denoted by the very word "Islamophobia", fear can be a primary motivating emotion. In fact, over the past 17 years, we have observed how fear was capitalized upon by generously funded media groups to assert that the concern for citizens' safety was so dire that the issue has become one of national security and protecting our very lives [6]. If it is indeed fear and vulnerability that drive the current vehicle of Islamophobia in most North American citizens—fear of another terrorist attack, fear of individual safety, fear for their families—then one may assert that the vulnerability experienced by the common American citizen is amplified in the patient experience.

There are few settings in which individuals must make themselves as vulnerable, exposed and trusting as that of the patient-doctor relationship. Perhaps individuals who generally feel confident in themselves, their opinions and their ability to defend themselves in common public settings such as malls and parking lots suddenly feel stripped away of these layers of protection when entering the physician's office. Physicians are felt to be in an authority position, especially when asking the patient to reveal private information regarding their health and wellbeing. This experience may be exacerbated when the physician is Muslim—when the image of a Muslim as portrayed in the media produces hostility and mistrust in the patient, when trust should be the basis of the patient-doctor therapeutic relationship. These individuals may have no problems in their interactions with Muslims while conducting business or travel, where there exists less of a power differential. Indeed, one may speculate if patients who lash out with Islamophobia or racist microaggressions in their doctors' offices are driven to do so by their perceived vulnerability which they are usually able to safeguard while outside the clinic doors.

Being Visibly Muslim in the Mental Health Setting

It is not surprising that the current sociopolitical environment has had repercussions on mental health encounters involving Muslim clinicians or Muslim patients. The negative public attitude affects any individual perceived as having an Islamic affiliation, thus colouring the patient-doctor relationship [18]. It is even clearer when the target is visibly Muslim as indicated by a religious symbol such as the veil. The veil (or *hijab*) is a key symbol in Islam with many layers of significance but is often misinterpreted as a representation of inequality in the Western perception. The visibility of the veil has made its wearer a vulnerable target for everything from large-scale political policies to violent Islamophobic attacks in the West [19]. In fact, Tell MAMA, a reporting agency in the United Kingdom that monitors Islamophobic attacks, reports that Muslim women make up the majority of victims of anti-Muslim hate in the streets and in person [20, 21].

This is important to bear in mind when visibly Muslim clinicians are attending to psychiatric patients. Several mental illnesses manifest with symptoms of disinhibition, impulsivity, irritability, risk-taking, paranoia and delusions. Verbal aggression is generally not uncommon amongst psychiatric patients, but when one's ethnicity

is clearly visible, it may easily become the target of anger with slurs and insults. A veiled woman can be viewed as an easy target for patients with borderline personality disorder to unleash their anger upon when in crisis. She can also easily become incorporated into the delusions of a psychotic patient. Being met with personal questions about one's religion and practice by manic or psychotic patients on the ward happens frequently. The medical field has taken a strong deontological stance against patient discrimination and efforts are made to treat every patient equally regardless of gender, ethnicity, religion and sexual orientation. On the other hand, there is limited literature on the opposite reality wherein a patient expresses racism and prejudice against a clinician. In the following chapter, cases will be used to illustrate the many clinical problems that may arise between the Muslim medical student, resident, psychotherapist or staff psychiatrist (henceforth referred to as "the clinician") and a mentally ill patient expressing religious prejudice. These cases reflect more severe mentally ill patients seen in tertiary care psychiatry centres. We offer recommendations tailored to each situation. All cases used in this chapter are derived from personal experiences, and any identifying characteristics have been changed to preserve confidentiality.

Conceptualization of Racism in Clinical Settings

Racism has been understood psychologically as a projection of what is unacceptable in the self displaced onto out-group members [22]. Most prejudices are commonly held beliefs present in the general population and could be the consequences of strong in-group identity [22]. Some have argued that extreme racism can be viewed as a delusional psychotic symptom [23], whereas others see it a societal problem [24]. However it can certainly co-occur with other psychiatric disorders and can be clinically significant in the patient's interaction with out-group members. There is limited clinical research around race and ethnic prejudice in the patient-doctor relationship and its manifestation in mental health settings. Sullaway and Dunbar [22] have conceptualized five subtypes of prejudice that could have clinical implications in mental health. These categories may help better understand the prejudiced patient and tailor help accordingly.

A. The critical incident prejudice response – a prejudice that forms after a traumatic experience with a member of the out-group member. It can be ego-dystonic to the person.
B. Avoidant out-group disorder – comparable to social phobia and avoidant personality disorders with avoidance and withdrawal from the out-group members.
C. Antisocial prejudice disorder – closely aligned with sociopathy and antisocial personality disorder, impulsivity and conduct disturbances are ideologically motivated.
D. Narcissistic/labile prejudice disorder – as manifested in cluster B personality disorders with affective lability, emotional instability and hostility/paranoia towards out-group members. We can hypothesize that it is produced by defence

mechanisms such as black/white thinking and splitting that characterize such personalities.

E. Paranoid/delusional prejudice disorder – expressed through fear reactions and rigid beliefs of the potential harm from out-group members as seen in psychosis-related disorders.

Case 1

Mr. A is a 62-year-old male with schizophrenia who was lost to follow-up after believing that his psychiatrist had entered his body. He self-referred to the ER, but when asked by a veiled psychiatrist about his reason for presenting to the hospital, he informed her, "Muslim society is homophobic, I want a Christian psychiatrist. Even a Jewish psychiatrist would do".

Mr. A would be categorized as exemplifying the avoidant out-group disorder with some paranoid/delusional prejudice. He is avoiding the veiled psychiatrist who represents the feared out-group by requesting another health-care provider with a less threatening religious affiliation. The Canadian Medical Protective Association issued a recommendation that primarily addresses patients who ask for another physician on religious or cultural grounds such as a woman wanting a female physician for a gynaecological exam [25]. They recommend clarifying the reasons behind the request and making an effort to accommodate those based on religious and cultural reasons. They note that the ability to accommodate the requests depends on the availability of resources and the urgency of the situation. They also advise clinicians to document the request as a way of protecting themselves legally and advising the patient of any risk they might encounter by delaying the clinical procedure [25]. In a patient-centred approach, the autonomy of the patient is respected within the limit of what is clinically indicated, reasonable, available and non-harmful for the patient and others. It does not imply accommodating *any* patient's request. In Mr. A's case, he is in an emergency setting with limited resources and only one psychiatrist on call. Moreover, these recommendations do not help when a request is discriminatory or racially motivated. Finally, there is limited literature available for recommendations on how to deal with patients with mental illness who are making requests of this nature. These kinds of request are emotionally harmful not only to the clinician but also to the other patients or health-care workers observing the discriminatory remarks. The Caregiver preference guideline developed and used at University Health Network in Toronto offers a standardized way of approaching discriminatory requests [26]. The first step is to "start a dialogue with patients to clarify the reasons, values, and beliefs behind [their] preferences, and offer them the opportunity to withdraw or clarify their request when provided additional information about the clinical competency of the care provider and organizational and government policies prohibiting discrimination" [26]. The second step is to involve a manager or supervisor to evaluate the reasons behind the patient's request and meet with the patient. In this meeting, this authority's goals are twofold: first to revaluate the reasons behind the request to ensure it is not a conflict of fundamental rights

protected by the Human Rights Code and second to inform the patient that the organizational policy prohibits discrimination and harassment against staff and that certain requests may violate the Charter of Human Rights. The third step is to give the control of the decision to the affected clinician; the clinician should have the choice of continuing care for the patient or transferring responsibility to someone else if feasible [26]. In Mr. A's case, a dialogue was started surrounding his worry that Muslim society is at large homophobic, exploring the impact of his belief in this situation, reassuring him about his legally binding right to not suffer discrimination in a patient-doctor relationship and insisting on the lack of availability of another psychiatrist when on call. While it took more time than expected, this approach was successful in dispelling Mr A's prejudice which is a manifestation of his paranoia and his personal sexual identity concerns; in this case, his transference in the interaction took the form of Islamophobia.

Case 2

Mr. B is a 56-year-old man with schizophrenia who presented as actively psychotic. He complained of his neighbours being immigrants, hearing "Islamic music" from their homes, feeling waves through the walls and feeling threatened by them.

Mr. B expresses paranoid/delusional prejudice. Persecutory delusions are the most common type of delusions expressed in psychosis according to the DSM-5 [27]. This preponderance persists across time periods and various cultures. Persecutory delusions may be influenced by sociocultural factors and contemporary or historic events. Delusional content has been documented to reflect the culture of the times, with increased frequency of delusions of being spied on in the 1950s, consistent with the Cold War and advance in technology [28]. Witnessing an increase in Islamophobia and the rhetoric around Muslims today, persecutory delusions involving fear of Muslims are likely within the current context of the "war against terror" where anti-Muslim and anti-Arab sentiments are widespread and higher than other anti-immigrant sentiments [29]. Would it be dangerous for a visibly Muslim psychiatrist to reassess Mr. B in the emergency department? What should we expect from patients when the psychiatrist is viewed as the enemy or the persecutor?

Safety should always be the first concern. Mental health clinicians have the responsibility to evaluate violence risk in patients and to make a judgement on the risk of danger with the power to restrict patients' civil liberty, which may put clinicians at risk of encountering anger and its consequences. Assaults and threats are known to be prevalent against psychiatrists. A 1990 review and survey by Faulkner estimated that ≥50% of psychiatrists risk being victim of assault during their career with a 5% risk of sustaining serious physical injury [30]. More recently, 16% of 196 psychiatrists reported being victims of assault and 46% of verbal threats in a year [31]. In the past decade, there has been an increased interest in violence management training in residency, given that psychiatry residents have the highest rate of assault by patients, ranging from 25% to 64% [32–34], and given that two-thirds of

residents feel undertrained in violence management [35]. Non-violent crisis intervention programs that have become popular in psychiatry residency programs include training to accurately predict and avoid risk, which can be assessed using validated tools such as the PCL-R, the HCR-20 or the VRAG, in addition to clinical judgement [36].

The fact that Mr. B viewed himself as a victim of persecution, demonstrated a lack of insight, endorsed hallucinations and was destabilized by being exposed to a visibly Muslim physician [37] were all risk factors for immediate violence. In this case, relying on other team members to conduct the assessment is a safer choice than having the visibly Muslim physician see the patient herself. A resident and a medical student assessed Mr. B instead, who continued to be overtly hostile and guarded when noticing the student had a beard but Caucasian skin, asking him if he spoke “immigrant English or white English”. We can only hypothesize how strong the reaction might have been if he was interviewed by a psychiatrist who appeared unequivocally Muslim. One of the first concepts taught in medicine as part of the Hippocratic oath is to “do no harm”. Risking a paranoid psychotic crisis that could require forceful intervention may not only be traumatic to the patient and the staff involved but also nontherapeutic to the patient’s health.

However, in a less acute setting, could this polarized relationship become therapeutic? Dr. Fennig argues it can be part of the treatment by describing clinical cases illustrating the relationships between Arab nurses and psychotic Jewish patients during the highly socially polarized Israeli-Palestinian conflict [38]. He argues that being treated by someone perceived as a formal enemy during a vulnerable period could be therapeutic. At first, the Arab staff would be seen as mistrustful and hateful, evoking primitive aggressive feelings in the Jewish patient. Most of these feelings seem to stem from projective identification. The Arab staff is seen as inferior and unreliable, aspects of the patient himself that he refuses to acknowledge but identifies with unconsciously and projects onto the staff. The accumulation of good experiences acquired during the therapeutic relationship makes the hate expressed towards the staff more tolerable and in parallel reduces the unconscious feelings of self-hate that patients were projecting [38]. While further research on the subject is needed, it can be hypothesized that allowing for time and positive experiences to build the therapeutic alliance can be beneficial in breaking down prejudiced ideas in patients. Clinicians should be aware of their own countertransference reactions to some remarks that can be perceived as discriminatory. They should avoid categorizing the patient as being “difficult” or “hateful” by making more effort to understand him and find his humanity [39].

If, during the therapeutic relationship, there is an instance of threat, verbal aggression or assault, the physician should discuss the case with his colleagues to get support and advice. Depending on the gravity of the situation, the local medical protection association, such as the Canadian Medical Protection Association in Canada and the British Medical Association in the United Kingdom, should be consulted for legal advice and legal protection can be sought. Charges can be pressed against the patient. A transfer of care to another professional should be

considered for both the clinician's and the patient's benefit. Research finds that the majority of assaulted physicians (59%) will continue caring for their patient, while 21% do not discuss the events with the patient [40]. If the physician decides to continue caring for the patient, time should be dedicated to review the events together. This could help the clinician understand the triggers and find better ways for the patient to deal with his feelings. It could also be an occasion for cooperative safety planning to identify the early warning signs of aggressive escalation and opportunities to intervene: what should be the best way to pacify the patient, and what might be the limits for when the session should be interrupted and rescheduled? This might prepare both the patient and clinician in the event of another anger outburst, verbal or physical threat. Such steps might have a beneficial impact on the clinician's feelings of safety while avoiding adverse feelings of rejection by the patient. Documentation is key (the adage, "If it isn't written down, it didn't happen" is pertinent here), and the assault or aggression as well as all steps taken afterwards should be on record.

Case 3

Mr. C is a 40-year-old male with schizophrenia who was hospitalized for a relapse of psychosis. During an interview with the psychiatry staff and a visibly Muslim medical student, he discussed his belief around Arabs and Muslims being "terrorists" and "vermin", using aggressive and prejudiced language while sending hostile looks to the medical student. The staff did not interrupt or end the interview but instead fully explored his paranoia and persecutory delusions.

Mr. C shows some paranoid/delusional prejudice with antisocial prejudice disorder. In this situation, the content of the delusion could be of relevant interest to the clinician but is very harmful to the medical student who may feel targeted by the patient's racist rant. The psychiatrist failed to express his firm disagreement with the patient's view, which could be interpreted as tacit agreement of his delusional beliefs. For the medical student who plays the role of a silent observer, the psychiatrist's lack of disagreement may be felt as complicity in the patient's clear disgust for Muslims. The psychiatrist here has the dual role of acting as the clinician who needs to complete his intake/safety assessment, but is also the trainee's supervisor. He must be aware of his student's level of comfort and tailor the interview to be educational for the student, or at the very least, not harmful. In this case, interrupting the interview once the content becomes too prejudiced, setting limits for the patient while showing disagreement and perhaps continuing the interview later without the medical student present could have been better options. He could also use this time with the patient to explore the patient's insight and awareness of the impact of these beliefs, challenge them and offer some psychoeducation. A debriefing session with the medical student after this encounter would also be a good educational opportunity to discuss safety and limit setting.

Transference in Therapy

The above cases are examples of clinical encounters where prejudice is expressed overtly and is an issue in the relationship that must be addressed. Although often not to this extreme, transference and countertransference are part of most mental health encounters. In psychotherapy, while the therapist may try to avoid disclosing personal information, some are evident: the social status from clothing, the academic status from the diplomas on the wall, the ethnicity from the name and the appearance, the marital status from the presence of rings, the religion from the presence of religious symbols and the sexual orientation from some mannerisms. No therapist is completely neutral, as everyone comes from a culture, a tradition or a society that shapes one's views of the world and can influence one's interactions. Being visibly different, the religiously visible clinician should be more aware of the dynamics and transference that occur in therapy, leading him to develop a comfort in discussing it more readily. To increase his awareness of his own transference and prejudice, a therapist should consider pursuing his own psychotherapy. Also, religious symbols could be used intentionally as a tool to discuss transference and prejudice and help the patient attain better insight, especially if his prejudices are somewhat ego-dystonic. It could also be an opportunity to open a conversation around spirituality.

Spirituality in Mental Health

Studies indicate that the majority of patients want more attention given to their spiritual identity [41]. Psychiatrists are less religious then other medical specialists [42]. This might stem from the historical anti-religious stance of Freud and the liberal views of early psychoanalysts of the 1950s–1960s [42]. However, psychiatry, like most medical fields, has evolved to integrate religion and spirituality in recognition of its importance in patients' lives, seeing patients as a biopsychosocial-spiritual whole. This has been made clearer with the DSM-5 and the development of the cultural formulation. Religious or spiritual problems are classified in the DSM-5 under problems related to other psychosocial, personal and environmental circumstances, thus reflecting the importance for psychiatrists to pay attention to this subject when relevant [27].

For the religiously devout, religion influences all aspects of life, playing a motivating role in most life decisions. Assessing the patient's religion/spirituality can help the clinician determine the religious and spiritual concerns that may influence medical decisions and compliance. Sharing a patient's religious view is not a prerequisite to discussing religion; even when physicians do not share the patient's religious view, they can approach the subject in a culturally sensitive way. They can empathetically discuss it on the patient's terms and what it means for him [41]. Some have suggested enquiring about frequency of religious service attendance as a way of measuring the patient's receptiveness to such questions and to facilitating a spiritual care referral [43]. Although it could be a good icebreaker, this inquiry

risks reducing spirituality to only organised religion and may oversimplify what it means to be religiously devout. However, for patients who do practice a popular organized religion, religiously integrated cognitive behavioural therapy is available and continues to be developed, providing complete training manuals for clinicians and patients [44, 45]. Overall, it appears more training in religion and spirituality is needed for psychiatry staff and residents to increase awareness and comfort and to have culturally sensitive dialogues around religion and spirituality with patients [46–48].

Self-Care

While the Muslim clinician may be aware of these issues when approaching patients, sensitive to their transference, trying to understand the reasons behind their expressed prejudice and to have a safe and sensitive approach, ultimately some consideration must be given to his own wellbeing. Muslim clinicians are not immune to the sociopolitical context in which they live and are at risk of the same mental health ailments as any other Muslim. With the stress of heavy workloads, high achieving personalities and constant exposure to human suffering, physicians at large are at increased risk of burnout by neglecting other important parts of their life involving wellness [49, 50]. Self-care is important to feel well enough to care for other vulnerable people and avoid burnout. Possible self-care strategies for all mental health clinicians include discussing challenges that arise with supervisors and colleagues, nurturing a pleasant working environment with colleagues to decrease the impact of the occasional negative encounters and, as mentioned above, seeking one's own psychotherapy or being part of a Balint group. In fact, Balint reflection groups aim to increase the understanding of doctor-patient relationship and can improve insight into cultural countertransferences that play a role in clinical work [51] while preventing burnout [52]. While being reminded often of their religious affiliation, Muslim clinicians should not neglect their spirituality, if such appeals to them. Developing meaning and life purpose through religion coupled with a sense of community can play a major role in attaining more satisfaction in life [53] and protect against some psychological ailments [54, 55]. At the same time, Muslim clinicians should recognize when their boundaries are being crossed by discriminatory patients and keep a reasonable threshold for transferring patients when their own wellness is at stake.

Conclusion

We hope to have provided an overview of how Islamophobia has become the force it is today in North America, demonstrating its impact on Muslims at large and specifically upon Muslim clinicians. It should be a sobering reminder that this sociopolitical climate itself has become responsible for the creation of some mental health conditions in the Muslim population that has endured the post-9/11 period and has

resulted in murders and violent hate crimes. A quarter of Muslim physicians experience discrimination in their careers due to their religion, and likely many, many more experience religiously motivated microaggressions that form the foundation for a potentially much more dangerous Pyramid of Hate. We may try to empathize with patients expressing Islamophobic sentiment and understand their vulnerability as a factor in their otherizing of their clinician, whom they might otherwise trust and respect. However, religiously visible clinicians should prioritize their safety and the patient's health in determining how to proceed with encounters of overt discrimination, such as delusions involving Muslims. In a longer-term setting, a patient's subtle or overt Islamophobia may be explored as simply another type of transference, and patients' own spirituality and religiosity should be explored in understanding the individual as a whole. Finally, we stress that Muslim clinicians must continue to prioritize their own self-care. That must include acknowledging their own reactions to any racist encounters they experience and reflecting on the challenging yet incredibly rewarding work that they do.

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18 Islamophobia from an American Muslim Perspective

Rania Awaad, Sara Maklad, and Imman Musa

Unique Experience of Muslim Americans

At a rally in Birmingham, Alabama, Republican presidential candidate Donald Trump stated that he saw thousands of American Muslims cheering on September 11, 2001, as the World Trade Center was attacked [1]. Though many reject his claims [1], his remarks reinforce the increasingly widespread narrative that Islam is a violent religion and Muslims are enemies to the Western world [2]. It is estimated that over three million Muslims live in the United States [3]. Though present beforehand, prejudice and discrimination against Muslims have increased dramatically since the terrorist attacks of September 11, 2001 [4, 5]. One study, which examined data collected from 72 Muslim Americans between the years 2003 and 2006, sought to examine the impact of stigma on Muslims' responses to the September 11th terror attacks. The study found that heightened perceptions of stigma against Muslims and Arabs predicted negative emotional, cognitive, and behavioral responses, including feeling threatened, believing they must prove to others that they are American, and changing their daily routine in fear of violence or discrimination [6]. This brief report demonstrated that Muslims are aware of the Islamophobic

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environment in which they find themselves and many live in anticipation of being treated poorly or discriminated against [6]. Discrimination has been found to be a common experience for Muslim Americans. A survey of 1050 Muslims in the United States found that 42% of participants under the age of 30 reported that within the past year, they had been verbally taunted, treated with suspicion, physically threatened or attacked, or targeted by police because they are Muslims [7]. Furthermore, in a study on discrimination, identity, and anxiety symptoms, 87% of the Muslim American sample endorsed experiencing some kind of religious-based discrimination within the past year, and discrimination predicted greater levels of depressive and anxiety symptoms [8].

Incidents of discrimination are related to the rise of Islamophobia, which is broadly defined as "a fear or hatred of Islam and its adherents, that translates into individual, ideological, and systematic forms of oppression and discrimination" [9]. Islamophobia has led to Muslims being stigmatized in Western societies. Stigma, defined as an attribute or social identity of a person, such as their race, ability status, or national origin, which is treated as deeply discrediting by others [10], is often studied from the perspective of majority group members. However, it is additionally important to examine personal feelings of stigmatization from the perspective of the stigmatized [11]. Despite the prevalence of Islamophobia in the United States, research examining the psychological impact of Islamophobia on Muslim Americans is scarce; however, our knowledge is growing.

Historical Background

Although the terrorist attacks of September 11, 2001, are often identified as the starting point of Islamophobia, stigma against Muslims has existed for quite some time in America. One prominent group of Muslim Americans includes Arab Americans, who have a rich history in the United States dating back to the late nineteenth century. The first wave of Arab American immigrants consisted of mostly Christians from Syria, who, like most immigrants at the time, were seeking economic opportunity [12]. Their Muslim counterparts would follow 20 years later, settling in cities across the Midwest [13]. The early Arab American experience was similar to that of white ethnic groups in that they were able to assimilate and had rights, such as land ownership, employment, voting, and naturalization [14]. The second major wave of Arab American immigration occurred after World War II and was primarily Muslim [12]. By the 1950s, Arabs had settled in many major cities across the United States, and a new type of Arab immigrants began arriving: those who were educated and seeking white collar professions or higher educational opportunities, many coming from Egypt, Palestine, Yemen, Jordan, Syria, and Iraq. After the Arab-Israeli war of 1967 which led to the displacement of over 300,000 Palestinians, many Palestinians immigrated to the United States, bringing with them a greater ethnic pride and political awareness than prior groups. This group of immigrants contributed greatly to the formation of a unique Arab American identity and political consciousness, which grew stronger throughout the 1970s and 1980s.

However, as the presence of Arab Americans grew, so did the negativity surrounding them as a group. The Arab American experience since the late 1960s differed from prior years in that it was marked by exclusion, prejudice, discrimination, stereotyping, and strict immigration policies [14]. Even prior to the events of September 11, 2001, popular media and culture frequently portrayed Arabs as inferior to and quite different from whites [15]. Zogby commented that these portrayals, which included greedy oil sheiks and bloodthirsty terrorists, were more tied to political and economic movements in the Middle East rather than to the Arab communities within the United States [16]. Nevertheless, these portrayals led to negative repercussions for the Arab-American community, sparking the foundation of organizations in the 1960s such as the American-Arab Anti-Discrimination Committee, the Arab American Institute, and the National Association of Arab Americans, which all sought to reverse these negative conditions and dismantle misconceptions about Arab culture [14]. The aftermath of September 11th consolidated the racialization category of "Arab/Middle Eastern/Muslim" as a nonwhite outgroup [15].

It is worth noting that Arabs compose only 25% of the Muslim-American community, which includes approximately 33% South Asians and 30% African Americans [17]. However, the racialization of Islam and Muslims led to a backlash against any individual perceived to be Arab, Middle Eastern, South Asian, and/or Muslim [15]. Minoo Moallem explained that although the representation of Islamic fundamentalism has been decades in the making in the West, it had now become "a generic signifier used constantly to single out the Muslim other, in its irrational, morally inferior, and barbaric masculinity and its passive, victimized, and submissive femininity" [18].

Islamophobia in Context

Within the United States, Muslims' perceptions of Islamophobia derive not only from pervasive anti-Muslim rhetoric but also from systemic injustices imposed upon the Muslim community by the government and other policing bodies. One such illustration includes the massive surveillance program launched by the New York Police Department (NYPD) in 2003, which directly targeted the entire Muslim community in and around New York City [19]. Reports revealed that the NYPD placed informants in several Muslim student associations at local colleges and also used US census data to chart a map of where all of the Muslims in New York lived [20, 21]. This mapping was completed by the NYPD's Demographics Unit, later renamed the Zone Assessment Unit, and included neighborhoods predominantly occupied by individuals with national origins associated with Muslim populations, as well as Black American Muslims. Thus, many Muslim individuals were systematically investigated, spied upon, and even arrested by the police with no evidence of criminal activity [22]. Another concerning aspect of this program included designating a number of mosques in the area as "Terrorism Enterprises," which indicated that visitors of these places of worship could be investigated. Conversations and sermons occurring within the mosques were monitored and recorded [20]. In 2014,

after the NYPDwas forced to admit that they did not find any leads on terrorist activity, and through active efforts from New York's Muslim communities and their allies, the department announced that it would disband its Demographics Unit. However, the NYPD did not indicate closure of other aspects of surveillance of the Muslim community, including using informants in mosques [22].

Though the NYPD operates one of the largest surveillance programs on Muslims, Muslims throughout the country have been targeted due to the assumed link between Muslims and violence and terrorism, leading to incidents of mass detentions [23] and registration requirements. Furthermore, a controversial FBI initiative to infiltrate mosques across the United States with secret agents remains operational) [23, 24].

Knowing that they belong to a stigmatized group, many Muslim Americans must adapt and respond to discrimination and harassment. O'Brien explored stigma management strategies through collection of ethnographic data from Muslim youth and adults at a mosque in a major American city [24]. O'Brien argues that, though Muslims are not constantly suffering negative effects of stigma, they are often in situations of potential or anticipated stigma and thus must learn potential responses through stigma management rehearsal. Stigma management rehearsal is a type of practicing how to respond to instances of stigma. It occurs privately among members of stigmatized groups and sometimes with non-stigmatized allies; real or potential instances of stigma are discussed, along with possible strategies and approaches for responding. Results of the study revealed two types of management. The first type included direct preparation, in which the anticipation of an impending stigmatizing event led group leaders to coach an individual in the locally dominant stigma management strategy. In the case of this Muslim community, the locally dominant strategy included passively ignoring the stigmatizing experience and responding "peacefully." The second type was called deep education, in which leaders instruct members in acceptable cultural justifications for the locally dominant stigma management strategy. This type of instruction could also include discussions of hypothetical stigmatized situations and how to generally respond. One example of this type of instruction included a discussion in which a youth group leader asked if any of the youth were ever bothered due to being Muslim and what they did about it. One girl recounted a story in which she and her friends were stared at, laughed at, and followed by a group of skaters in the park due to wearing hijabs. She stated that they ignored those who were harassing them. The youth group leader quoted passages from the Quran, which highlighted responding peacefully to those who are ignorant or bothersome. In this way, time was being taken to justify or explain peaceful responding through religious teachings [24].

There is also an emotional aspect of stigma management rehearsal, in which members feel a shared sense of identity and an openness to express emotions in a safe and secure space [24]. For example, the same study reported that a young college student expressed to a youth group leader that his college was hosting an "Islam Fascism Week." The student wished to express anger at the organizers of the event, indicating that he felt like screaming at them and punching them. The youth leader advised the student that any kind of protest may attract negative attention toward Muslims and that ignoring the events may be for the best. Though the leader

encouraged passivity in managing the stigmatizing experience, the young student was able to openly express his anger in a safe space. This study highlights important aspects about Muslims' experiences and responses to belonging to a stigmatized group. First, significant time and effort is used toward managing stigma, including in hypothetical, anticipated, and present situations. Next, it is significant that young Muslims are encouraged by leaders to remain passive in responding to stigmatizing situations, often based in religious and cultural teachings to promote peace and harmony. O'Brien argues that the private release of publicly inappropriate responses such as aggression is helpful and allows for more acceptable public reactions. Additionally, as a targeted community, Muslims live in fear of being investigated by law enforcement or targeted for discrimination and thus prefer not to disrupt the status quo [24]. However, this dominant passive stance may discourage more assertive stigma responses, such as speaking out when one is mistreated, that could be psychologically helpful and socially proactive. These specific cultural strategies and norms provide important context for understanding Muslims perceptions of Islamophobia and its relation to mental health.

From September 11 to the Present: Impact of the 2016 Presidential Election

Clinical Vignette

Maya is a 22-year-old Pakistani American college student with no history of mental health treatment. Maya was referred to her college's Student Health Center by one of her professors after she had a panic attack during class. She felt scared, confused, and alone. In her first therapy session, Maya shared with her counselor that she had been worried about the election of Donald Trump as president and increasingly anxious since the "Muslim Ban" had taken effect. She had three panic attacks in the last week. Despite being extroverted and having many friends, Maya had been avoiding socializing with friends due to "feeling drained." Maya stated that she started wearing the hijab this year even though her parents have asked her not to wear it due to their concerns about safety given increasing hate crimes.

Shortly after the twin towers fell on September 11, 2001, America was not the same. As the nation mourned, the aftermath of this terrorist attack had a significant impact on Muslims in America. Research shows that hate crimes targeting Arabs and Muslims increased dramatically in the months following 9/11. For years, the attacks in 2001 held the record in modern times for hate crimes against Muslims in the United States. However, another significant rise in hate crimes started in 2015, easily surpassing the 2001 record.

This backlash against American Muslims is hypothesized to be a result of a series of terrorist attacks in Europe and in the United States. The anti-Muslim rhetoric in the media and the political arena in response to these attacks is thought to have played a heavy hand in flaming the waves of anti-Muslim hatred and alienation of the Muslim-American community.

Vilification of several minority groups, highlighted among them the Muslim community, and spreading derogatory stereotypes about these groups was a commonplace tactic of the 2016 presidential race [25]. The day of the Brussels attack, Republican presidential hopeful Ted Cruz said that the United States needs to “empower law enforcement to patrol and secure Muslim neighborhoods before they become radicalized”. Furthermore, there was a plethora of anti-Muslim rallies attended by thousands of people during the 2016 presidential race.

This sociopolitical environment continued to exist after the current administration took office in November 2017. The first executive order issued by the current administration was Executive Order #13769, titled “protecting the nation from foreign terrorist entry into the United States” and dubbed the “Travel Ban” or the “Muslim Ban.” This order suspended the entry of Syrian refugees indefinitely into the United States. It also suspended the entry of citizens from several Muslim majority countries into the United States. This executive order has caused considerable mental and emotional distress for Muslims living in America [26].

Violence, Discrimination, and Mental Health

The rise in hate crimes against American Muslims may reflect the increasingly hostile anti-Muslim sentiment in political discourse and media representation. According to the Federal Bureau of Investigation (FBI), of the 5462 hate crimes committed in 2014, roughly 154 (2.8%) were anti-Muslim, which averages to 12.8 per month (FBI). In addition to the hate crimes reported, about 60% of hate crimes are not reported to police, indicating that this number is likely an underestimation of Muslims’ actual experiences. A survey of 1050 Muslims in the United States found that 42% of participants under the age of 30 reported that, within the past year, they had been verbally taunted, treated with suspicion, physically threatened or attacked, or targeted by police because they are Muslims [7].

Acts of Discrimination and Mental Health

Clinical Vignette

Renda is a 45-year-old Palestinian-American married woman with four children. Renda has been experiencing symptoms of irritability, difficulty sleeping, and depressed mood. She indicated that much of her stress is related to her children. Her 10-year-old son displays what she described as mood swings and temper tantrums and has also been misbehaving in school. She is an involved parent at school and believes she has to “represent Islam in a good light” to the fellow parents as a Muslim woman who wears hijab. She worries about her children being discriminated against by teachers and others students due to their religion. Her 14-year-old son had an instance of bullying at school in which he was called a “terrorist” by another student.

In a study on discrimination, identity, and anxiety and depressive symptoms, discrimination was found related to both depressive and anxiety symptoms, consistent with past studies on discrimination [27–29]. Research also shows that Muslims endorsed subtler or ambiguous forms of discrimination at higher levels than overt forms, such as being ignored or being stared at, which is consistent with the literature stating that covert forms of discrimination tend to be more common than overt forms. However, overt forms were reported as well.

Stigma and Mental Health for Western Muslims

To examine the psychological impactof Islamophobia on Muslim minorities in Europe, Kunst et al. developed the Perceived Islamophobia Scale (PIS) and found that perceived Islamophobia was related to psychological distress for Muslims, even after controlling for instances of discrimination [30]. The PIS was the first scale developed to assess Muslims' perceptions of Islamophobia, though other research has studied non-Muslims' fear of Islam [5]. These researchers conceptualized Islamophobia as a fear of Muslims and Islam. In contrast to an awareness of negative stereotypes toward Muslims (e.g., putting Muslims on a level with terrorists), Islamophobia focuses on the fear response toward Muslims and their religion [30]. It was also important to differentiate perceived experiences of discrimination from perceived stigma. When Muslims personally experience such fear from others in their own lives, for example, by being avoided, this experience could be understood as discrimination. However, they can also gather a more aggregated perception of fear-based Islamophobia as a group norm or general attitude of members of society [30]. The goals of the first part of the study were to validate the PIS in multiple ethnic samples and conduct an exploratory factor analysis, with predictions that the scale would be positively correlated with psychological distress and moderately correlated with an established measure of personal discrimination, indicating that it assesses a similar yet distinct construct. Psychological distress was measured by Kessler's Psychological Distress Scale [31], which includes items that assess symptoms of nervousness, anxiety, and depression. Discrimination was measured using the Everyday Discrimination Scale [32], which assessed instances of discrimination such as being treated with less respect than others, being threatened or harassed, and people acting as if they are afraid of you.

The initial item pool for the PIS was created based on a qualitative pilot study and literature review regarding Islamophobia. Participants of the qualitative study, which included 53 Muslims living in European countries such as Germany, the United Kingdom, Norway, France, and Denmark, were asked to describe what they perceived as a typical Islamophobic person. Two dominant themes emerged: first, that the person is afraid of Islam due to its association with danger, terror, and violence; and second, that the person is afraid of Islam due to believing Islamic values are incompatible with Western values, such as democracy and women's rights. Thus, items in the pool reflected these two themes. Additionally, researchers included items about Islamophobia in the media based on reports indicating an

increase in negative media portrayals of Muslims as well as research indicating that Muslims perceive high levels of negative media portrayals of Islam. An initial exploratory factor analysis resulted in a three-factor solution. Items loading on the first factor measured the perception of a general fear toward Islam or Muslims, including the perception of fear-related responses, such as avoidance and nervousness. The second factor reflected the perception of fear of Islamization within society. The last factor assessed the perception of Islamophobia in national media.

As hypothesized, the cumulative PIS and some of its subscales were correlated with greater degrees of psychological distress. The general fear subscale predicted greater distress in the German-Arab sample; the fear of Islamization predicted greater distress in the British-Pakistani sample; and the cumulative scale score predicted greater psychological distress in all three ethnic samples of German-Arabs, German-Turks, and British-Pakistanis. Discrimination was also related to all subscales across ethnic samples, with the greatest correlations occurring for the general fear subscale and cumulative scale score. After controlling for discrimination, specific subscales of the PIS predicted psychological distress in the German-Turkish and British-Pakistani sample. Specifically, the general fear subscale predicted psychological distress for the German-Turkish sample, and the fear of Islamization subscale predicted greater psychological distress for the British-Pakistani sample [30].

Results of this study are significant because they highlight that perceiving greater levels of Islamophobia is related to greater psychological distress, even after controlling for instances of discrimination. It was also notable that different scales were more significant for different ethnic groups, indicating that the sociocultural and political context of each group may affect their perceptions of Islamophobia and the way it relates to distress.

Another clinical example to highlight this phenomenon is the case of Layan, a 29-year-old Indian American Muslim woman with a history of anxiety and depression. She currently lives with a roommate and is attending graduate school for occupational therapy. Layan has had a difficult relationship with both of her parents since she was younger because she reportedly did not feel love or affection from them the way in which she saw her friends being loved by their parents. She stated that she identifies as a Muslim but does not spend time with the Muslim community because she worries that she would be judged for not living up to Islamic standards. She spends most of her time with non-Muslim friends but reports that she has difficulty connecting with them and tends to become highly irritable and distance herself when she feels that a friendship is becoming too close. At the same time, she often feels lonely and isolated. She reported she does not fit in with anyone and feels "stuck between two worlds."

Supporting the Mental Health of Muslim Americans in the Wake of Islamophobia

Research confirms a consistent relationship between experiences of discrimination and poor mental health among Muslims. This is observed irrespective of racial identification, skin color, Arab American identification, or area of residence. Given the high

levels of discrimination experienced by the Muslim-American community especially over the past few years, an urgent need arose for the support of members of the Muslim community undergoing psychological distress. One of the pioneers in this field is the Khalil Center – a social and spiritual community wellness center that utilizes faith-based approaches rooted in Islamic theological concepts while integrating the science of psychology in order to address psychological, spiritual, and communal health. The Khalil Center has several branches in the United States and has been working with the American Muslim population to support their mental health and well-being. In addition to direct clinical services for American Muslims, the Khalil Center has partnered with legal advocate groups like CAIR (Council on American-Islamic Relations) to address mental wellness and stress reduction strategies on panels where CAIR was addressing "know your rights" strategies to the Muslim community in the aftermath of the Muslim Ban. The Khalil Center also provided support groups in the wake of the 2016 Presidential elections and inauguration and again in the aftermath of the Muslim Ban. The positive response to seeking out the assistance of mental health-care providers despite the stigma found in the community is indicative of the need of more such efforts focused specifically on the Muslim community and integrating resiliency derived from the faith into mental health programming [33].

Conclusions

In past years, a need has risen for research and applied programming that specifically focuses on the well-being of the Muslim-American community especially in the wake of the largest spike in anti-Muslim hate crimes that corresponded with the 2016 Presidential elections. This focused research and programming serves to provide mental health professionals with guidelines to help their Muslim clients. It also serves to examine Islamophobia and other discriminatory challenges to which Muslims are exposed at present to bring them to public awareness and aid those who are advocating necessary changes. More applied efforts are needed, like those of the aforementioned Khalil Center, and research efforts like those of the Islamophobia Studies Center at the University of California-Berkeley that examine the roots of Islamophobia and provide empirical data to quantify the problem with the ultimate goal of educating policymakers on how to best encounter its devastating effects. It is hoped that such efforts will inspire and create more robust programming in order to make continuous progress in building a positive sense of American Muslim identity, both for Muslims themselves and for the larger communities in which they reside.

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19 Islamophobia: A British Muslim Perspective

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Introduction

We begin with an anecdote to illustrate just how pervasive and insidious the phenomenon of Islamophobia is in the United Kingdom (UK). Not too long ago, AH, a proud British Muslim, was in Manchester Airport in the UK on his way to Orlando, Florida, to deliver a talk about challenging Islamophobia in the United States of America (USA) [this was in the wake of the heinous and horrific terror attack perpetrated by Omar Mateen against the lesbian, gay, bisexual and trans (LGBT) community and the spike in anti-Muslim hate crime that subsequently ensued]. Just before AH was "randomly selected" for further security checks, he came across a fellow Muslim traveller, albeit this Muslim "brother" was clad in traditional Islamic attire. There was nothing remarkable about the scenario; the Muslim "brother" was calm and composed throughout, and he was even courteous towards others. However, despite the serenity of the situation, something quite astonishing occurred; AH suddenly noticed that he was developing tachycardia that his palms were moist and that he was experiencing a panic attack! AH immediately admonished himself and felt ashamed. As a British Muslim who

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experienced Islamophobia himself, AH thought that he should really have known better and that he should be impervious to the anti-Muslim rhetoric and fear-mongering which was rife and seemingly ubiquitous (this was during a period of heightened populism and isolationism when President Donald Trump issued an Executive Order banning people from Muslim-majority countries entering the USA and Brexiteers were dominating newspaper headlines with their anti-immigration slogans). Once AH regained a state of equanimity, he asked himself, "If that is how I, as a Muslim, felt when I saw someone wearing traditional Islamic attire, how would a non-Muslim in my situation have felt and reacted?"

The sad reality is that not only has Islamophobia become deeply ingrained and entrenched in British society, but it has also stealthily infiltrated the policy and provision of mental healthcare services. This book chapter provides background information about Islamophobia in the UK. We will then discuss and describe the ill effects of Islamophobia on Muslim mental health and the far-reaching ramifications that countering violent extremism policies in the UK have on mental healthcare services.

Islamophobia in the British Media

The rise of radicalisation, the immigration crisis in Europe and the demonisation of Muslims by demagogues [i.e. Tommy Robinson, who is the leader of the far-right political party the British National Party (BNP)] all collude and contribute to heightened levels of Islamophobia in the UK [1]. Moreover, perceptions of Muslims are strongly influenced by how they are portrayed in the media. Academics at Lancaster University conducted the most extensive study to date on the representation of Muslims in the British press. The research team, led by Paul Baker, collected over 200,000 newspaper articles written about Islam and Muslims from 1998 to 2009. This amounted to 143 million words of journalism which was analysed using computer software technology to search for and identify patterns and the most frequent ways that Muslims were portrayed in the British press. The researchers revealed that for every positive word describing Muslims and Islam, there were 21 negative words. Adjectives such as "fundamentalist, fanatical and radical" and nouns such as "terrorist, extremist and cleric" were frequently used by the British press to describe and name Muslims, respectively. The authors of the study concluded that "…a wider set of representations of Islam would signify a welcome change to reporting practices. Muslims deserve a better press than they have been given in the past decade…" [2].

Negative stereotypes and caricatures of Muslims in the media can perpetuate Islamophobia which helps to fan the flames of fear, incite hatred and cause division and fragmentation of British society. Media representations of Muslims as the "other" encourage avoidance behaviours and may instill the idea that "the Muslim way of life" is incompatible with British values. Danish academics Rytter and Pedersen described this as a "cultural war of values" in which Muslims are depicted as threatening and

therefore unable or unwilling to embrace Western society [3]. From the perspective of the British Muslim, there is also a general sense of feeling “under siege” due to constantly being bombarded with negative images associated with Islam [4]. This is consistent with a free-text comment from a respondent of a cross-sectional study conducted on Muslims in the UK and their perceptions of British combat troops: “Perhaps if the media wasn’t constantly attacking us from all angles and demonizing us we wouldn’t be so defensive towards occupation of Muslim lands by Western troops. We’d perhaps give them more of a chance to hear why they are involved in what they do” [5]. Muslims in the UK may therefore feel discouraged about integrating and embedding themselves in British society since they anticipate that they will be rejected and/or excluded. However, despite these formidable forces in operation, a recent survey on Muslims residing in the UK revealed that 94% of respondents either disagreed or strongly disagreed that “Being Muslim means that you cannot be British” [5], thus indicating that Muslim values and British values are not dichotomous but that there is substantial overlap between them.

Islamophobia in British Society

Vulgar letters encouraging and enticing citizens, including Members of Parliament, to take part in “Punish a Muslim Day” on the 3rd of April 2018 were circulated throughout major cities in the UK. The “Punish a Muslim Day” letter, which received global media attention, opens with the following provocations: “They [Muslims] have hurt you. They have made your loved ones suffer. They have caused you pain. What are you going to do about it?” Images of the A4 notes, which contain a list of violent acts alongside a point scoring system for performing them (i.e. 10 points for verbally abusing a Muslim, 25 points for pulling the headscarf off a Muslim woman, 50 points for throwing acid onto the face of a Muslim and 1000 points for bombing a mosque), were also widely distributed and shared online and on social media. Counterterrorism police treated the letters as a possible hate crime and advised Muslim communities, especially Muslim women who wear the hijab and burqa, to be vigilant [6]. Although “Punish a Muslim Day” was not associated with an increase in Islamophobic attacks, it was a painful crystallisation of Islamophobia in the UK.

Islamophobia has been defined as “An exaggerated and irrational fear, hatred and hostility towards Islam and Muslims perpetuated by negative stereotypes resulting in bias, discrimination and marginalization of Muslims from civic, social and political life” [7]. British society has absorbed Islamophobic sentiment which has had profound, multidimensional effects on Muslims. In the last 20 years, Muslims have become a greater focus of policy-makers in terms of countering terrorism and violent extremism. Criminal laws such as the Terrorism Act (2000), Anti-terrorism Crime Security Act (2001) and the Counter-Terrorism Strategy (CONTEST) (2006) have popularised the belief that Muslims are a threat to British society.

Muslims are being treated as a suspect community, and alarming reports have emerged that they are being placed under surveillance [8]. Antiterrorism laws have led to the disproportionate targeting of Muslims. The Metropolitan police reported a 41% rise in stop and searches on Asian men in the year 2000/2001 to 2001/2002, the highest for Asians compared to any other ethnic group, which represents the stereotypical profile of Muslim men since they are often racialised as Asian [9]. The Lammy review also notes a 50% increase in Muslim prison intake over the last decade with Muslims making up 15% of the prison population when they are only 5% of the general population [10]. The statistics reflect the way in which Muslims are being criminalised considering counterterrorism objectives, without recognition that Muslim communities are at material disadvantage and deprivation in British society, with 46% of them living in 10% of the most deprived local authorities in Britain [11].

Employment is a key area where Islamophobia is prevalent, and consequently Muslims are being deprived of occupational opportunities [12]. The Social Mobility Commission reported that only 6% of the Muslim population in Britain are in higher-level professional jobs and that racism and Islamophobia are not allowing them to progress in the workplace and climb the career ladder. Some typical occurrences involve Muslim-sounding names being turned away in recruitment or Muslims not having the opportunity to join the social groups or gatherings that will enable promotion [11]. In a focus group study, 100% of Muslim participants expressed that they had directly experienced and witnessed or had family members experience some form of discrimination in the workplace. Some even felt reluctant to report such forms of discrimination because Islamophobia had become normalised [13].

Islamophobia in British Schools

Islamophobia in British schools is rampant and has had a profound impact on the way youth practice their faith and how they perceive their Muslim identity in relation to British culture and values. The Ofsted chief called for inspectors to question Muslim girls wearing hijab in primary schools and further alleged that this Islamic garment could be "interpreted as sexualization of young girls" [14]. The obsession with Muslim women's dress (such as the hysteria around the hijab and the "burka ban") reflects Western ideas on female liberation and feminism which is a challenge for young Muslim women who choose to practise their faith but also must navigate the values of British society. It is important to note that institutional Islamophobia has a gendered element, which adds sexism to the mix of oppression experienced by Muslim women. The Women's Equality Committee highlighted that visibly Muslim women face more discrimination as they must deal with the "triple whammy" of being women, being from an ethnic minority and being Muslim. It comes as no surprise that Muslim women are the most economically disadvantaged group in Britain, with 35% of all Muslim women aged 16–64 not in employment compared to 69% of all British working-age women [15].

Islamophobia in British University Campuses

The implementation of British government's countering violent extremism programme Prevent (see below) in university campuses has negatively impacted the general academic experience of Muslims in the UK. There are several examples that illustrate the way Prevent is being practiced at university settings and its eroding effects on higher education ethos and culture. Indeed, one of the UK's most prestigious universities warned its students that their emails are routinely being monitored as part of the Prevent programme [16]. At another university, Prevent officers regularly attend Friday congregational prayers at University prayer rooms to screen sermons for "extremist" content [17]. Those who have engaged in University Islamic Societies' activities (particularly on the topic of Israel and Palestine) have experienced more stringent speaker approval protocols and in some cases have had their events cancelled. Prevent has been described as having a "chilling effect on open debate, free speech and political dissent" in an open letter signed by academics and students [18]. Freedom of speech is being censored in a space where topics should be explored. Muslims are not offered the same rights as their counterparts to understand and develop their ideas, without being treated as potential criminals.

The Lethal Effects of Islamophobia in the UK

Islamophobia in the UK can be deadly. Mohammed Saleem, an 82-year-old Muslim pensioner and grandfather of 22, was a law-abiding and peace-loving member of his community in Birmingham. On the 29th of April 2013 whilst walking home from his local mosque after evening Isha prayers, Mr. Saleem was stabbed to death by far-right terrorist Pavlo Lapshyn. At the Old Bailey, a 25-year-old Lapshyn pleaded guilty to murder, as well as plotting to cause explosions near mosques throughout the UK. Mr. Saleem's daughter Shazia Khan said: "He [Mohammed Saleem] did not do anything to deserve this - other than be a Muslim" [19].

The month following Mr. Saleem's murder, British army soldier Lee Rigby was hacked to death with a cleaver knife by Michael Adebolajo and Michael Adebowale near the Royal Artillery Barracks in London. The attack was condemned by political and Muslim leaders in the UK and the international press [20]. In an article for *The Independent*, Mohammed Saleem's son stated: "When Lee Rigby was murdered – three weeks after my dad – his murder received global news coverage and cries of protest. But my father's brutal murder on the street, in a similar attack, received comparatively little attention. Instead of lengthy discussions about the dangers of neo-Nazi ideology in our society, there was a deafening silence. A Muslim terrorist, on the other hand, would certainly have led to conversations about the dangers of radical Islamism" [21].

Prevent: The British Government's Countering Violent Extremism Programme

Prevent is one of four strands of the British government's countering terrorism strategy, known as CONTEST. According to the British government, Channel, a key element of Prevent, is a multiagency approach to identifying and providing support to individuals at risk of being drawn into terrorism [22]. The British government's Prevent programme makes the UK the only country in the world where a duty to report signs of radicalisation is expected of a healthcare system. Healthcare professionals, amongst others, are trained to spot signs of "radicalisation" and report individuals with extremist proclivities to the relevant authorities [23].

Prevent cannot be taken in isolation from the climate of Islamophobia that pervades and permeates British society today – it is both legitimised by the deep-seated hostility towards Muslims in public and political discourse and media portrayals that mark out terrorism as being inherently a "Muslim" problem. Those trained on Prevent are already biased to see Muslims as the suspect group and most in need of surveillance. As a result, Muslims are up to 50 times more likely to be referred, when 95% of all referrals are dismissed due to unfounded suspicions [24].

Islamophobia and Psychological Distress

The pressures on British Muslims are immense since they are seemingly being targeted on all fronts. Intrusive governmental surveillance systems, intensive scrutiny from employers, educational bodies and healthcare and social care staff and day-to-day microaggressions in public areas place a tremendous toll on the Mental Health of Muslims. But what is it like to be a Muslim in the UK? Channel 4's documentary My Week as a Muslim sought to answer this question. My Week as a Muslim featured Katie Freeman as the protagonist, a quintessential British mother from a provincial town in England that has a negligible Muslim community. Katie decided to live with a devout Muslim family in Manchester for a week to gain a deeper understanding of the Islamic faith and the British Muslim experience. The programme coincided with the terror attack that occurred in Manchester on the 22nd of May 2017 when Salman Abedi detonated an improvised explosive device killing 22 people and wounding hundreds of others. Following the attack, Katie experienced first-hand the toxic effects of Islamophobia when, clad in a burqa, she passed by a pub in Manchester and drinkers verbally abused her and even asked her if she planned to blow them up. Katie was visibly distressed when she described her ordeal to viewers. For Katie, her experiences with Islamophobia came to an end the moment she removed her Islamic attire. However, this certainly is not the case for many Muslims in the UK, especially Muslim women, who must continue to bear the ongoing brunt of Islamophobic attacks on a regular basis.

Law enforcement agencies reported that there was a 500% increase in Islamophobic attacks following the 2017 Manchester terror attack [25]. What effects do Islamophobic attacks have on the psychological well-being of Muslims? Studies

on Muslim mental health show that the "chronic daily hassles", microaggressions and discrimination that Muslims endure can increase their risk of developing common mental disorders [26]. Moreover, hate crimes were found to "hurt more" than normal crimes [27]. Muslims who are at the receiving end of hate crimes experience higher levels of emotional discomfort and distress and associate those feelings with their Islamic identity. A British study revealed that Muslim participants reported suffering a range of psychological and emotional responses to the religious and racial hatred they received, including lowered self-confidence, insecurity, isolation, depression and anxiety. A common theme that emerged from the participants was the feeling of extreme vulnerability for themselves and their family members, resulting in a constant need to be vigilant in public spaces [28].

Simon Wessely and colleagues at the Institute of Psychiatry, Psychology and Neuroscience conducted a landmark study on the psychological and behavioural reactions to the suicide bombings in London on the 7th of July 2005. The outcomes that the researchers used were the presence of substantial stress as measured by administering an identical tool to that used to assess the emotional impact of 9/11 in the US population. The study showed that being Muslim was associated with a greater presence of substantial stress. The authors suggested that the fear of backlash (in the form of Islamophobic attacks) was a factor that contributed to their findings [29]. Wessely's results are consistent with those of other studies on the association between Islamophobia and psychological distress in Muslims in Europe. Jonas Kunst and colleagues at the University of Oslo developed and validated the Perceived Islamophobia Scale (PIS). The researchers recruited 1344 Muslim participants from the UK, France and Germany and revealed that PIS was positively related to psychological distress in their samples. The authors concluded that "… Anti-discrimination laws may be insufficient at protecting Muslims against the adverse effects of stigma on psychological well-being..." [30].

The Prevent Programme and Mental Health Services in the UK

Concerns have been raised by reputable organisations such as the Muslim Council of Britain [31] and the Royal College of Psychiatrists [32] around how surveillance impacts the well-being and mental health of Muslims. In one study investigating the American-Muslim experience, it was found that anger and anxiety are the dominant emotions felt by those who imagine being monitored by the government. They were also more likely to adopt vigilant behaviours, such as the avoidance of certain settings or discussion of topics that may cause them to be reported [33]. The regulation of this anxiety and use of avoidance strategies are taxing and detrimental to the mental health of Muslims [34] and may also serve as a mechanism that is partly responsible for the elevated rates of psychological distress found in Muslim communities [33].

Prevent unjustly targets Muslims including those most in need of mental healthcare. The result is that Muslims feel alienated and ostracised by both society and psychiatry when they are at their most vulnerable. The Royal College of Psychiatrists has expressed deep concerns about the implementation of Prevent, particularly on the

variable quality of the evidence underpinning the strategy, and potential conflicts with the duties of a doctor as defined by the General Medical Council (the professional body that regulates doctors in the UK). The College argues that Prevent could reduce the willingness of people to access mental health treatment, that identification of a mentally ill patient as a terrorist may further exacerbate the stigma already attached to mental illness and that the definition of "extremism" could be extended to encompass those who object to certain aspects of UK foreign policy [32].

Dr. Adrian James, Consultant Forensic Psychiatrist and Registrar for the Royal College of Psychiatrists, authored a poignant article for *The Guardian* entitled, "I'm a Doctor, Not a Counter-Terrorism Operative. Let Me Do My Job". In his scintillating article, James emphatically states that to help his patients – who often suffer from complex, debilitating mental illnesses – it is vital to build up trusting, transparent, patient-doctor relationships and that this will be difficult if patients feel they are under suspicion by virtue of their illness and at risk of being subsumed into a process dominated by the criminal justice system just for seeking psychiatric help [35]. James cites a report from the University of Warwick that states that the Prevent programme "inappropriately positions" those with mental illnesses as a community from which terrorism originates [36]. This is completely contrary to the National Health Service guidance on how the Prevent duty should be administered which clearly states that "There should be no conflation of mental ill health and terrorism" [37]. James argues that more evidence needs to be published regarding any perceived benefit from Prevent for patients, and he concludes with the unsettling statement that "Rather than preventing terrorist attacks, I fear that Prevent measures, at present, do little more than prevent people seeking support for serious illness" [35].

The University of Warwick study entitled "Counter-terrorism in the NHS" surveyed 329 NHS staff on Prevent anti-radicalisation measures in the British public health service. The report revealed that four NHS mental health trusts are subjecting patients to blanket screening for radicalisation, with some referred to the Prevent programme for watching Arabic TV or going on pilgrimage to Mecca. Two-thirds of the NHS staff surveyed said they were not confident that they could distinguish someone who had been radicalised from someone who had an interest in Middle Eastern politics. The study authors Charlotte Heath-Kelly and Erzsébet Strausz revealed that less than half of the staff surveyed believe that Prevent belongs in the NHS or that it is intended as a safeguarding measure and conclude that Prevent is "a rationale more familiar to surveillance". The report takes issue with the definition of Prevent in the NHS as a safeguarding measure, saying that safeguarding has shifted from a welfare-oriented to a security-oriented endeavour [38].

Impact of Islamophobia on Healthcare Providers

> Personal accounts mainly from Muslim female colleagues who wear the headscarf describe patients and staff being hostile towards them in the wake of the recent terror attacks in the U.K. Patients accused them of plotting another attack, called them 'bombers' and 'murderers', and asked them to remove their headscarves before receiving treatment. I, myself, have had patients ask me to remove my headscarf during clinical consultations. Not all staff have

> the confidence to challenge such discriminatory behaviour in a manner which will not only uphold the values of the Trust but also protect staff members. Junior staff have informed me they feel they have no support from senior managers and therefore choose not to raise such concerns…

Heena Mahmood, Senior Physiotherapist, National Health Service, Chair, Muslim Engagement and Development (MEND) Leeds Working Group, England [Personal Communication].

As the above account from a female Muslim healthcare practitioner illustrates, Islamophobia not only has negative effects on healthcare service users but also on healthcare providers. The NHS is heavily reliant on healthcare professionals from Muslim majority countries. Twenty-six percent of all doctors working in the NHS are Asian or Asian British. Race and religious hate crimes at the workplace are on the rise [39]. In the USA, 25% of American-Muslim physicians reported that they experienced religious discrimination [40].

It is important for Muslim mental healthcare providers to realise that Islamophobia is incompatible with NHS values. Religious and race hate crimes can erode staff morale, have a negative impact on job satisfaction (there are higher rates of turnover of Black and Minority Ethnic (BME) NHS staff reported in the literature) and can negatively influence patient care [39].

The Prevent Programme in Practice: A First-Hand Account from a British Muslim Psychiatrist

The following narrative is written in the first person by US to provide an insight into the impact that Islamophobia has on the provision of mental health services in the UK.

I am a British psychiatrist currently working in Leeds. I completed my medical training in Liverpool and have been practising as a doctor for over 10 years. My ancestry is from the Indian subcontinent, and I am an openly practising Muslim.

In my career, I have seen a wide variety of patients, and over this period, I have also seen a shift in attitudes towards the National Health Service, psychiatry and people with mental illness. This shift has strongly been influenced by political events including violent extremism.

According to Kamran Ahmed, a Consultant Psychiatrist in Sydney, in his article for *The Guardian*, "…People with mental illness often derive their symptoms from the environment around them, so the social context we are operating in further exacerbates the problem. The round-the-clock coverage of terrorism, the constant hate speech, the all-too-easily accessible online propaganda: I am increasingly seeing both Islamist and far-right extremist ideas and behaviours featuring in the symptoms of patients with mental illness" [41].

I want to provide a couple of vignettes from my clinical experience working within psychiatry in the UK. In the first vignette, a Caucasian gentleman presented to mental health services with auditory hallucinations with a background of schizophrenia. His forensic history revealed some violence in the past and an affiliation

with the far-right group the English Defence League (EDL). No concerns were raised regarding this patient's risk to himself or to others, and no further action in relation to risk was taken. At the time, we were all completely oblivious, by definition, to the possibility that unconscious bias might be operating although with hindsight it became more apparent. Would we have referred this patient immediately to safeguarding if he was a Muslim with a forensic history who was watching online propaganda from Daesh? This, of course, was not intentional or deliberate but offers an opportunity for us to reflect and to learn. The patient was detained under the Mental Health Act and remained on the inpatient mental health ward for a month. He responded well to psychotropic medication and managed to abstain from smoking cannabis. Whilst on a period of authorised leave off the ward, the patient managed to obtain some cannabis, and after smoking it, he assaulted a lady at the train station. This patient's leave was subsequently suspended, and the level of his supervision was increased. The patient's mental state gradually improved, and he was permitted to leave off the ward with his mother. His mother, however, disclosed that she noticed that her son was accessing material from far-right web sites, and the patient's leave was suspended again. At this point, the patient was referred to Prevent for their advice and input. Prevent assessed the patient and advised that mental health services monitor his Internet usage and that they would like to know when the patient would be discharged. Apart from this, they did not provide any further input or advice.

The second vignette is in relation to a Middle Eastern male patient who presented to mental health services with first-episode psychosis. This patient had no background of violence or links to any extremist organisations. It appeared his illness was precipitated by illicit drug misuse and he became unwell over the year preceding his admission. Friends and family noticed that his speech was rapid and incoherent and that his train of thought was becoming increasingly difficult to follow. A mental state examination revealed that the patient held delusional and grandiose beliefs that he invented many devices and contraptions for the benefit of humankind and that he wanted to help society. He mentioned during an interview that he wanted to fight terrorism and he believed that he could invent technology that might help the US Security Services identify perpetrators of violent extremism. Never did the patient report that he himself wanted to engage in terrorist activities or that he had any thoughts of harming others. The patient, however, was immediately referred to Prevent for advice. They proceeded to visit him on the ward on a regular basis and offered him 1:1 time with an Imam (Muslim Chaplain) to discuss his beliefs and world views. Prevent officers also wanted to know where the patient would be discharged to and who he would be living with.

These cases, we feel, illustrate that an unconscious (or Islamophobic) bias might be operating in relation to referrals to the Prevent "safeguarding" team. We suggest that as part of mandatory training for Prevent, officers receive information about the psychology of unconscious/Islamophobic bias and the detrimental impact that this can have on the mental health of Muslim service users.

Conclusion

Now, more than ever, Muslims are in desperate need of mental health support; however, this need is not being met in the current provision of specialist care in the National Health Service in the UK. General awareness of the issues that Muslims face and the pressures that they are under, such as racism and hate crime, is important to recognise within a therapeutic context. Studies have shown that clinicians are usually unaware of Muslim beliefs and practices, which can present challenges when trying to deliver effective treatment to Muslim patients. A report from the Journal of Muslim Mental Health advises that "clinicians must recognize the types of microaggressions their Muslim clients may experience in their everyday lives, as well as potential microaggressions that may occur in therapy" [42]. Not only does this help the practitioner develop a more holistic understanding of the British Muslim patient experience, but it also helps to establish a therapeutic alliance between practitioner and patient. For Muslims, there is comfort from being understood without having to explain the seemingly obvious details of their negative experiences.

Muslims already face barriers in accessing and using mental health services such as those related to the stigma of mental illness [43], explanatory models that Muslims formulate of psychological disturbances (i.e. attribution to supernatural causes such as Jinn possession) and perceptions around the cultural insensitivity of services that operate from a secular framework [44]. These barriers to mental health services have been fortified by the surveillance of Muslim communities through Prevent. Consequently, many Muslims with mental health problems will continue to suffer in silence despite the availability of effective treatment, and Islamophobia will continue to cause psychological distress and exacerbate pre-existing mental illness. Mental health practitioners must therefore be cognisant of the way Islamophobia and its institutionalised form, Prevent, are being practised throughout their field and take measures to provide Muslims with mental illness with evidence-based, patient-centred care. Above all else, they must remain professional and non-judgemental and be mindful and wary of how pervasive and insidious Islamophobia is and how this has stealthily infiltrated mental healthcare policy and provision and how this can, consciously or not, influence the care that they provide.

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20 Islamophobia: Social, Religious, and Clinical Considerations from a Jewish Psychiatrist

H. Steven Moffic

> How do we address the variances between our patients who are from a different cultural background or religion than ourselves, and how do we help them? [1]

This chapter attempts to answer that question particularly for Jewish psychiatrists and Muslim patients in particular. Moreover, in this case, why should Jewish psychiatrists in particular be so especially concerned with Islamophobia?

One reason might be that Islamophobia is a relative of Antisemitism, and Antisemitism is an obvious concern for Jewish people [2]. Though Antisemitism has come to mean discrimination toward Jews, the Oxford Dictionary defines Semites as "including in particular Jews and Arabs." Arabs are one of the large populations who embraced Islam. Even if current Antisemitism refers only to Jews, and not Arabs, the separation of these peoples has not always been so clear-cut.

Another reason might be that Islamophobia is a problem of some sort that needs to be addressed by society and psychiatry. Would a Jewish psychiatrist like myself, who had specialized in cross-cultural psychiatry, have a useful perspective from the intersection of Judaism, Islam, and psychology?

One of the main principles of cultural psychiatry education is to know oneself from a cultural identity standpoint [3]. In a model educational program which I developed some time ago, one's religion, if any, is considered to be part of that cultural background. The key is to process, on one's own and in the educational group, how and why one identifies oneself as part of a certain culture. For instance, would I identify myself as a Jewish American or an American Jew, with or without hyphens? Put one way, American seems to be the priority, while put the other way, Jew seems to be the priority.

Of course, when I speak from the perspective of a Jewish psychiatrist, I am just one Jewish psychiatrist. What is important to my Jewish identity as a psychiatrist may or may not fit other Jewish psychiatrists well, but we all should at least have

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some things in common, starting with all being Jewish in some way. Similarly, I am using the mythical average Muslim unless otherwise stated. In general, I am on much firmer ground in psychiatry than on religion, and in religion, on much, much firmer ground with Judaism. In addition, each religion is by no means monolithic and each has had significant internal conflicts.

Despite those limitations of my uniqueness, there seem to be some commonly accepted Jewish values derived from the Torah, which are of relevance to almost all Jewish psychiatrists [4].

Jewish Values

In the story of how the Jews were exiled from Egypt to journey to Israel millennia ago, which is remembered each year during the Passover holiday, one particular Jewish value is emphasized. This value is to *show kindness toward strangers*.

The Torah, which the Jewish people received on the journey, warns against harming a stranger at least 35 times, depending on the translator. This is many more times than the one place where we are commanded to love our neighbor, as in the so-called Golden Rule. In the Golden Rule, the neighbor may also be those of one's own tribe. In Leviticus, it is written:

> The stranger who resides with you should be to you as the native among you, and you shall love him as yourself, for you were aliens in the land of Egypt.

Later, in Deuteronomy, the scripture includes the stranger in the establishment of judicial courts:

> Hear out your fellow men, and decide justly between any man and a fellow Israelite or stranger.

Other religions which came after Judaism also emphasize concern for the stranger. However, there is a particular twist in the Torah, which becomes relevant to psychiatry:

> You shall not oppress a stranger, for you yourself know the feelings of a stranger, for you also were strangers in the land of Egypt.

The last clause can also be translated as [5]:

> For you know the heart of a stranger.

This translation refers to empathy. In more metaphoric terms, it means to put oneself in the shoes of another. Sometimes, that empathy comes from similar experiences, like the psychiatrist's own mental health problems and sometimes from leaps of imagination. More rarely, there are devices to help enhance empathy, such as a device that pharmaceutical companies have shown at psychiatric meetings which mimics hearing auditory hallucinations. In psychiatry, empathy is a key to understanding the psychology of the patient. Therefore, if you are not Muslim,

sufficient empathy is a key to understanding patients of that background and, if coupled with compassion, enhances the likelihood of treatment success. Unfortunately, lack of empathy in healthcare clinicians is one of the most common complaints of patients [6]. Likewise, for the public, empathy, coupled with compassions, can be an antidote for Islamophobia.

Of course, understanding the patient is not easy. The patient usually can't – or won't – divulge or disclose outright what is wrong. Sigmund Freud, of Jewish background, came to understand that there were layers of potential understanding and memories, protected by defense mechanisms because of their psychological pain that would take much time to uncover through psychoanalysis.

Another pertinent Jewish value that could be considered to be an extension of kindness to strangers is Tikkun Olam, which in essence means to *try to heal the world.* Healing the world in psychiatry means to try to help the mental health of those in need, starting with those in most need: the vulnerable such as the poor, the discriminated against, the outsider, and more. Though such patients can be found in any psychiatric system, they are found in the United States most often in our public community mental health systems.

Tikkun Olam refers to healing the outside world. In addition, there is a Jewish emphasis on healing ourselves, our own internal world, as well as *turning toward the better*. This can be called Teshuvah.

No wonder, then, that Freud turned to understanding himself first by trying to interpret his own dreams [7]. Understanding oneself can prevent the intrusion onto the patient of one's own interfering issues, otherwise known as countertransference.

Jews and Muslims

Whereas Jews may have been strangers to many people (such as the Japanese), this certainly has not been the case with Muslims. Our mutual history indicates that we are only partially strangers. We are perhaps peoples who have become strangers, more like family members who have an estranged or, at best, an ambivalent relationship.

We do share being one of the clearly monotheistic religions traceable from Abraham through Judaism to Christianity to Islam. The early biblical story of Ishmael may be paradigmatic and in our Jungian collective unconscious, even when it seems to not be well known at times. Though the Torah and Qur'an may tell the story differently, the Jewish version goes something like this.

When Abraham, who was promised by God to be the progenitor of a large and great people, couldn't conceive a child with his wife Sarah, Sarah supported Abraham in having a child, later named Ishmael, by their handmaiden, Hagar. When Sarah was finally able years later to have her own child, Isaac, with God's apparent help, she insisted on the banishment of Ishmael. Abraham went along with this demand. God did, too, though then promised Ishmael that he would lead another great people, often said to become the Arab people.

To psychiatrists, much of the Torah can sound like typical family conflicts that we encounter in family therapy. Does not this split in Abraham's kith and kin sound like a long-lasting unresolved family conflict involving step-siblings, now playing

out in the Middle East? Given the Torah's coverage of several problematic and often unresolved family conflicts, as well as the deep introspection of such forefathers as Jacob and his son Joseph, perhaps, then, it is not surprising that Jews like Freud were so over-represented in the development of modern psychiatry. Given his dream interpretative skills and ability to resolve his sibling conflicts, Joseph could even be thought of as the first psychiatrist.

In the early Middle (or Dark Ages in European history), Muslims conquered extensive lands, including some of Europe, especially Spain. It has been called the Islamic Golden Age, which paved the way for the European Renaissance. Great advances in science and mathematics occurred in these lands.

This time period has also been called the Golden Age for Jews who lived in Islamic controlled lands. For instance, it was the time of the great twelfth-century Jewish physician and Rabbi, Moses Maimonides [8]. Usually deemed the most revered Jew in the last thousand years, Maimonides possessed a worldview infused with Islamic methods and ideology, coupled with the compassion, knowledge, and psychological insight of the best physicians of the time (Fig. 20.1).

Fig. 20.1 Image of Maimonides

Medicine flourished during this time in these lands. Centuries before Europeans, Muslims set up the first mental health hospitals in Mesopotamia (the present-day Middle East) and developed theories of mental processes that resembled some of Freud's later theories [9]. All this seems to have been forgotten in the ensuing centuries, when after these Islamic controlled countries lost their power, Western rule eventually emerged [10].

With a long view, one can see the reciprocal relationship of Muslims and Jews on religion and psychiatry: Islam used stories from the Jewish Torah, and Freud, wittingly or not, picked up on the psychological ideas of Muslim physicians from the early Middle Ages. Jews and Muslims, despite times of antagonism, each benefited from the other.

Judaism, Islam, and psychiatry are all thought to have layers of possible interpretation, at least by the less Orthodox. Religious leaders make lasting interpretations of holy books, and psychotherapists make interpretations of material, including dreams, from the patient. Consider the story of Abraham, Ishmael, and Isaac.

The narrative of this Torah (or Old Testament) story is that God asks Abraham to sacrifice his son by his wife Sarah, Isaac. Abraham begins to comply, but a messenger from God interrupts him. One of the many interpretations over the years has been that God was testing Abraham's loyalty as the forefather of a new faith, another that this was a punishment for the banishment of his first son Ishmael, and another that the common practice of human sacrifices should became morally abhorrent.

In the Qur'an, Abraham told his son about his vision and his son accepted being sacrificed to fulfill God's command. When they were ready for the sacrifice, God told Abraham he had already fulfilled the vision. The son, however, is not named; over time, many have come to assume that he was not Isaac but Ishmael. If Ishmael was sacrificed, then Isaac, born later, could be seen as a reward for Abraham obeying God in his vision.

Might Jewish psychiatrists feel more spiritually connected with Muslim patients if they knew that Muslims believe that Abraham, together with his son Ishmael, constructed the Kaaba, the most sacrosanct place in Islamic history? This is where Muslims throughout the world face when they offer their five requisite prayers and where they perform the hajj (pilgrimage) during Eid to commemorate Abraham's loyalty to God.

In psychiatry, a simple view could be that Abraham was having a command hallucination and, if he were living in our time, might be detained in the hospital since he would be considered as being dangerous to others! However, most psychiatric and literary interpretations of the story would relate it in one way or another to Freud's Oedipal conflict, in which the father and son are in competition for the wife and mother's love and may even have murderous fantasies at times. Successful resolution of the conflict involves the father gently guiding the son and trying to protect him from danger, the mother not becoming over involved with her son, and both encouraging him to individuate and separate.

Later on in the Torah, Abraham's grandson, Jacob, illustrates another issue, that being struggle, which will come to overlap with what is conveyed in the Qur'an. Jacob is renamed Israel, which also becomes the name of the "promised land."

Israel means “One who Struggles with God.” For Jews, struggle is sacred. For Muslims, Jihad can either mean a struggle against the enemies of Islam or the spiritual struggle within oneself. The latter, the internal struggle, is similar to the internal struggles that often leads one into psychotherapy.

Consider the contemporary relevance of these historical stories in the case of a father of two sons who had a midlife religious crisis. This case seems to illustrate both the processing of an Oedipal conflict as well as a struggle with God and with oneself. He was a successful businessman in a European city before turning to Orthodox Judaism, which became his primary focus. He then moved the family to Israel, living in Jerusalem, a holy city for both Judaism and Islam. His two sons eventually joined the Army. The younger served in an elite unit and was killed fighting in the Gaza occupied territory. The father became depressed and in psychotherapy processed both his guilt and his unresolved problems with his own father. After improving, he turned toward activities that could bring peace between Israel and the Muslim Palestinians.

In more modern times, the Jewish philosopher Martin Buber seemed to emphasize the kind of relationship to which Jews and Muslims should aspire and what psychiatrists try to establish in our therapeutic relationships [11]. This is the I-Thou relationship, which emphasizes the authenticity of the other, respecting and recognizing the dignity of the other. The I-It relationship, on the other hand, refers to an object or part of an object. In this kind of relating, we emphasize reducing symptoms of an illness, not necessarily healing a person. Buber came to this insight after brushing off an inquiry while he was busy, only to find out that the person who had approached him committed suicide soon thereafter.

Understanding Islamophobia

Though there are many definitions, the term Islamophobia literally refers to an excessive fear of the Islamic religion. This fear would generally extend to those identified as Muslims, whether their religious beliefs were known or not. It does not have the same meaning as an “anti-,” such as Antisemitism, which implies being against Semites, but not necessarily fearful of them.

Phobia is also a psychiatric diagnostic term [12]. Given that “specific phobia” is a diagnostic category, would Islamophobia be a diagnosable disorder? By itself, Antisemitism has never qualified nor has racism, despite attempts to at least make more extreme racism or bigotry qualify – the argument being “that so many Americans are racist that even extreme racism is normative and better thought of as a social aberration than an indication of individual psychopathology” [13]. Like racism, those who have Islamophobia will not always consciously recognize that they have it, especially if their lives end up without much exposure to Muslims or the Islamic. Reconsider, though, what might have happened if Hitler had been treated for his suicidal ideation in 1924 after his failed coup instead of being incarcerated [14], even treated by a Jewish psychiatrist! It was in jail that Hitler wrote his first draft of “Mein Kampf.” As part of their treatment for other conditions, there are

anecdotal reports that as patients became more aware of their own problems, they grew less paranoid and less prejudiced.

Islamophobia does meet all the criteria for a specific phobia except one essential one, which is that “the person recognizes the fear is out of proportion.” Perhaps that is why I have never heard of an actual patient being diagnosed with Islamophobia. People who overly fear Islam seem to feel that it is reasonable and realistic. Moreover, like racism, those who have Islamophobia will not always consciously recognize that they have it, especially if their lives end up being bereft of much exposure to Muslims or the Islamic religion.

No surveys are available to indicate whether certain groups of people, in this case Jewish people, have more or less Islamophobia, although there is a psychometric scale that has been developed to measure levels of Islamophobia [15]. One might expect Islamophobia to be psychologically connected to the Israeli-Palestinian conflict in the Middle East. Is that conflict more likely to make Jews in the United States more fearful, or can Jews empathize and embrace the fact that both peoples are scapegoated at times, falling back on the ancient and traditional Jewish value to help the stranger in our midst?

If Islamophobia would only rarely qualify as a psychiatric diagnosis of an individual patient, does it more closely resemble a social and group psychopathology, in the same way that Antisemitism influenced the Nazis to desire – and nearly achieve – genocide of the Jewish people in Europe? One problem with this is that there has never been a commonly accepted classification of social psychopathology.

Though in use for over a century, the term Islamophobia gained media currency after the 9/11/01 terrorist attack in the United States, since then referring to fears in the United States and elsewhere of terrorism perpetrated by people who call themselves Muslims. By contrast, the term Antisemitism has been in vogue for a much longer time.

To reiterate, the key word in the definition of Islamophobia is excessive. Millions of Muslims, from many countries and from the conversion of Black Christian Americans, have been living peacefully in the United States, both before and after 9/11. Actually, most people who die from terrorism seem to be Muslims, and most people fighting terrorism seem to be Muslims. Nevertheless, as in the case of most phobias, there is a kernel of truth that contributes to Islamophobia. Some terrorist examples around the world have been horrifically traumatic, such as the beheadings of Americans. Even a psychiatrist, Nidal Hasan, killed 13 people at Fort Hood in 2009 and reportedly desired to become a citizen of ISIS rather than ask for forgiveness. Would people who remember him be uneasy about seeing a Muslim psychiatrist?

The psychological nature of trauma leaves people who are traumatized more sensitive to any trigger that reminds them of the original trauma. If Jews think of terrorist attacks in Israel, or Muslims focus on the trauma inflicted on Palestinians, their complementary fears can escalate exponentially.

Although Freud did not try to analyze Islam, and we do not know what he knew of Muslim medicine, several of his concepts can help us understand Islamophobia, as well as related social phobias like homophobia or xenophobia.

One process he described is projection, in which people unconsciously ascribe characteristics of themselves which they would rather disown to others. In the case of Islamophobia, it may be that we project our own aggressive and/or hateful impulses onto those who differ religiously from us. Another relevant defensive, racist process may be to feel safer as part of our own "tribe" than overwhelmingly anxious in the face of others who differ from us.

On the other hand, some argue that a counter reaction to Islamophobia, called Islamophilia, can be harmful by minimizing problems with the Islamic world or within Islamic communities [16]. Islamophilia often refers to being overly solicitous to Muslims who have immigrated to a country, even to the extent of having rescue fantasies.

Despite the value of some of Freud's psychological theories of how the mind worked to understand Islamophobia, he also argued that in general religion, including the Jewish religion, was an expression of underlying psychological distress or neuroses, even an infantile delusion [17]. As to the Oedipal conflict, he also suggested that religion could be a way to control that complex.

Clinical Implications

Given the fraught history of Jews and Muslims, it would seem that Jewish psychiatrists could potentially play an important and unique role in addressing the psychological harm resulting from Islamophobia. To test this, I wrote several articles over recent years for behavioral healthcare related to Islam and Muslims.

In 2010, "American Muslims, Mosques, and Mental Healthcare" discussed the controversy of building a Muslim community center near "ground zero" in Manhattan [18]. Given that 9/11 was so traumatic to so many Americans, including Muslim Americans, I wondered if this proposed mosque would trigger too many traumatic memories and thereby cause more harm than good. The application for building the mosque was eventually turned down.

On December 30, 2015, I posted "Get to Know the Muslim Culture" [19]. Most Americans, other than Muslims themselves, seemed to have little knowledge about the Islamic religion, including those in mental healthcare. Continuing education in our settings seemed indicated, to include that:

- We need to reach out to representatives of the Muslim communities, as President Bush actually did after 9/11, which seemed to correlate with a reduction of hate crimes at that time.
- We need to establish such a positive reputation for helping Muslim patients.
- We need to establish referral relationships with Muslim clergy.
- If possible, we need to try to learn better ways to predict violence, especially terrorist violence.

More recently, on September 8, 2016, I posted "Should We Reach Out to American Muslims on 9/11?" [20]. That year was the 15th anniversary of the

tragedy, and such anniversaries heighten the emotion of memories connected to these events, especially since our so-called war on terror continues. I endorsed reaching out in various ways, including by:

- Sending out a positive message to the mainstream Muslims in our communities that we recognize and appreciate their positive contributions to American life
- Offering open houses in our institutions, or going to Islamic centers, to foster alliances with Muslims in our communities
- Trying to establish mutual educational programs on mental health and Islam

Such writings were geared primarily toward mental healthcare clinicians and administrators, though the public had access to them, too. One implicit goal was to reduce Islamophobia among ourselves as psychiatrists. Another was to reduce any reluctance of would-be Muslim patients to come for mental healthcare, especially to Jewish clinicians. Indeed, on the other side of the coin, Islamophobia in Jewish patients may unnecessarily prevent them from seeking a Muslim mental healthcare clinician.

Jewish clinicians, though, have other obstacles to overcome in providing culturally competent care to Muslim patients. At one extreme, perhaps out of a sense of unconscious guilt or fear, we can have Islamophilia, or being more positive and loving than indicated. In clinical care, that can turn into unnecessary rescue fantasies or into being overly solicitous.

Orthodox and fundamentalist believers in all religions prefer that their religious beliefs be incorporated into their psychiatric treatment. Groups of Christian psychiatrists and therapists who offer biblically informed psychotherapy are examples. However, mainstream practitioners of most religions are less concerned that their religious beliefs be integrated into treatment. Literature on Muslim mental healthcare in general has been relatively sparse, perhaps reflecting a scarcity of Muslim psychiatrists and researchers and/or of Islamophobia. However, research is emerging which indicates a preference for faith-based psychotherapy for mainstream Muslims. Such approaches may even have better outcomes [21].

Therefore, psychiatrists need to respectfully ask new Muslim patients about their expectation for incorporating their religious beliefs into the treatment. In treating a patient with a preference for faith-based psychotherapy, it behooves the non-Muslim clinician to learn about the Islamic religion. While patients can educate the clinician as to what they consider their important Islamic beliefs, it is also helpful for the clinician to be able to put these into a context.

We are well past the contention that it takes one to know one to be culturally competent. We also seem to be well past the Freudian position that religious belief is neurotic. It is crucial to begin any patient interaction with respect for the beneficial aspects of their religious beliefs and careful consideration of when they can be harmful.

Having values too similar to that of the patient may cause erroneous assumptions to be made by the clinician. Moreover, sometimes patients, even religiously Orthodox patients, prefer a non-Orthodox clinician for confidentiality and objectivity [22].

When the cultural values of the patient and clinician are very different, respectful sharing of knowledge is essential in bridging the gap.

Because of sensitivity about the cultural background of both patient and clinician, it is important to bring up in the first session how the patient feels about this, no matter how the match was made. What are the hopes, the concerns, and the uncertainties that the patient has in this pairing? The clinician should also be careful about nonverbal communication, trying to follow the patient's lead, whether in regard touching as in shaking hands, and/or eye contact and focus, and even whether or not to leave the office door ajar or not. If the patient would prefer another family member to be present, that should be considered and agreed upon early.

Whatever the nature of these individual matches turns out to be, how well these cross-cultural matches work can only be accurately assessed by comparative outcome studies.

Perhaps some of these cross-cultural challenges help to explain why, since 9/11/01, the number of my Muslim patients gradually dropped. Was there an increased concern on their part about whether they would be treated fairly? Especially by a Jewish psychiatrist? Were they better at speaking Arabic than English? Was there some new countertransference problem in myself? Was I having some Islamophobia without knowing it? Few other Muslim psychiatrists were options for them in the Milwaukee community.

At the same time, the need for therapy seems to have escalated due to the extensive psychological damage of Islamophobia inflicted on Muslims. In one study, Muslims perceived that Islamophobia stereotyped Muslims as terrorists, that Islam is pathological, that all Muslims have similar religious beliefs, and that they are undesired citizens [23]. Indeed, that seems to be the picture of Muslims shown on television by other media, including an overwhelming preponderance of negative words associated with Muslims. One study of the print media portrayal of Muslims and Islam in the United Kingdom found that for every 1 positive word describing Muslims and Islam, there were 21 negative words [24].

Besides the occasional overt violence to Muslims, which can in turn result in posttraumatic stress disorder, Islamophobia is associated with more everyday micro-aggressions, including for Muslim patients and Muslim psychiatrists, all of which can increase anxiety and reduce self-esteem. Muslim adolescents may be at particular risk at a time of identity formation, leading some to take on polarized positions and more often embrace extreme causes. Adverse physical reactions are also common. These include cardiac problems, high blood pressure, and low-birth-rate infants [25].

Is it possible to go upstream from these mental healthcare repercussions for patients from Islamophobia to try to reduce Islamophobia in the public? Does the same sort of interventions for individual phobias apply to social phobias? It appears that it would, as a meta-analysis revealed that social contact was the most effective way of reducing stigma in adults toward members of the stigmatized group [26]. Just as "positive exposure" to those who were homosexual has lessened homophobia, more positive exposure to Muslims should help citizens and psychiatrists alike form realistic and respectful relationships. Subsequent to the recent traumatic

Jewish cemetery desecrations in the United States, the support of the surrounding Muslim communities was a most positive aftermath. Interfaith gatherings can also accentuate what we have in common.

If such live exposure is not readily possible, studies indicate that imagery can have a positive impact [27]. Simply imagining a positive social interaction with Muslims can often lead to more positive views of that group. As virtual reality technology develops, that may become a way to prevent and lessen Islamophobia through depicting positive interactions with Muslims.

In family therapy for conflict and trauma, forgiveness helps resolution. Can people of different faiths like Jews and Muslims use mutual forgiveness to help them overcome historical traumas? After all, we can rise above our suffering. Can therapeutic alliances and understanding help Jewish and Muslim clinicians and patients undo false assumptions of similar backgrounds and the distrust of unfamiliar backgrounds? Together, we have unique potential to enhance our peoples' mental health.

Conclusion

Psychiatrists are often reluctant to consider that our expertise and skills can be useful in society beyond the care of individual patients. However, we have an ethical responsibility to address societal problems that are psychologically harmful to people and patients:

Section 7 of the American Psychiatric Association's Principles of Medical Ethics, with annotations especially applicable to psychiatry, states: "A physician shall recognize a responsibility to participate in activities contributing to the improvement of the community and the betterment of public health" [28].

We should test this out. While it may be practically impossible to conduct a double-blind randomized study of a societal intervention, as we can with treatments for individual patients, let us see if the principles that apply to personal healing also apply to the healing of society. This calls for Jewish and other psychiatrists to use empathy, compassion, and knowledge to do what we can to reduce Islamophobia and increase Muslim mental health. This would be the bio-psycho-social-spiritual model of psychiatry in action.

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21 Islamophobia: A Christian Psychiatrist's Perspective

John Peteet

Many Christians fear Muslims and consider Islam an existential threat. Here I explore reasons rooted in history, theology, culture, and psychology for the irrational and harmful reality of Islamophobia among Christians, before considering potential responses, and some clinical implications.

History

Christians and Muslims have experienced long periods of both peaceful coexistence and intense hostility. Many Christians are not aware that in the early centuries of Islam, particularly during the Rashidun period when Muslim armies engaged in military conquests and expeditions, respect for People of the Book (Jews, Christians, and Muslims) allowed them all to survive under Muslim rule. Omar ibn Al-Khattab, the second successor of the prophet Mohammad, rescinded the ban imposed on Jewish people from entering Jerusalem, and while the Qur'an banned Muslims from marrying polytheists, it allowed Muslim men to marry Jewish or Christian women without their converting to Islam. Furthermore, after the seventh-century Muslim conquest of Syria, previously a stronghold of eastern Christianity, churches were not disturbed or desecrated, and new ones were built. During the first century of Islam, places of worship were also shared by Muslims and Christians in Jerusalem, Damascus, and Homs [3].

In 628 C.E., Muhammad granted a Charter of Privileges to the monks of St. Catherine Monastery in Mt. Sinai. It consisted of several clauses covering all aspects of human rights including such topics as the protection of Christians:

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> …This is a message from Muhammad ibn Abdullah, as a covenant to those who adopt Christianity, near and far, we are with them.
>
> Verily I, the servants, the helpers, and my followers defend them, because Christians are my citizens; and by Allah! I hold out against anything that displeases them.
>
> No compulsion is to be on them.
>
> Neither are their judges to be removed from their jobs nor their monks from their monasteries.
>
> No one is to destroy a house of their religion, to damage it, or to carry anything from it to the Muslims' houses.
>
> Should anyone take any of these, he would spoil God's covenant and disobey His Prophet. Verily, they are my allies and have my secure charter against all that they hate.
>
> No one is to force them to travel or to oblige them to fight.
>
> The Muslims are to fight for them.
>
> If a female Christian is married to a Muslim, it is not to take place without her approval. She is not to be prevented from visiting her church to pray.
>
> Their churches are to be respected. They are neither to be prevented from repairing them nor the sacredness of their covenants.
>
> No one of the nation (Muslims) is to disobey the covenant till the Last Day (end of the world) … [7]

The church's attempt to wrest control of the Middle East from Muslims during the Crusades continues to poison the historical memory of both faith communities. Yet even the Crusades were marked by moments of chivalry and gallantry shown to opposing forces. For example, Saladin, leader of the powerful Muslim forces, offered his own personal physician to his adversary King Baldwin of Jerusalem, who was suffering from Hansen's disease – an example of shared Christian and Islamic values in practice.

The recent attacks of 9/11 revived deep-seated feelings about violently competing world views and the need to fight back, leading to and worsened by the subsequent wars in Iraq and Afghanistan. Militants report that military operation in Muslim-majority countries is what motivates them to carry out their heinous terrorist attacks. The emergence of religiously dominated governments in Turkey, Egypt, and Iran; the ongoing refugee crisis; and increasing religious oppression in historically Christian Europe continue to exacerbate tensions. President Trump's revised executive order on travel, which temporarily halts the refugee program, restricts entry from several Muslim-majority countries, and created chaos in airports across the USA, received considerable media attention on a global scale. Although Trump cited 9/11 when he issued this order, none of the perpetrators of 9/11 were from the Muslim-majority countries that were on his list, and no evidence has emerged to support the idea that this executive order would prevent radicalization.

A recent Pew Research Center survey showed that white Evangelicals supported by a 3–1 margin President Trump and were the only religious group in America to become more supportive of banning Muslims from America. The survey also showed that a majority of white Evangelicals (67%) do not believe Islam is part of mainstream American society.

Meanwhile, in other parts of the world, various forms of intertwined political and religious violence continue. Christians are clearly oppressed by Muslims in Pakistan, Iraq, and Sudan. Muslims are clearly oppressed by Christians in the Philippines.

Mutual, less clear oppression takes place in sub-Saharan Africa; mutual, clear violence exists in Nigeria; and oppression of both Christians and Muslims by other faiths takes place on occasion in Palestine, Burma, Thailand, and India.

Theology

Muslims, Christians, and Jews as theological descendants of Abraham are People of the Book. Both Islam and Christianity value personal morality, submission, and obedience to God, as well as love of neighbor and a respect for Jesus as the Messiah and the word of God who is destined to return at the end of time. Muslims believe in the Immaculate Conception and revere Mary, for whom a chapter in the Qu'ran is named.

Theological differences remain, centering on controversies over what to call God, how to understand the Trinity, the validity of the Gospels and the Qu'ran, exclusive claims about Jesus and Mohammed, and the status of the Jews. However, some US Christians see these differences as extending to core values. In a Pew Research Poll conducted in 2016, 74% of white Evangelicals, 66% of white mainline Protestants, and 63% of white Catholics viewed Islamic and American values in conflict. Many seem unaware of the similarity between the Christian Golden Rule and the Muslim statement "No man is a true believer unless he sincerely desires for his brethren that which he desires for himself" (Bukhari). Western Christians often view political violence in the name of "jihad" as a reflection of Muslim doctrine – hence the use of "radical Islamic" in referring to terrorism perpetrated by groups such as ISIS.

However, many Western Muslims such as Mustafa Akyol [1] contend that the disturbing strains of hostility in the attitudes of self-proclaimed Muslims toward Christians derive less from Islam's core texts and more from political grievances against the West, which leads to a selectively negative reading of these texts out of context and without reference to the interpretive tradition. For example, a common misunderstanding held by Christians is that Muslim scriptures teach violence toward Christians as infidels, when in fact the Qu'ran regards Christians and Jews as believers. Another is that most Muslims (cf. the Charter of Privileges, above) believe that literal forms of Shari'ah law should be imposed on their fellow citizens. In fact, a recent American Muslim Poll from the Institute for Social Policy and Understanding found that 55% opposed the use of Shari'ah as a legal source and only 10% said it should play a role.

However, Pew survey data from around the world indicate that almost all Muslims in Afghanistan (99%) and most in Iraq (91%) and Pakistan (84%) support Shari'ah law as official law, whereas in some other countries of Eastern Europe and Central Asia – such as Turkey (12%), Kazakhstan (10%), and Azerbaijan (8%) – relatively few favor the implementation of Shari'ah law. As a result, many Christians see major schools within Islam as intrinsically historically, theologically, and in many parts of the world still practically more militant and intolerant than their own faith. [This is despite the fact that a textual analysis revealed violence is more common in the Bible than the Qu'ran and that the Old Testament was found to be more than twice as violent as the Qu'ran (http://www.independent.co.uk/arts-entertainment/books/violence-more-common-in-bible-than-quran-text-analysis-reveals-a6863381.html).]

These Christians are not at all sure whether moderate, more Westernized schools of Islamic thought will win out in this struggle within the faith. We should recognize that those concerned that certain aspects of Islamic theology and practice in many parts of the world are problematic do not necessarily deserve the designation Islamophobic.

Culture

Many Western Christians fail to appreciate that only a minority of Muslims live in the Middle East and have little direct contact with Muslims, who constitute about 1% of the US population. In fact, only 35% of white Evangelicals say they have any personal connection to Muslims, according to a 2016 Pew Research poll. As a result, they often fail to appreciate how much practices such as covering with the hijab vary from culture to culture and may take their cue from media portrayals of Muslims, which research indicates are more negative and emotional in the USA since 9/11. While Christians in the West commonly stereotype Muslims as fanatical and dangerous, non-Western Muslims often view Christians as materialistic, immoral, and likely to stereotype them as terrorists.

Psychology

Unfamiliarity and ignorance of Islam, which we have seen are widespread among Western Christians, provide fertile ground for the development of fears and xenophobic projections. A growing body of literature shows how negative stereotyping and prejudice can take the form of unconscious or implicit bias. On the other hand, research shows that knowing someone from a religious group is associated with more positive views of their faith [11].

Religion, derived from the term religio, or to bind together, can be a powerful force for solidarity in the service of a good cause but when becoming a vehicle for tribalism can reenforce some of its most harmful forms [4]. Scapegoating of an innocent victim whom society conspires to see as guilty and deserving of exclusion and violence has been a particularly entrenched and harmful form of tribalism throughout history [6]. In the same way that Jewish people have historically served as scapegoats in Europe, Blacks and Muslims have been scapegoats both throughout American history [12] and conspicuously in the present day [8]. Cycles of mutual aggrievement, suspicion, and hostility often follow violence, making it noteworthy when one party calls for forgiveness instead of vengeance, as in the case of Egyptian Coptic Christians targeted in 2016 by extremists identifying as Muslim.

Chapter 32 of this book explores the psychology of radicalization and recruitment into terrorist organizations that claim to represent Islam. This is of course not a phenomenon unique to Islam – the Southern Poverty Law Center lists 20 Christian Identity hate groups in the USA which are Christian in name only.

Potential Responses

How can Christians respond appropriately and effectively to Islamophobia? First, they can be more aware of the subtle power of implicit bias and scapegoating. Girard [5] has argued that appreciating that Jesus was an innocent victim of scapegoating offers hope for breaking the cycle of scapegoating and violence, because now the victim looks too much like him. Nietzsche accurately if contemptuously accused Christianity of engendering empathy for victims. Jesus instructed his listeners to "take the beam out of your own eye before trying to remove the speck from your brother's."

Second, they can educate themselves about real Muslims, ideally through personal contact. For me, these have included a former student Areej from Iraq (now an oncologist and local resource on working with Muslim patients), patients from Saudi and Kuwait, a Muslim psychiatrist who had to leave Pakistan out of fear for his safety, and American colleagues at meetings such as the Annual Conference of Medicine and Religion and at symposia of the American Psychiatric Association, where the idea for this book originated. Each of these has impressed me with the integrity, affection, and openness they have shown in relation to their faith and to mine.

One way to learn from Muslim neighbors is for local churches to share Iftar dinners, which take place after the Muezzin issues the call for sunset (maghrib) prayers during Ramadan. Prior to President Trump's administration, Iftar dinners were a White House tradition, begun in December 1805 when Thomas Jefferson famously hosted Tunisian ambassador Sidi Soliman. Interfaith advocacy activities present additional opportunities. One international example is the initiative A Common Word (ACW, http://www.acommonword.com/) that begun in 2007, sponsoring conversationsworldwide between Muslims and Christians in areas marked by tension. In response to an ACW letter signed by 138 Muslim leaders, a Christian response was signed in 2013 by 281 Christian leaders and scholars affirming common ground and the need for dialogue. Another example is the 2017 meeting of Pope Francis with Muslim leaders in Egypt, at which he encouraged them to join him in fighting violence in God's name.

More didactic resources include books [10] and videos (https://www.youtube.com/watch?v=TyTJNgI_uuM) specifically designed to educate Christians about Islam. *The Message*, a 1976 epic motion picture directed by Moustapha Akkad, chronicling the life and times of the prophet Muhammad is a well-accepted source of information about what it means to be a Muslim (http://bbfc.co.uk/releases/message-arabic-version-1970). A compelling, more accessible resource is Dalia Mogahed's TED talk, What it's Like to Be Muslim in America (https://www.ted.com/talks/dalia_mogahed_what_do_you_think_when_you_look_at_me).

In my own city of Boston, police data indicate that hate crimes against Muslims nearly quadrupled from 5 in 2015 to 19 in 2016. But the Islamic Society of Boston has welcomed the mayor's decision to distribute posters at bus stops and other public places showing a viral online illustrated guide on how to respond to Islamophobic harassment, which has been adopted by other US cities to make commuters more confident to intervene if they witness abuse.

Third, Christians can draw upon their understanding of God and of the world to welcome the stranger, love their enemies, and forgive, recognizing how much we ourselves have been forgiven. Those interested can find a fuller explication of this in Matthew Kaeminck's book, *Christian Hospitality and Muslim Immigration in an Age of Fear* [9], in which he advocates a pluralism that goes beyond coexistence "to pursue moments of commonness, connection cooperation," as well as advocacy and activism for vulnerable immigrants. Examples of the ways that Christians have counteracted cycles of mutual aggrievement are seen in the lives of Martin Luther King, Desmond Tutu, and the recent survivors of the Charleston killings. Recent examples of Christians and Muslims joining to bring their communities together after terrorist tragedies can be found in the work of the Tower Heights Interface Forum and the British nonprofit Muslim Aid, which sponsored a "sunset walk" from the steps of St. Paul's Cathedral in London to the East London Mosque. Public statements made after such events by leaders such as President Obama, communicated widely by digital media, can powerfully combat Islamophobia. Canadian Prime Minister Justin Trudeau's response to the terrorist attack on Muslim worshippers in a mosque in Quebec is an example: "Know that we value you. You enrich our shared country in immeasurable ways. It is your home. Last night's horrible crime against the Muslim community was an act of terror committed against Canada and against all Canadians. We will grieve with you. We will defend you. We will love you. And we will stand with you."

Fourth, Christians can better appreciate how much they and Muslims share. Most Christians and many Muslims are not aware that the Qu'ran describes Jesus as a major prophet. As Mustafa Akyol writes in *The Islamic Jesus*, the method and message of Jesus have the potential to bring Christians and Muslims past the modern crisis in two ways: by teaching that the Kingdom of God (or the Caliphate) is "within you" and that the purpose of religious law is to serve man, and not vice versa. He writes (p.215): "With Christians, we agree that Jesus was born of a virgin, that he was the Messiah, and that he is the Word of God. Surely, we do not worship Jesus like Christians do. Yet still, we can follow him. In fact, given our grim malaise and his shining wisdom, we need to follow him."

Clinical Implications

Given the fact that in the USA, psychiatrists are on average less religious than their patients, they may need to educate themselves about the clinical importance of faith. Christian clinicians caring for Muslim patients also need to educate themselves, first of all by being curious about what is important to their patients, and what their experience has been. To establish rapport and meet them on their own terms, it can help to establish how the patient likes to be greeted. Does he or she feel comfortable with "salam" (peace be upon you)? Given the powerful impact of stigma (one half of US Muslims report experiencing discrimination), clinicians need to be honest with themselves and alert to the potential impact on the transference and

countertransference imposed by centuries of mistrust, ignorance, and misunderstanding. When this is palpably interfering with treatment, it may be helpful for a psychiatrist to explicitly clarify that being a non-Muslim or a Christian does not mean that he endorses a particular foreign policy or looks down on Muslims. Psychiatrists who explicitly identify themselves as providing "Christian" or "Biblical" therapy should be sensitive to fears that Muslim patients may have that they could be proselytized. As authors of other chapters in this book point out, clinicians need to appreciate both what being a Muslim may have cost them, and how their faith can serve as a resource. Similarly, Muslim clinicians treating Christian patients need to appreciate the range of meanings their faith or cultural identification as Christian may have for them. More detailed suggestions for working sensitively with both populations can be found in Dr. Koenig's chapter in this volume. Additional general strategies suggested by Yousef Abou-Allaban in the *Handbook of Spirituality and World View in Clinical Practice* [2] are to:

- Involve family members in the treatment process wherever possible.
- Assess the level of education and religiosity.
- Emphasize the biological basis of mental illness and that medication may be able to relieve symptoms.
- Use exploratory-directive methods rather than exploratory-reflective methods to solicit information.

Finally, Christian psychiatrists can use their expertise in the development and consequences of Islamophobia to educate their communities; to advocate for more equal, accessible, and informed treatment of Muslim patients; and even to become agents of cultural revolution.

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Part III

Specific Clinical Challenges

22 Addressing the Mental Health Needs of African American Muslims in an Era of Islamophobia

Balkozar Adam

People who identify as African American and Muslim reflect a myriad of cultures, ethnicities, and identities. Who falls within this subgroup may differ based on the speaker or audience. This is a diverse population with areas of intersection and divergence. Some trace their roots back to the earliest slave ships that came to America. They may identify as African American or Black. Others emigrated from Africa in the last one to two generations and may prefer to refer to themselves as African or Middle Eastern or even more specifically as Somali or Nigerian, for example. Their level of acculturation often plays a role.

The issues of race, ethnicity, and labels are frequently related to identity. The terms used in academia and health care are often socially imposed; youth of diverse heritages may report the racial identities ascribed to them by the school setting or other systems. However, these may not reflect the identity they have internalized. To understand the journey of African American Muslims, we must first understand their history. Fifteen to 20% of the enslaved Africans were estimated to be Muslim. They came from Muslim-dominated countries of West Africa. Many struggled to hold onto their religious beliefs and cultural practices [6]. They shared the same plight as their counterparts, including the notion that black slaves were "immune to mental illness" [12].

In the early twentieth century, institutions and movements alike influenced the religiosity of African American Muslims. In 1912, the Moorish Science Temple was founded [4]. It taught Muslims beliefs, greetings, and dietary restrictions.

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The Ahmadiyya movement originated from what is now known as South Asia and focused on inclusion and support under oppressive leaders. Oppression connected two groups – Black Muslims in American and Muslims in South Asia – even if one group was British and the other American. Significant figures throughout history also impacted the way African American Muslims viewed themselves. Elijah Muhammad, for example, converted to Islam in 1931 and later preached his own version of militant Islam. His message was that African Americans were the original race and that Whites were devils. He built the religion from a small fringe group into a large, complex organization known to many as the basis for the Black nationalist group Nation of Islam (NOI). He preached financial independence for Black Americans, racial separation rather than integration, and a strict code of moral behavior. He mentored other key Muslim leaders, including Malcolm X and Louis Farrakhan.

Malcolm X was born Malcolm Little before eventually becoming a high-ranking official in the NOI movement. He was charismatic but received disapproval and condemnation for statements he made after the assassination of President Kennedy. After later taking a pilgrimage to Mecca that changed his understanding and connection with Islam, he returned with a renewed understanding of the faith that stressed civil rights, equality, and peace. He left the NOI and was assassinated shortly thereafter in 1965. Amid the civil rights movement and conversions of Muhammad Ali and Malcolm X, America experienced a rediscovery of Islam. The discrimination faced by African Americans has led many African American Muslims to report that their identification with Islam has played a powerful role in asserting within themselves a separate, positive, and integrated identity [3].

In fact, Islam is the fastest growing religion in the world. Some African Americans have found a connection to Islam that ties them to the heritage of West Africa. Others are connected to the absence of racism in Islamic theology. African Americans have faced the utmost adversity, racism, and struggle throughout our country's history. The impact of the NOI and the seeds sown by early Muslims made it possible for many people to access this faith and to find comfort in a message with which they can identify in their fight against racism, slavery, lynchings, segregation, and social injustice.

In the twenty-first century, most African Americans have left behind Islamic organizations focused on a message of black nationalism and become more connected with the faith in the more traditional, Sunni interpretations of the Qur'an, the Muslim holy book, and Sunnah or the traditions of Prophet Mohammad [10]. Current estimates are that American Muslims number between 3 and 6 million. They are concentrated mostly in urban areas of the East and West coasts, Midwest, and parts of the South, especially Texas and Florida [8]. According to research published in 2017 by the PEW Research Center, 20% of Muslims in America are Black. Of those approximately 90% were born in America [16].

Four-in-ten Muslim American adults are white

	White	Black	Asian	Hispanic	Other/mixed
	%	%	%	%	%
All U.S. Muslims	41	20	28	8	3=100
Foreign born	45	11	41	1	1
U.S. born	35	32	10	17	5
Second generation	52	7	22	17	2
Third generation+	23	51	2	18	7
U.S. general public	64	12	6	16	2

Note: Results repercentaged to exclude nonresponse. Figures may not add to 100% due to rounding. White, black, Asian and other races include only those who are not Hispanic; Hispanics are of any race.
Source: Survey conducted Jan. 23-May 2, 2017. U.S. general public data from U.S. Census Bureau's 2016 Current Population Survey Annual Social and Economic Supplement.
"U.S. Muslims Concerned About Their Place in Society, but Continue to Believe in the American Dream"

PEW RESEARCH CENTER

The September 11, 2001, terrorist attacks killed more than 3000 on US soil. All major Muslim organizations condemned the attack as abhorrent and in direct violation of Muslim teachings, but it nonetheless changed the public's perception of Muslims in this country. Since September 11, the spotlight has shone brightly on Muslims in America and abroad. Media coverage has fueled a combination of fear and curiosity for many with regard to the social and cultural behaviors of this population [9]. Despite increased attention, American Muslims continue to be misunderstood and misrepresented. The public most often identifies American Muslims as immigrants or refugees who have recently migrated from developing nations. However, many American Muslims refer to themselves as indigenous Muslims, a term generally used in Muslim communities to refer to individuals from African American, European, or Hispanic backgrounds who were born and raised as Americans [1]. Many American Muslims have subsequently experienced increased religious harassment and racial profiling in recent years.

Clinical Presentation

In the last 100 years, it has become more apparent how much Islamic theology has resonated with the African American experience. From standing up to oppression to the acceptance of one another as brothers and sisters in Islam, the themes identified

earlier as part of the African American experience are key teachings of Islam. Any historical moment from the shackles of slavery to the shift to a more inclusive movement may play a role in the clinical presentation of the impact of Islamophobia.

Clinicians must understand the cultural and religious backgrounds of their Muslim patients to provide them with optimal care and treatment [2]. Many Muslims face heightened stress following increased hate crimes, discrimination, and major changes in the political climate which has left them feeling "unwelcome and unwanted."

Some research indicates a higher incidence of schizophrenia among African Americans. Additionally, African Americans with schizophrenia are overrepresented in state psychiatric hospitals. Research also indicates that African Americans are underdiagnosed with mood disorders and overdiagnosed with schizophrenia. Moreover, Black Americans reported major depression at a similar rate to their White counterparts in the late 2000s, but they were more likely to rate their depression as severe and disabling. While the rates of disorders were not higher among minority groups, psychological symptoms were [14]. There is significant research that shows disparities in access to mental health care in minority groups [17]. While Hispanics and Blacks have a lower lifetime risk of psychiatric disorders than Whites, their participation in treatment and prognosis may be significantly reduced [14].

Disparities in mental health care for African Americans are evident. The severity of their illness is heightened, and their use of services is reduced. Blacks were only 50% as likely to receive psychiatric treatment than Whites for diseases of similar severity [5]. This indicates that African Americans are not getting the level of help they need compared to others.

Complicating matters is the fact that a subgroup of Americans, African Americans, is also Muslim. The double minority effect occurs when two devalued identities interact in a way that overcomes the independent effects of their individual identities [7]. Many in this group also face what is known as the stereotype threat when people in a minority group begin to believe or internalize negative ideas about their group. Together, these factors can lead to increased health disparities, negative outcomes, and harmful psychological effects. In reality, African American Muslims with mental illness are a triple minority.

Environmental and socioeconomic variations can also play a role in the presentation of a patient's complaints. It is important to appreciate that the patient's community of origin, whether urban, suburban, or rural, can affect the patient's explanation of illness. Other factors, including lack of parental education, employment, housing stability, and food security, also play a role.

Community

Identifying with and being an active part of a community can provide significant support to its members. For African American Muslims, however, it may be a challenge to determine the community in which they best fit. In 2017, nearly 60% of American Muslims were immigrants. More than half of them immigrated to the

3167 **UNWELCOME & UNWANTED: THE STRUGGLE OF AMERICAN MUSLIMS IN 2018**

Balkozar Seif Eldin Adam, M.D., Farha Zaman Abbasi, M.D., Rania Awaad, M.D., Fatten Elkomy, DNP, PMHNP-BC

ABSTRACT

Background: Muslims in America are currently under unprecedented stress. With the current political climate, a spike in hate crimes and the proposed travel ban on individuals from six predominately Muslim countries, they feel unwelcome and unwanted. Many have expressed a fear for their safety and an attack on their identity and faith. They have described feeling like the country they call home has rejected them. The tragic events in Charlottesville, VA in August 2017 only compounded feelings of alienation and increased the levels of toxic stress they are experiencing. The heightened stress puts them at risk for cognitive impairment and stress-related disease. An exposure to microaggressions – even by clinicians – can breed resentment and damage the professional relationship.

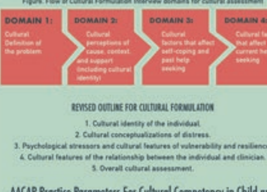
Method: The authors had worked closely with Muslim patients and thoroughly reviewed the literature.

Results: Continued terrorist attacks perpetrated by those who self-identify as Muslims and increased Islamophobia has left many Muslims patients in need of mental health care. The stigma of mental illness acts as a barrier that has kept many Muslim patients from obtaining that care. In addition, some Muslims are reticent to seek help if that treatment does not conform to their beliefs. Historically, a significant segment of the population has expressed a preference for faith healers who will not pathologize their illness and instead refer to scripture to address their suffering. However, such religious healers or Imams need the appropriate training to identify mental illnesses in their congregations and to be educated on how to collaborate with mental health providers. Muslims also struggle with microaggressions, covert forms of brief, common discriminatory acts that can be verbal, behavioral, visual or environmental. They can occur daily, whether intentional or unintentional, against a person or group, and based on religious, ethnic, or gender affiliations.

Findings: Significant research demonstrates that Muslims tend to be more reluctant to seek mental health treatment. To provide the best treatment and care, clinicians need to understand the cultural and religious backgrounds of Muslims. Many Muslims are under increased stress following the major shift in the political climate. Many mental health providers have not been able to keep up with the rapidly changing developments.

Conclusion: Given the current situation of Muslims in America, it is imperative that, as clinicians, we are aware of the significant challenges faced by this subset of the population so we can better serve the Muslim patients.

Figure. Flow of Cultural Formulation Interview domains for cultural assessment



REVISED OUTLINE FOR CULTURAL FORMULATION

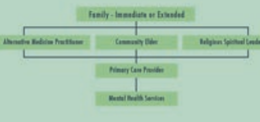
1. Cultural identity of the individual.
2. Cultural conceptualizations of distress.
3. Psychological stressors and cultural features of vulnerability and resilience.
4. Cultural features of the relationship between the individual and clinician.
5. Overall cultural assessment.

AACAP Practice Parameters For Cultural Competency in Child and Adolescent Psychiatry Practice

1. Identify & address barriers preventing diverse children & their families from getting mental health services.
2. Complete the evaluation in the language in which the child & family are proficient.
3. Understand the impact of dual-language competence on child's adaptation & functioning.
4. Be cognizant that cultural biases might interfere with clinical judgment & work on addressing.
5. Apply knowledge of cultural differences in developmental progression, idiomatic expressions of distress, & symptomatic presentation to the clinical formulation & diagnosis.
6. Assess for a history of immigration related loss or trauma & community trauma (violence, abuse) in the child & family & address these concerns in treatment.
7. Evaluate & address in treatment the acculturation level & presence of acculturation stress & inter generational conflict in diverse children & families.
8. Make special efforts to include family members & key members of traditional family in assessment & treatment.
9. Evaluate & incorporate cultural strength in their treatment interventions.
10. Treat culturally diverse children & their families in familiar setting within their community.
11. Clinicians should support parents to develop appropriate behavioral management skills consonant with their cultural values & beliefs.
12. Preferentially use evidence-based psychological & pharmacological interventions specific for ethnic/racial population.
13. Identify ethno-pharmacological factors that may influence the child's response or experience of side effects.

Cultural identity is multi faceted, fragile, jagged with rough edges

THE SENSE OF ISOLATION, DISCRIMINATION AND ALIENATION CAN IMPACT SELF ESTEEM, IDENTITY, LONG TERM RELATIONSHIPS AND CAREERS
FARHA ABBASI M.D



Hierarchy of Help-Seeking

MICROAGGRESSIONS

Microaggressions are a covert form of brief, common discrimination acts that could be verbal, behavioral, visual, or environmental occurring daily whether intentional or unintentional against a person or group based on religious, ethnic, or gender affiliations.
Types of Microaggressions: microassult, microinsult, and micro-invalidation.

Forms of Microaggressions

Model of a Spiritual Wellness Center

Khalil Center (KC) is a community psychological and spiritual wellness center pioneering the application of Islamic spiritual healing to modern psychological practice.

KHALIL CENTER
HEALING • SPIRITUALITY • COMMUNITY

The Khalil Center

The Khalil Center is a spiritual wellness center pioneering the application of traditional Islamic spiritual healing methods to modern clinical psychology. With branches in the Chicago-land Area and San Francisco Bay Area, the Khalil Center (KC) offers individual, couples, adolescents, family and group therapy. The aim of KC is to offer a holistic integrative approach to counseling and therapy by emphasizing cultural and spiritual competence. This is also known as the bio-psycho-socio-spiritual approach in psychological practice. Psychotherapy or Counseling is a process of intervention that is rooted in the idea of the "talking cure". This process is guided by extensive research done on human behavior and empirically validated ways of intervening to alleviate psychological disarray. In Islamic terminology this is an attempt at understanding Allah's Sunnah (system and structure that Allah has created) and the practical application of Islam. The Qur'an instructs humankind to seek out and reflect on the signs and creation of Allah and to study them as a means of attaining nearness to Him. Islamically integrated therapy may utilize psychotherapy by means of assisting in the attainment of spiritual serenity.

Psychotherapy is the therapeutic attempt to revitalize the spiritual self by paving the way towards the exploration of the self via guided introspection. Coupled with this method is the inclusion of traditional Islamic healing practices that are part of the healing process. These may include references to Quranic verses or stories and statements from the lives of the Prophet of Islam and his companions. It must be noted that Islamically integrated psychotherapy is not coercive nor is it about preaching. Rather it is an attempt to help guide and extract from the individual their own potential to resolve their psychosocial and spiritual dilemmas. An essential part of the Islamic creed is the belief in the essence of goodness that lives within all human beings. The psychotherapeutic forum is an attempt to help realize and actualize that potential.

Stemming from the Islamic belief that an individual is an atom that is connected to the molecule of his/her community, part of Islamically integrated psychotherapy entails reconnecting individuals with strong social support systems and empowering them through healthy integration into environments that nurture the mind and spirit.

United States since 2000, according the Pew Research Center [16]. This history contrasts sharply with that of a population with centuries in this country.

Nearly 60% of American Muslims are converts, according to a 2007 PEW Research survey [15]. Muslims who convert to Islam vary in their religious and racial/ethnic backgrounds, pathways to conversion, as well as interpretation and practice of Islam. While conversion can have a significantly positive impact on the patient's life, the conversion process can include both distress and comfort. Converts may face challenges connecting to their new community and feeling part of it. There also may be a tug-of-war with their family, stemming from their concern for the convert's new way of life, including their new ideas or community. They themselves might pull away from that family out of a desire to assimilate into a religious community. They may alter their views on marriage or parenting. This may all contribute to a sense of isolation.

In addition, whatever issues Muslims struggled with before converting do not go away just because they converted. New religious or community norms may make those historical issues, whether they be substance abuse or mental illness, more difficult to address. Conversion to Islam is common among African Americans in prison. Young Muslim converts who still do not understand the religion have been involved in ISIS-related cases in the United States, according to the Center on National Security at Fordham University's School of Law.

Another challenge African American Muslims face is their relationship to the mosque. Like other places of worship, mosques can provide social support and community programs. Mosques are open to all, but some local mosques are ethnically focused as Arab or South Asian mosques. That puts those who do not fall into those groups at risk of feeling left out. In addition, African American Muslims may face stereotypes within the Muslim community resulting from prejudice based on cultural variations or related to immigration. Some members who have emigrated from another country may incorporate the negative stereotypes of increased incarceration and drug use.

There is a tendency to conflate the recently immigrated Muslim experience with that of refugees or Black Muslims, but each is unique. Trauma and struggle may be common themes, but the history of intergenerational trauma cannot go unaddressed. Clinicians can recognize the experiences and help patients reconcile them.

Identity formation in the context of competing cultural norms can be a distressing contributing factor to mental health and mood disorders. Black culture and norms can vary significantly from those of Muslims with Arab or South Asian roots. They may clash at times. During the acculturation process, the child and adolescent may try on practices from other cultures. This may be viewed as cultural appropriation and can be negatively perceived by individuals who identify with the struggle and have the lived experience of that cultural behavior.

Another form of variation in culture can be seen in the expressive nature of narratives. In Black culture, for example, there may be an expectation of weaving music into religious practices, an expression typically frowned upon by South Asian and Arab cultures. How much African American Muslims can practice their faith

with behaviors that feel authentic and supportive to them will vary depending on the level of support and acceptance they find in their families and their communities. Black Muslims may also experience frustration when they practice Islam with an intentional focus on equality and resistance to oppression, while others in the religion embrace an Islamic identity that is inherited and contains prescriptive norms.

Adolescents especially face intense pressure to find their authentic, self-constructed identity. Only one-third of Muslims under 30 pray five times a day, even though two-thirds under the age of 40 say religion is very important to them [16]. This dissonance between the tenets of the faith and actual practices can cause distress for patients uncertain about their life choices. Women in particular face a major decision in choosing whether to wear the hijab or headscarf. This personal decision has significant public implications [11].

Mental Health Services

Discrimination and racism are realities for the African American Muslim population. They live at the intersection of Islamophobia and anti-Black racism. That increases the implications of stigma. Research has shown that minorities are late to seek help for mental illness. The impact of trauma also has been associated with mental illness. There is a high rate of trauma, including racial, physical, emotional, and intergenerational trauma exposure in this population. Clinicians need to understand the value of the oppression, struggle, and sacrifices in this population from both a historical and a current perspective.

The need for mental health treatment often is identified by schools and other systems, not by parents, which may contribute to increased stigma and decreased awareness. Self-referrals are more among Caucasian patients. When medication is used, African Americans experience reduced response to serotonin reuptake inhibitors and more frequent extrapyramidal side effects with antipsychotics [13].

A small fraction of Muslims, including African Americans, may reject treatment that was not described in the Quran or Sunnah. Some Muslims, especially recent immigrants, may associate psychiatric symptoms with the effect of black magic or action of spiritual creatures known as jinn. At times, they may push to address psychological and psychiatric illnesses with prayer and other non-pharmacologic interventions. Counseling and therapy are less likely to be used.

In addition, this population spends less than the average length of time in the treatment process. This is compounded by the fact that there is a delay in seeking or accepting mental health services. This leads to systemic consequences such as an overrepresentation of African American in state-run psychiatric institutions and the criminal justice system. Efforts to address health disparities include wraparound services, though these services also are less likely to be utilized with this minority population. All of these factors taken together negatively impact the health outcomes of this high-risk population.

Case #1

Rahman is a 17-year-old African American Muslim teenager. His school counselor referred him to a clinic after noting that he was not eating or sleeping for days. His teachers noticed he stopped turning in his homework and was no longer participating in class. His clinician was a Muslim psychiatrist of South Asian descent. When asked about his symptoms, he reported feeling guilty about his strained relationships with his parents and friends. He said that he thought about ending it all. He was extremely depressed. Rahman lives with his mother and two sisters. His parents divorced 3 years ago, and his father recently remarried.

After being seen in the clinic, the psychiatrist started him on antidepressants (SSRIs). Both he and his mom noted improvement after he began the medication. However, his father who lives out of state was hesitant to participate in his treatment plan. He is not agreeable to the use of SSRIs. When asked about the medication, the father reported that he did not feel it was necessary and questioned the diagnosis. He indicated that the Prophet Mohammad was neither diagnosed with depression nor used medication to treat emotional distress. He wished for his son to follow the religious doctrine, pray five times a day, make supplication to God, and eat honey every morning.

A family meeting was held to ensure understanding and acceptance of the treatment plan. Family counseling was encouraged, but the family did not ultimately follow through with it. The father, while initially upset, decided to stop opposing the treatment and stopped being involved. Rahman and his mother continue to see improvement in his mood, behavior, and school performance.

Case #2

Kareem, a 22-year-old African American Muslim young man was seen at an outpatient clinic after his friends and family noticed he had been displaying bizarre behavior, talking to himself, staying up for days, talking very fast, and rearranging furniture in the middle of the night. He reported hearing and seeing things that weren't there for the past month and a half. In particular, he said he heard a male voice talking to him about sports and his plans for the day. He also reported having thoughts about the military, bombing Iraq, and being the lead singer in a rock band. Other times, he said he thought about killing himself by shooting himself with a gun.

The patient was referred from the clinic for acute inpatient psychiatric stabilization. His psychiatrist was a Caucasian-American. He was diagnosed with schizophrenia and was started on antipsychotic medications. A few months later, it was noted that his symptoms were more consistent with mania. He was then diagnosed with bipolar disorder type 1 with psychotic features. He is now being treated with medication for bipolar disorder and his symptoms are well managed.

Conclusions

African American Muslims are a unique population whose history, multi-minority status, and cultural norms require additional awareness in the clinical environment. They have multiple risk factors that impact their presentation, acceptance, and likelihood to maintain treatment. The richness of the Black experience and resiliency models mean they also have exceptional opportunities for successful treatment and mental well-being.

Clinicians can benefit from tools including the DSM-5 Cultural Formulation Interview to facilitate the assessment and to guard against misdiagnosis of the African American patient. The AACAP Practice Parameters for Cultural Competence in Child and Adolescent Psychiatric Practice may aid in comprehensively addressing the whole person.

Clinicians should look to identify and address barriers, including those that are cultural in nature, as increased awareness of implicit bias is critical and clinicians are challenged to reflect and assess their own biases to decrease their own stereotypes and prejudices. This high-risk population is not homogeneous. Focusing on resilience and identity formation, norms, and community association as experienced by these patients can improve their outcomes. The opportunities to educate Muslims, especially African American Muslims, about the need for mental health interventions early on will help improve access to and use of effective treatment.

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23 Islamophobia and Ethical Challenges for LGBT Mental Healthcare

H. Steven Moffic

All religions have long grappled with variations from whatever is considered normal and appropriate in terms of sexual orientation, sexual behavior, and gender identity [1]. The Abrahamic religions, Judaism, Christianity, and Islam, have traditionally forbidden sodomy, teaching that such behavior is sinful. Currently, some of the more liberal denominations in Judaism and Christianity are more accepting of homosexuality. In the so-called Eastern religions, the traditional viewpoint has been more diverse. In the Hindu religion, there seem to be both acceptance and diverse opinions, whereas in Buddhism it seems that same-gender sexual relationships are not considered a religious matter. Those with gender identity variations seem to be viewed more positively across various religions, though there are variations here, too. We also now know that these sexual preference and gender identity categories are not strictly binary ones, but exist on some degree of continuum.

In the United States, LGBT (lesbian, gay, bisexual, transgender) is the main moniker connecting people with such sexual and gender diversity. Sometimes "queer" is added on to make it LGBTQ. There are marked similarities and differences between sexuality and gender. The most well-known basis of both is biological predisposition, but in modern society there can be sexual and gender experimentation for social reasons. For instance, in the United States, the turning of heretofore heterosexual men to homosexual behavior in male prisons is fairly common. Joining these identifications together in the LGBT moniker seems to have had political and social benefits. People with gender identity variations can be heterosexual or homosexual, both before any gender physical transition or after.

In psychiatry, once upon a time, homosexuality (The L, G, part of B, and Q if used) was a diagnosable disorder, but no longer. Along with this change within psychiatry has come a societal lessening of homophobia and the legal acceptance of same-sex marriage.

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Transgender seems to be following a similar path, both diagnostically and in terms of social acceptance in the United States. Here is a timeline summarizing of the history of LGBT in our DSMs (Diagnostic and Statistical Manuals), as prepared for the American Psychiatric Association (APA) by Robert Paul Cabaj, M.D., as one of an APA series on working with various minority groups:

- DSM-I (1952)
- Homosexuality is listed as a sociopathic personality disturbance.
- DSM-II (1968)
- Homosexuality continues to be listed as a mental disorder.
- DSM-II (1974)
- Homosexuality is no longer listed as a disorder, but replaced with the category of "Sexual orientation disturbance."
- DSM-III (1980)
- "Sexual orientation disturbance" is replaced with ego-dystonic homosexuality. In addition, gender identity disorder is added as a category.
- DSM-III-R (1987)
- Ego-dystonic homosexuality is removed and replaced by "sexual disorder not otherwise specified," which can include "persistent and marked distress about one's sexual orientation."
- DSM-V
- Includes a separate, nonmental disorder diagnosis of gender dysphoria to describe people who experience significant distress with the gender they were assigned to at birth.

In addition, the ICD 10 (International Classification of Diseases) removed homosexuality per se in 1990.

While these aspects of identity have become better accepted in American society, being identified as Muslim has worsened since September 11, 2001. It seems that to some extent Islamophobia has been replacing homophobia as a prominent example of xenophobia, the fear or hate of people from different cultures. Microtraumas from Islamophobia can occur daily, with occasionally major trauma. Being devalued can also cause some internal Islamophobia, as it did with homophobia and other examples of xenophobia.

Having a mental disorder includes its own stigmatization. Even working in that field can be stigmatizing.

Each aspect of these sexual, gender, and religious identities seems to carry with it an increased risk of mental disorder [2]. LGBT people have elevated rates of mood and anxiety disorders, alcohol misuse, and suicidality, particularly in LGBT youth [3, 4]. Within the LGBT community, bisexual and transgender persons have greater mental health vulnerabilities [5]. The mental health vulnerability in transgender persons usually decreases with transition, whereas bisexual individuals often experience stigmatization by lesbians and gay men who regard bisexuality as a noncommittal identity.

The American Muslim Health Professionals (AMHP) identified mental health literacy as the number one area of public health concern for Muslims in America. The increased micro- and macrotraumas experienced by Muslims may contribute to a possible increase in stress-related disorders, including PTSD. However, many Muslims are unable to recognize psychiatric symptoms. Moreover, mental illness itself may often be stigmatized in Muslims, so that symptoms reflective of mental distress end up being somatized as physical problems and help sought in general medical settings before psychiatric ones [6]. In addition, many Muslims with mental and/or behavioral disturbances attribute their experiences to supernatural causes such as jinn possession or "the evil eye." The explanatory models that Muslims with mental health problems formulate can influence why they approach a faith healer as opposed to a mental health professional, and this can deprive them of the benefits of early intervention and render them vulnerable to abuse and exploitation by self-proclaimed Iraqi (Islamic faith healers). For some, these aspects of identity can also come into internal conflict. Believing in any religion which does not value the LGBT can drive the individual to have to try to choose one or the other. If these identities are synergistic in terms of mental health risks, the prevalence of mental disorders could be hypothesized to be extraordinary – and unnecessarily – high.

Treatment is just as challenging. Unfortunately, there seems to be virtually no literature available about how to effectively treat such individuals, especially when an identity as a Muslim is at stake. The best we may be able to do right now is to examine each category separately and then try to put what we know about each together for those who have all these aspects of identity. As may be apparent, increasing social inclusion and decreased stigma may reduce the incidence of mental illness in these individuals and thereby reduce some of the need for treatment in the first place.

Homosexuality

As noted, historically there has been an evolution of how psychiatry has responded to homosexuality and homophobia. By the 1980s, it no longer was viewed as some sort of dangerous sociopathy but as one of the social "minority" groups which received inadequate and inappropriate mental healthcare [7, 8]. Removing the diagnosis completely from DSM in 1987 correlated with changes in psychiatry and society [9]. In psychiatry, any support for conversion therapy has dissipated, replaced with a focus on the health and mental health needs of patients who are homosexual. The societal changes in many countries include the repeal of sodomy laws, serving openly in the military, marriage equality, adoption rights, and serving as clergy in increasing number of religious denominations.

Like Americans overall, Muslims in the United States now seem more accepting of homosexuality, this despite scholars in the Islamic sciences opposed to it. A recent Pew Research Center poll (July 25, 2017) found that 52% of US Muslims say that homosexuality should be accepted by society. This percentage has increased

from 27% in 2007 to 39% in 2011. The current degree of Muslim acceptance is much higher than that of white Evangelical Protestants. On the other hand, it is not at all clear from such a survey that Muslim acceptance of homosexuality in general also means acceptance of homosexuality, especially homosexual-related sexual behavior, within the Islam religion itself. That there is an Islamic view that one who is homosexual cannot by scripture be Muslim is why Muslim was left omitted from the title of this chapter.

Though homophobia seems lessened in the United States, recent research suggests that the argument that sexual orientation is innate may not be enough to promote more positive attitudes toward lesbian, gay, and bisexual people [10]. What also may be crucial is what else those with negative attitudes believe is relevant to that orientation, including what it means religiously.

Transgenderism

From one perspective, social inclusion seems to be improving for those with gender variations. Seventeen openly transgender individuals won state and local elections in the November 2017 elections. However, violence toward those thought to be transgender is still rising. The Human Rights Commission claims that at least 25 were killed in the United States up to this election time. Though there is usually psychological improvement after whatever degree of transition occurs, often high rates of suicidality can still occur [11]. In Milwaukee, where I was medical director of a clinic (Pathways) that specialized in sexual and gender problems, we encountered reports of discrimination when the gender variation was known. The local Cream City Foundation and Marquette University Center for Gender and Sexuality studies substantiated that by reporting that 27% of trans people reported being denied healthcare, with another 70% reporting healthcare discrimination [12].

What seems to help their mental health is positive community attitudes, societal acceptance, and post-transition attractiveness. Historically, in some societies, like many Native American tribes, those with gender identity variations are viewed as having special powers of perception and understanding. Currently, mental health clinicians still have an important role in the prevention, assessment, and treatment of any gender dysphoria in transgender individuals.

There can be different religious opinion regarding sexual orientation and gender identity variation. Sometimes, gender identity variations can be viewed more positively. Currently, that is the case in Iran, where gender transition is accepted and accepted to the extent that those who are identified as homosexual can be forced into hormonal treatment and then gender reassignment surgery [13, 14]. That sort of change will result in acceptable heterosexual sexual behavior in Iran.

Ethical Conundrums

Some clinicians will inevitably have adverse personal religious beliefs regarding LGBT people and patients. That is, such clinicians may view LGBT-related sexual behavior as sinful. With that point of view, they may not want to provide care to LGBT people, even for medical problems, since that might seem like a tacit endorsement of their relationships and sex life.

One old example, relevant for both the clinician and the healthcare system, is whether to prescribe birth control pills if you do not believe in abortion. This is more than a personal countertransference challenge, that is, it may not be a personal conflictual issue of the clinician. If it is, and the clinician recalls struggles with it in their personal history, then the help of colleagues or personal psychiatric care may be indicated.

The legal grounds for such decisions seem to be changing in the United States [15]. Some states, like Mississippi, are passing laws that allow clinicians to opt out of any patient care if doing so would compromise their conscience.

Medical and psychiatric ethics go beyond the law. In fact, we in the United States are ethically supported in helping to go beyond the law in Section 3 in the Principles of Medical Ethics [16]:

> A physician shall respect the law and also recognize a responsibility to seek changes in those requirements which are contrary to the best interests of the patient.

From a specific ethical point of view, if you are a member of the American Psychiatric Association (APA), your primary ethical principle is in the Preamble:

> As a member of the profession, a physician must recognize responsibility to patients first and foremost …

If not followed, our ethical responsibility to colleagues would include us reporting such refusal. Yet that principle may seem contradicted by Section 6:

> A physician shall, in the provision of appropriate patient care, except in emergencies, be free to choose whom to serve, with whom to associate, and the environment in which to provide medical care.

How can we all resolve this apparent ethical conundrum with LGBT patients who, in terms of this book, identify as being Muslim and clinicians who feel their behavior is unacceptable from their own religious beliefs? In writing about LGBT Jewish or Christian patients, the same conundrum might occur for psychiatrists who have religious beliefs on the fundamentalist extreme. Atheists or agnostics can also have to grapple with how they react to the importance of religion in the lives of their patients.

Taking all that into consideration, here are some possible pathways for an ethical way:

1. Be up front in any advertisement of your services with whom you would not prefer to treat and/or who you do treat.

   This information comes alive in many situations, including whether to see patients with certain known risks, whether suicidal or homicidal, or needing treatments you do not provide, or even patients for which reimbursement seems inadequate. This principle can include conveying up front what patient personal characteristics the clinical would not treat if known.
2. Alternatively, there are psychiatrists and systems that spell out their preferred patients or groups for which they feel that have expertise.

   That can include "Christian psychiatrists" or Bible-oriented therapy.
3. Even if the first two pathways are followed up front, a patient may reveal a personal belief that counters that of a clinician during the treatment phase.

   The decision, then, is if there is already a possible therapeutic alliance, to proceed ahead or make a careful and compassionate referral to another colleague.
4. No matter our personal beliefs, we should never advocate for a treatment that is known not to work or be harmful, such as conversion therapy for someone with a firm homosexual orientation.

   That would be unethical and grounds for a malpractice suit. Of course, the patient could disregard such treatment guidelines and still pursue whatever they desire.

It is clearer how to follow each of our individual psychiatric ethical principles. What is much more difficult is to decide what to do when these principles come into conflict, as seems possible with LGBT patients in general, as well as with LBGT patients who connect with being Muslim in particular.

Treatment Challenges

Given that our particular population of LGBT who identify with Islam in one way or another have not received much attention in the psychiatric literature, what guidelines can we use to help until more research is done? Here are some resources that refer to the overall struggle of general religious identity in people and their sexual orientation.

Many faithful Muslims (as well as conservative Christians and Jews) who are attracted to members of the same sex experience conflict between their sexual orientation and their religious commitments – conflict which can be disturbing to the point of seriously increasing risk for suicide. While some individuals try to resolve the tension by denying or repressing their sexual feelings or by rejecting their faith, others struggle to reconcile these core aspects of their identity and may come to a secular or a religious therapist for help. How can a therapist best help such patients?

The American Psychiatric Association has declared reparative therapies to be unethical because they are generally ineffective and often harmful, but the American

Psychological Association's Task Force on Appropriate Therapeutic Responses to Sexual Orientation (https://www.apa.org/pi/lgbt/resources/therapeutic-response.pdf) has gone further to provide some guidance by citing the sexual identity therapy framework developed by Warren Throckmorton and Mark A. Yarhouse (https://sit-framework.com/wp-content/uploads/2009/07/sexualidentitytherapyframeworkfinal.pdf) to reduce sexual and religious identity conflicts in ways that preserve patient autonomy and professional commitment to diversity. The four stages of sexual identity therapy are assessment, advanced informed consent, psychotherapy, and sexual identity synthesis. In this process the role of the therapists is not to encourage a particular outcome but to help him or her explore available options and their consequences. Referral may be indicated for reasons of therapeutic capability and/or value conflicts between the therapist and the patient. Obviously, the more familiar the therapist is with the patient's faith tradition, including the range of theological interpretations and supports available to same sex attracted individuals within that tradition, the more help that therapist should be to the patient in finding a resolution with which he or she can live with integrity - that is, unless the therapist has personal countertransference problems that interfere with using that knowledge.

A growing number of resources for LGBT individuals who report connecting with Islam are now available online (https://en.wikipedia.org/wiki/LGBT_movements_within_Islam) for the many who struggle with the double stigmas of Islamophobia and homophobia.

If we then take into account what is in common in the specific treatment recommendations for these intersecting identities, we can come up with these general treatment recommendations which can suffice for now:

1. Clinician Education

   Generally speaking, cultural competence for clinicians would be an overall requirement for adequately caring for people who identify as LGBT and Muslims. In this book, the chapter by Neil Aggarel, M.D., Clinical Assessment Tools for the Culturally Competent Treatment of Muslims, provides reliable tools to do so. They can help the clinician find out about how the patient culturally defines the present problem, how the patient has tried to cope, and treatment expectations. They should not be used by rote, but with appropriate curiosity and respect.

   Although those with an LGBT identity can be considered to also belong to a cultural group, the difference may lie in the biological base of that identity, rather than learning the values of one's ethnic cultural group, although there may be overlap between the two processes. If unfamiliar with LGBT patients, studying case examples can be useful [17].
2. Informed Consent

   Informed consent about treatment is always important and ethically required, but perhaps it is even more important with patients who have likely been discriminated against, thereby reducing their trust, even with the healthcare system. Moreover, some treatments may be quite controversial and even harmful, such as

conversion therapy for homosexuality. Objective information about treatment options and their success rate and side effects is critical.

3. Inclusion

   In conducting any evaluation, the ethnic and religious identity of the patient needs to be included, whether on a written form or during the live interview [18]. That conveys interest in that aspect of the patient. However, any follow-up questioning about that should be prefaced with an explanation about why the information should be needed. Do not assume anyone is heterosexual just because they do not say otherwise. In regards to language, if someone identifies in the LGBT category, especially the T (transgender), use the name, pronoun, and terms preferred by the patient. Even in public situations, the terminology is changing. Following a step taken by the London Underground subway, the New York City subway is switching to gender-neutral terminology, replacing “ladies and gentlemen” with “passengers,” “riders,” and “everyone.” Paperwork should properly distinguish between sexual orientation and gender identity, as well as the patient’s way of identifying themselves ethnically.

4. Treatment or Referral

   Whereas the ethical ideal is that any clinical should be able to help treat a patient of any background, our own values and countertransference may preclude that. For instance, despite my presumed expertise in cultural psychiatry, I, as a Jew, may not be able to objectively treat a patient who embraces Nazi values. If we have to decline, we need to apologize to the patient and make sure a referral is made to a clinician with the appropriate skills and values.

A Clinician Model

There is a clinical psychologist who provides an example of how to successfully overcome this combination of obstacles [19]. Here is how he describes setting up a practice that serves LGBT who have some identity with being Muslim.

The interviewer introduces Ben Herzig, PsyD, who practices in the Boston area. As regards to his own faith, he replies: “I don’t want to get into my own faith because it’s personal and I have patients of many different backgrounds.”

He points out the crucial importance of reaching out to the Muslim community, given the reluctance of many to come for mental healthcare. So, he established a pro bono (free) clinic with one of the local Islamic Centers. He had contacted an imam of a mosque who was seeing psychological problems that he felt unequipped to handle. He then triaged such congregants to this psychologist. Now, over many years, the clinician has a caseload of about 30% Muslim.

In considering Islamophobia in his patients, he assesses how they handle it, whether finding a positive outlet or getting aggressive. Often, just processing the fears helps, as well as such problem-solving approaches as to think about what the patient can do when experiencing Islamophobia. This clinician does not push a religious coping strategy, but will work with that if the patient feels it is important.

Naturally and inevitably, with such a welcoming attitude, it turned out that many of his Muslim patients identified as LGBT, though often they had not come out yet.

Once trust is established, the LGBT identity can be processed for its connection to the psychological problem, just like the Muslim identity would be.

He points out that American Muslims can fall into many other identity categories, including African-Americans and Hispanic Muslims, as well as LGBT who identify with Islam. Half may be female. All these categories have been targeted politically and, hence, the felt negativity will be increased.

Clinicians working with the LGBT who identity with Islam should also be familiar with local support groups that would accept such an individual. Loneliness and isolation is common, so finding an accepting social group can be therapeutic in itself. In a personal communication on whether he knew of any research or treatment guidelines for this group, he answered:

> Thanks for your message. I'm not familiar with any specific research on LGBT Muslims and mental health, although there are some online communities, support groups, etc. I've treated patients within that group but I wouldn't say I have guidelines for doing so.

Conclusions

There are multiple obstacles that seem to prevent LGBT people who also connect in some way to the Muslim community from readily receiving competent psychiatric care. These include the legacy of the history of psychiatry in pathologizing LGBT identity, increasing Islamophobia, and very limited numbers of similarly matched clinicians. The LGBT who identify as Muslim can experience being unwelcome in the LGBT mainstream due to Islamophobia and being unwelcome in the Muslim community due to the Islamic beliefs about homosexuality. That can also lead to an individual feeling that they need to choose one of the other of those identities. If the stigma of presumed mental illness is added, then the potential patient may fell triply stigmatized. To complicate matters further, the microtrauma and major traumas this subgroup experiences in society seem to correlate with an increased prevalence of various psychiatric disorders.

Psychiatric literature, including case reports, on this subgroup is minuscule. That lack in turn leads to inadequate education of those in training and continuing education for those in practice.

When needing psychiatric care, individuals experiencing that social rejection can show initial mistrust in medical systems. That mistrust needs to be countered with an outreach of welcome, supplemented with culturally competent caregivers on-site or via referral.

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Islamophobia and the Mental Health of Rohingya Refugees

24

Salman Majeed

Background

The Rohingya, described as the most persecuted minority [19] in the world, are a predominantly Muslim minority in a Buddhist majority country Myanmar, previously known as Burma. Rohingya have coexisted with the Rakhine minority (who follow Buddhism like the Burmese majority) in Arakan State for centuries. In the eighth and ninth centuries, as Arab merchants traveled to China and India, most Rohingya converted to Islam [2]. In a historically complex and turbulent Southeast Asia, Arakan mostly remained an independent kingdom, but in 1784, Burma conquered Arakan. Forty years later, British took control of the Arakan state and later the rest of Burma. Colonial rule ended in 1948 with Arakan remaining part of Independent Burma. In 1989, the government changed the name of the country from Burma to Myanmar and the name of the Arakan State to Rakhine State (Fig. 24.1).

Myanmar government does not accept the use of term Rohingya, which violates the minority's right to self-identify based on their ethnicity, culture, and language. There is clear historical evidence of the use of the term from pre-colonial era. In 1799, a Scottish physician, Francis Buchanan, documented that among the native groups of Arakan are the "Mohammedans, who have long settled in Arakan, and who call themselves Rooinga, or natives of Arakan" [5]. The Classical Journal of 1811 identified "Rooinga" as one of the languages spoken in Burma. Also, a British survey by Charles Paton shortly after the British conquest of Arakan indicates that about one-third of Arakan's 100,000 population was Muslim, and among them, he notes the most substantial community was in the north – the Rohingyas [33].

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Fig. 24.1 Bay of Bengal. (Credit Norman Einstein, Wikimedia Commons)

History of Conflict

Pre-colonial and Colonial Period

In 1784, Burma's conquest of Arakan was marked by extreme violence [18]. Thousands of people were killed violently and more than 30,000 Arakanese, mostly Rohingya, escaped to Bengal under British rule to save their lives. Forty years later, as the British took over Arakan, Rohingya felt a sense of relief from Burmese violence. During the colonial era, as the British ruled the whole Indian subcontinent, there was no longer any international boundary between the regions. Thirty thousand Rohingya refugees returned to their homes.

During the colonial era, despite their ethnic differences, Muslim Rohingya and Buddhist Rakhine minorities coexisted peacefully. Violent regional conflicts started in World War II. When Japan invaded British-controlled Burma in 1942, the Rakhine along with the Burmese army aligned with the Japanese, while the Rohingya supported the British. When British forces retreated for several months, the Japanese

Army and Rakhine committed Arakan's massacre of 1942, in which they tortured, raped, and killed thousands of Rohingya [18]. Over 22,000 Rohingya fled to Bengal in British India. The British used the displaced Rohingya to fight for them and in turn promised independence for Northern Arakan [23, 39].

Post-colonial Period

Burma gained independence from the British in 1948, with the Arakan state included in its territory. Rohingya became a vulnerable minority in a Buddhist majority country. Despite their loyalty and sacrifices, the British abandoned the Rohingya to the mercy of very people they had fought against – the 90% Burmese Buddhist majority and Rakhine Buddhist minority. At the time of independence, several ethnic minorities including Rohingya asked for their separation, which was handled by the military.

After independence, Rohingya were denied citizenship but ironically were recognized as an indigenous ethnic nationality. Rohingya were eligible to get National Registration cards. The state issued them a statement of citizenship, assuring them that they did not have to apply for citizenship as one of the indigenous races of the Union of Burma [16]. Rohingya were barred from military service, and those in the civil service and police were replaced by the Burmese government and military officials [18]. They were able to participate in elections and politics and were able to elect a very few representatives in Burmese Parliament.

In 1962, the military took over the country after a coup. The military junta slowly created systemic discrimination against Rohingya, labeling them foreign Bengalis (from Bangladesh) and depriving them of their rights. In 1974, through an immigration act and constitutional changes, the military excluded Rohingya from citizenship.

Their ethnic rivals the Rakhine allied with the military in hating the Rohingya. By 1977, state violence escalated significantly toward the Rohingya as "Operation Dragon King" was launched to identify foreigners. Army and Rakhine forces used this as a license to attack Rohingya. These events led to the first significant exodus in 1978 when 200,000 Rohingya sought refuge in Bangladesh to save their lives. After bilateral agreements, the majority of them were forcibly repatriated back to Burma [12].

Statelessness

In 1982, the military implemented a new citizenship law which recognized 135 "national races" as citizens. Rohingya were not on the list. To gain citizenship, they had to prove the impossible condition that their ancestors settled in the area before 1823 – the year of British invasion in Arakan. This systematic discrimination violated the Universal Declaration of Human Rights by taking the Rohingya's right to citizenship. Undoubtedly, statelessness without legal protection made them vulnerable to all kinds of atrocities and crimes [24].

After the 1988 pro-democracy uprising, the military held elections in 1990 but later refused to transfer power to democratically elected representatives. The military jailed Rohingya leaders, banned their political party, and intensified their persecution.

Military and various militias used forced labor from Rohingya men, women, and children and on non-compliance tortured them with physical punishment, rape, and even murder [4]. They were also forced to construct villages for non-Rohingya on land acquired from Rohingya [34]. The military declared that land belongs to the state, so they confiscated Rohingya people's houses and farms and did not allow to take their valuables such as animals with them. The military also destroyed Mosques, banned religious activities, and harassed Muslim leaders [12].

Through the next operation, openly named "Operation Clean and Beautiful Nation," the state started another wave of ethnic cleansing. From 1991 to 1992, 260,000 Rohingya fled to Bangladesh refugee camps in the second major exodus. Without giving them citizen status, the Government of Myanmar signed a memorandum of understanding with Bangladesh in April 1992 to start repatriation. Terrified refugees did not want to return, but they did not have an option to stay in Bangladesh or go elsewhere either. The vast majority of vulnerable Rohingya returned to Myanmar by December 1995 where they had no home, income, or legal protection.

The state confined Rohingya to their villages in an open prison setup [24]. They were restricted strictly to Northern Rakhine; even visiting neighboring villages required these impoverished people to apply for and buy travel passes. This restriction of movement limited their ability to move to escape persecution or access markets and employment opportunities. Healthcare facilities and higher education options also became inaccessible. Those who overstayed their travel pass time limits could not go back to their villages, as authorities deleted their names from the family lists. They were forced to leave the country and then denied the right to return [24].

In 1994, the government stopped issuing birth certificates to Rohingya newborns. In 1995, on UNHCR's efforts to document the Rohingya, authorities issued them Temporary Registration Card (TRC). To prevent its future use as evidence for citizenship, TRC does not mention the place of birth. By these maneuvers, the government extended the cycle of statelessness to the next generations.

The state has systematically blocked the doors of education to Rohingya children as well. Over the decades, this has caused the Rohingya illiteracy rate to reach about 80%. Those few who completed early education were prevented from pursuing higher education, thus denying chances for success for them and their community.

The military allowed a weak and controlled democratic transition through 2012 elections. Political parties used hate against the Rohingya minority as a political tool to win majority votes. Even those who viewed Rohingya as fellow humans remained silent so as not to alienate influential Buddhist Nationalists who openly campaigned against any moderate political candidate [16]. Extremist Buddhist nationalist movements like 969 or MaBaTha worked actively to shift Buddhist attitudes toward Muslims and provoke violence through hate speech [21].

Under international pressure, the government loosened restrictions on media in 2012. Buddhist extremists, who had been using paper pamphlets, started using the platform of social media to spread hate and propaganda. UN investigators concluded that Facebook, as the primary social medium in Myanmar,

played a determining role in stirring up anti-Muslim hate. Extremists planted videos, stories, and news to portray the already isolated Rohingya as violent monsters [37].

In 2012, Rohingya and then Muslims in other parts of Myanmar faced organized massacres by Buddhist mobs with police complicity [17]. These massacres resulted in 138,000 internally displaced Rohingya in refugee camps which have been described as concentration or detention camps [23]. These camps, monitored by police, selectively restricted Rohingya people's movement and travel [26]. While the state did not pay for Rohingya education or nation building, they allocated security resources to monitor their every move.

To control the narrative, the government strictly controlled the local media and restricted access for international media. Rakhine Buddhists also controlled international humanitarian aid to Rohingya, which resulted in worsening malnutrition and healthcare [27] (Fig. 24.2).

To escape this suffocating land with no home and hope, thousands of Rohingya have attempted to flee to neighboring countries by boat over the years and came to be known in the media as boat people. In 2015, UNHCR estimated that between January 2012 and June 2015, 170,000 people fled by sea from the Myanmar/Bangladesh border. Those who survived the risks of the sea faced extortion, human trafficking, or death in neighboring Thailand, Indonesia, and Malaysia. Their plight received international attention in 2015 when thousands of them were being passed in a game of ping-pong among Thailand, Indonesia, and Malaysia.

Fig. 24.2 Displaced Rohingya mother and child. (Credit: Tasnim News Agency, Seyyed M Hosseini/Wikimedia Commons)

In October 2016, a small previously unknown Rohingya militant group, Arakan Rohingya Salvation Army ARSA, coordinated attacks on police checkpoints and killed nine police officers. ARSA had no known connection with international terrorist organizations and was noted to be comprised of dozens of young adults and adolescents with machetes and swords. Following the attacks, the Myanmar military began a significant crackdown with extensive human rights violations including extrajudicial murders, rapes, arsons, and other brutalities.

During the summer of 2017, the military started preparations for clearance operations, arming and training Rakhine Buddhists. At the beginning of August, the military also brought in a battalion of reinforcements to Northern Rakhine. On August 25, ARSA coordinated multiple attacks on security posts leading to the deaths of 12 government officers and 50 rebels. Immediately afterward, the military together with mobs of Rakhine Buddhists started their well-planned "clearance operations." After detailed surveys of survivors, the organization Doctors Without Borders/Medicines Sans Frontiers (MSF) assessed that at least 6700 Rohingya including at least 1000 children were killed within the 1st month after the August 25th attacks. According to MSF calculation, about 69% were killed by firearms, 9% were burnt to death (including 15% of children killed), and 5% were beaten to death [11]. In addition to mass killings, rape and arson were used to force the displacement of 700,000 Rohingya to Bangladesh in 2017 [10]. This has swelled their total number in Bangladesh refugee camps to 1.3 million, half of them children.

Over the years, Rohingya have also settled in other countries, as shown in Table 24.1.

About 14,000 Rohingya have settled in the United States, primarily in Chicago, Illinois, and Milwaukee, Wisconsin [15]. For most, this is the first time that they have felt safe from threats to their lives. For school-age children, this is their first time entering school. For newborns, this is the first time that someone in their "stateless families" has been born with an identity and citizenship. As immigrants, they can

Table 24.1 Estimated Rohingya distribution in different countries – May 2018

Country	Number
Bangladesh	1,300,000 – Mar 2018
Saudi Arabia	500,000 – Oct 2017
Myanmar	400,000 – Nov 2017
Pakistan	350,000 – Oct 2017
Malaysia	150,000 – Oct 2017
UAE	50,000 – Dec 2017
India	40,000 – Sep 2017
United States	14, 000 – May 2018
Thailand	5000 (Oct 2017)
Indonesia	1000 (Oct 2017)
Japan	250 (Jan 2018)
Nepal	200 (Sep 2017)
Canada	200 (Sep 2017)
Ireland	104 (Dec 2017)
Sri Lanka	36 (Jun 2017)

travel to other cities, towns, and states without the fear of getting arrested. Rohingya are also adjusting to the new daily stressors in a new country. Many of them still do not know English. With the language barrier and no prior work experience, many adults are still looking for employment. A few of them work as interpreters for refugee resettlement agencies, and some find other low paying jobs at the airport or in a chicken factory. A few of the previously settled Burmese population express their dislike and hatred toward Rohingya in the new country as well [7]. Nevertheless, Rohingya have been exhibiting significant resilience and have developed their community. In Chicago, they have built a Rohingya cultural center which helps these refugees to better assimilate into the new culture [22]. They have been able to start sharing their stories, grieve, and heal [31]. The director of Rohingya Cultural Center, Nasir Zakaria, expressed that they feel safe here but worry extensively about their families and hundreds of thousands of Rohingya still trapped in Myanmar and refugee camps.

Mental Health Challenges

There is a dearth of research into the mental health challenges faced by Rohingya. Trauma exposure in Rohingya population is severe, collective, and protracted. Trauma has accumulated not only through the lifespan but the generations. For the overwhelming majority, various forms of trauma include, but are not limited to, direct experience of physical and/or sexual violence, living under the threat of violence, witnessed or unwitnessed loss of loved ones, loss of property, limited access to food and financial opportunities, denial of access to healthcare, denial of legal protection, restriction of movement, displacement, and forced migration [35]. Most Rohingya remain uncertain of their future and fear more atrocities as stateless people [30].

Lindert and Priebe systematically reviewed papers from 1945 to 2005 to explore the health outcomes of genocide and transgenerational trauma and concluded that man-made disasters like genocide have a long-lasting impact on mental health far greater than other health emergencies [25].

Lack of a consensual construct or framework in conceptualizing the impact of genocidal trauma on the mental health of persecuted group hinders clinical and research work. Our current diagnostic manuals, the Diagnostic and Statistical Manual of Mental Disorders, DSM-5, and the International Classification of Disease, ICD-10, are designed for individual assessment, while large-scale atrocities exert an impact on whole communities and their next generations. The legal framework of crimes against humanity classifies various atrocities from a legal standpoint, but not its impact on the mental health of victim communities or their descendants.

Through a literature search for a framework for conceptualizing the mental health impact of atrocities on Rohingya, we find most helpful the construct of transgenerational trauma given by Evans-Campbell [6]. We will use her model to review the impact of such protracted trauma at individual, family, and community levels and, in the absence of much research on the Rohingya, consider how similar atrocities have impacted other similar groups.

Individual Level

Rohingya refugees have high rates of PTSD, clinical depression, and anxiety. From the perspective of Maslow's hierarchy of needs, Rohingya people are struggling to survive and meet their basic physiological needs. In a small cross-sectional study of 148 Rohingya adults residing in the refugee camps of Kutupalong and Nayapara, 36% endorsed PTSD symptoms and 89% met criteria for depression [35]. Daily environmental stressors appeared to partially mediate the development of PTSD [35]. Daily environmental stressors in post-emergency status include ongoing concerns of survival needs like water, food, and the shelter difficulties of living in overcrowded camps [29].

In the above cross-sectional study of 148 Rohingya, somatic symptoms are frequently endorsed, including headache (67%); back pain (55%); burning sensations in the head, stomach, or all over the body (50%); pain all over the body (49%); and gastrointestinal problems (digestive, chronic constipation; 49%) [35]. Elevated somatic complaints have also been noted in other survivors of genocide in the immediate aftermath of events such as Holocaust [36]. Ten percent of Rohingya in this sample also reported feeling or believing that they were under a spell or possessed by a bad spirit or demon [35].

Brave Heart and colleagues [13, 14] through their work with the American Indian Lakota population described a "historical trauma response" in survivors and their descendants which includes rumination over past events and lost ancestors, survivor guilt, unresolved mourning, feeling numb in response to traumatic events, anger depression, intrusive dreams and thoughts, and fantasies about saving lost ancestors. Holocaust survivors in concentration camps experienced similar symptoms, described as the survivor syndrome, concentration camp or KZ syndrome, or asthenia progressiva gravis. In KZ syndrome, Ryn [36] differentiates the characteristic phases: (1) psychosomatic inanition, marked by extreme exhaustion and lack of motivation; (2) latency of disease; (3) personality and adaptation disturbances – signified by adjustment difficulties in marriage, family, work, and social environment; (4) a pseudoneurotic and depressive phase; (5) premature aging; and (6) organic phase.

Also studying post-concentration camp adjustment, Orwid [32] distinguishes three groups of disorders: (1) severe social functioning impairment, marked by complaints about physical weakness, fatigability, apathy, and unwillingness to initiate contact with others; (2) role fulfillment disorder, marked by excessive social activity trying to overcompensate; and (3) adjustment disorder, marked by numerous subjective difficulties in dealing with social conventions and applicable norms, despite preserved social functioning. These symptoms persisted years after the concentration camps [32].

A 2015 review by the United Nations Human Commission for Refugees UNHCR from two sites, the Kutupalong and Nayapara refugee camps, found rates of epilepsy of 26.7% and 57.1%, respectively. For intellectual disability and medically unexplained somatic complaints, the only available date from the Nayapara site indicates respective rates of 14.3% and 9.5%. The reported prevalence of psychotic disorders in the Kutupalong camp was 43.3% [30].

Select stranded individuals, who have lost all hope of better future and loved ones, are also vulnerable to becoming a target for radicalization as extremist groups attempt to recruit them [30].

Family Level

The impact of trauma at the family level is not well-researched for genocidal trauma, and no research was found for Rohingya on the topic. Evans-Campbell's research [6] on genocide indicates that trauma affects the next generation through the significant impact of impaired family communication and stress around parenting. Bar-on et al. [3] identified two major themes in children of Holocaust survivors. First, children were noted to be preoccupied with their parent's trauma and tried hard to not cause them more pain, particularly by asking questions about their traumatic experience. Second, descendants noted pervasive and persistent guilt, trivializing their own stress, and feeling that they were not entitled to happiness [3].

Since Rohingya have been struggling to survive for generations, most probably did not experience healthy peacetime parenting and may feel stress around parenting.

Community Level

Evans-Campbell [6] indicates that community-level impact might be marked by the loss of traditional culture and values, high rates of alcoholism and physical illness, and internalized racism [6].

As noted, the majority of Rohingya did not have access to (particularly higher) education which impacted their whole community adversely. Some reports indicate that the Myanmar military selectively eliminated the articulate, educated, and outspoken people [20].

Born as stateless, the overwhelming majority of Rohingya are not recognized as citizens of Myanmar. We do not know how decades of negative propaganda, hate speech, and assaults on their identity have impacted them at a community level.

An experience of microaggression such as racial harassment for one member of the minority might trigger the recall of the events that might not be directly experienced by the individual – for example, "other people from my race have been treated unfairly for centuries." This collective recall could generate a hypersensitive reaction.

Concentration camp survivor literature indicates that survivors experience a sense of otherness and experience difficulty in trusting others who have not experienced the same atrocities.

Despite these difficulties, those who have been safely relocated to other countries have demonstrated extraordinary resilience. In the United States, Rohingya have adjusted well in Milwaukee, Wisconsin, and Chicago, Illinois.

Transmission of Trauma to the Next Generations

It has been demonstrated that trauma is transmitted to the subsequent generations. Here, we review the biopsychosocial mechanism of such transmission for large-scale atrocities.

Through their study of cytosine methylation within the gene encoding for FK506 binding protein 5 (FKBP5), Yahuda and colleagues (2016) revealed alterations in stress hormone (cortisone) expression carried over to the children of Holocaust survivors [40].

Vicariously, the story and narrative of parents become part of identity for the next generation.

Genocidal trauma and resulting psychopathology lead to deprivations of livelihood, as illiteracy and depression in parents impact the next generation.

Help and Healing

Although a great deal of work has been done to treat trauma and PTSD for individuals, little is known about how to help the victims of genocidal trauma heal successfully.

Miller and Rasmussen [28] reviewed the divide in the field between "trauma-focused" and "psychosocial" approaches. They note that "trauma-focused" advocates view the violence and direct destruction in the war as a critical factor mediating the mental health challenges for the victims. Advocates of a "psychosocial approach" consider that critical factor to be the social conditions, and the daily stressors caused or worsened by the conflict – such as poverty, displacement into overcrowded refugee camps, strife and division within the communities, loss of social networks, and struggle for survival. Consistent with Maslow's hierarchy of needs, Miller and Rasmussen recommend prioritizing efforts to address daily stressors.

Utilizing the above transgenerational trauma framework, we review interventions at individual, family, and community level.

Individual-Level Intervention

For the members of this highly persecuted and vulnerable minority, it is easy to imagine that trusting a therapist could be quite a challenge. Developing cultural competency, historical awareness, and normalizing the distrust can help build the rapport. A sense of control over what the patient shares can relieve some anxiety. Confidentiality and reporting laws should be explained more straightforwardly.

Psychoeducation about trauma, trauma responses, grief, and their symptoms forms the foundation of treatment. For children and adolescents who were born into these traumatic situations, psychoeducation has to start with helping them develop emotional language. To reduce shame and stigma, normalizing and humanizing their symptoms will encourage psychological rather than somatic expression of emotions.

Islam has been a significant source of support and strength for the Rohingya. For many, their belief system helps them gain purpose and make sense of their suffering. Exploring the religious narrative of individuals can provide further insights into their thinking. It is also important to note if negative religious explanations of atrocities exist, such as “we are sinful, and this was God’s punishment” or “I’m angry at God”. Self blame or some of the negative attributions could be worked through with the help of spiritual leaders. Positive religious narratives, such as “this life is a test and a trial,” are supported by Quran. Consider these verses:

> Every soul will taste death. And We test you with evil and with good as a trial, and to Us, you will be returned. (Quran, Sura 21; Ayat 35)

> And We will surely test you with something of fear and hunger and a loss of wealth and lives and fruits, but give tidings to the patient. (Quran, Sura 2; Ayat 155)

Seeking spiritual consult from the local religious leaders can also assist individual treatment.

Prayer as a form of meditation can help Rohingya if practiced on a regular basis. Because of traditional meditation’s association with Buddhism, any such recommendation should be explored and explained cautiously.

Vocational training can address daily life stressors and help prevent downward social drift.

Altruistically directing energy into raising awareness and advocating for the broader community can help individuals focus in a positive direction on bringing about change for themselves and others.

Family-Level Intervention

Family-level interventions can help mitigate transgenerational transmission of trauma.

Parenting is a demanding and challenging job even in the absence of trauma. For these families who have been through atrocities and been deprived of education for decades, one could imagine that support and training for parenting may be needed. Issues that may need to be addressed include improving communication about trauma and grief and avoiding trivializing the daily stressors of children in comparison to the horrors faced by parents.

No direct statistics of domestic violence are known for Rohingya population. But the global prevalence of domestic violence among all ever-partnered women is 30.0%. Regionally, Southeast Asia ranks worst for intimate partner violence, with a global lifetime prevalence of 37.7% among ever-partnered women [38]. Therefore, domestic violence will be an essential area to explore and treat this population.

Community-Level Intervention

Community-level interventions would arguably have the most impact on this minority. Fogelman [8] has reviewed the differences in the mourning and healing of Holocaust survivors in American vs. European Jewish communities. He notes that European Jews who stayed with their perpetrators exhibited stunted mourning, more difficulty with integration and adaptation, and fears of losing control. As a result, European Jews experienced more psychic numbing.

To heal collectively, Rohingya people need to tell their story as well as write their collective narrative and history. With some estimates of illiteracy rate ranging to 80%, educational programs could play a vital role in the whole populations' growth and well-being and prepare them for future jobs. Rohingya are working on building on their written language script. In the author's opinion, they would also need to learn the English language to advocate for themselves better on the international stage (Fig. 24.3).

Sports can be an effective way to foster community cohesion, promote a sense of normalcy for children, and provide a healthy emotional outlet.

Group therapy has been documented to be effective as a way of healing unresolved historical trauma and grief, both by Fogelman [9] for Holocaust survivors and by Heart [13] for American Indian populations. Group therapy can provide a safe place to communicate otherwise tightly controlled emotions and allow people to mourn more effectively.

Fig. 24.3 Rohingya children inside Balukhali refugee camp in Bangladesh. (Photo credit: Anna Dubuis/DFID, UK Department for International Development)

Regular community gatherings in non-clinical settings can also be of benefit. Mosques and community centers can provide the opportunity on a regular basis to consolidate identity, experience a sense of belonging, appreciate shared history, and extend the network of kinship.

Brave Heart has presented a model by which to integrate clinical group therapy with traditional Indian American interventions [13]. A similar integration by experienced culturally competent clinicians could be highly therapeutic for the Rohingya population. Brave Heart also suggests that tribes should conduct specific grief ceremonies to grieve not only the lost ones but also their historical trauma, loss of property, land, and possible opportunities [13].

For Rohingya, solving the issue of statelessness is at the core of their collective recovery. The international community must give up the role of spectator [41] and actively fulfill its responsibility to protect the victims of this genocide [19]. The Myanmar government needs to change the discriminatory1982 law to include Rohingya as an accepted minority [1]. Those who are responsible for these crimes against humanity must be served justice. Widespread hate campaigns, Islamophobia, and propaganda against Rohingya have to be replaced with their acceptance, inclusivity, and equal rights. Another repatriation without citizenship will keep Rohingya vulnerable and perpetuate the atrocities.

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Part IV

Social Psychiatric Implications

25 Muslim Women and Islamophobia

Fauzia Mahr and Tania Nadeem

The Social Fabric of Islam

Although Muslims constitute the majority of the population in 49 countries, rituals and cultural expectations vary greatly by region in these countries and often have little to do with Islamic principles. For example, gender differences sometimes seen in education have no root in Islam, as the Holy Prophet (Peace Be Upon Him) stated:

> Quest of knowledge is the responsibility of each Muslim man and Woman even if you have to travel to China in that pursuit.

Dr. Alaa Murabit [7], a physician, has championed many causes related to women and is an emerging leader in global policy addressing issues related to women. Her work is notable for challenging the misogyny stemming from cultural beliefs in Muslim societies by researching the religious scriptures.

Unfortunately the West has stereotyped Muslim women as homogenous oppressed beings [8] who need to be rescued from patriarchy, overlooking the fact that the majority of the world's cultures regardless of faith are patriarchal. However, Islam has made an effort to promote women's rights within society by allowing women the right to work, handle their money, marry, divorce, and inherit.

Islamic history is rife with women taking many leadership roles: Bibi Khadija (Raziallahu Taala Anhu) was the Holy Prophet's (Peace Be Upon Him) wife and owned and managed her own trading business [9]. Similarly, Bibi Nusaiba (RA)

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fought in the Battle of Uhud and is famous for having shielded the Prophet (PBUH). Bibi Aisha (RA) is famous for transmitting religious knowledge, narrating the highest number of Hadiths, and participating in political life. Muslims during that period regularly sought her opinion in matters pertaining to religion, politics, and social life.

The Central Position and Role of Women in Islam

The core tenets of Islam promote active involvement of Muslim women at home and in society. Their roles are central in many aspects of Muslim family life. Islam gave women a venerable role, and the word of God in the form of the Holy Quran strongly condemns injustice against women.

It is notable that Islam came at a time when the birth of a daughter was considered a reason for embarrassment and infant girls were buried alive in the Arab world. The Holy Quran strongly condemned and outlawed that practice. Furthermore, women at the time had no rights to inheritance, to education, or in marriage. They were traded off or passed along from one male member of the family to other males without their consent or any lawful proceedings.

Islam led to a paradigm shift by presenting a highly contemporary view of the role of women at the time when women in Europe and the rest of the western world had no rights to inheritance, voting, or major roles in the civil proceedings of society. Muslim women were empowered and their contributions in each role were religiously recognized. They were given rights which were unique to their roles.

The Holy Quran states that the pious acts of men and women determine who is closer to God and that gender alone is not a rite of passage. The following roles and entitlements are exclusively reserved for Muslim women and have been mentioned repeatedly in the Holy Quran and in the Hadith (sayings of the Holy Prophet, PBUH). Women's rights are so critically important that in his last address to Muslims, the Holy Prophet (PBUH) urged Muslims to protect the rights of women.

Mother

Mothers hold a revered position in the Muslim household and society. Allah has strongly urged Muslims to be respectful of their mothers and to take good care of them in their old age. In fact, one of the biggest sins is disrespect toward the mother, with dire religious consequences. The matter of courtesy toward parents is emphasized so much so that the Holy Quran states the following:

> And your Lord has decreed that you not worship except Him and treat your parents well. When one or both of them reach old age with you, say not to them even as much as 'Hmm' and do not repel them but speak to them a noble word. (Al-Isra 17:23) [10]

Muslims are urged to give thrice the respect and aid to their mothers given to their fathers in accordance with the teachings of the Holy Prophet (PBUH). When a man came to him for advice as to who should receive the benefit of his good

behavior and kindness, the Holy Prophet (PBUH) told him "Be good to your mother" the first three times. When he repeated the same question the fourth time, he asked him to be good to his father.

Another famous Hadith states:

> Heaven is under the feet of the mother.

This simple sentence not only sanctifies the prime position of a mother in a Muslim household but also dictates the obligatory duty of being humble, accommodating, kind, and respectful toward a mother. Islam encourages Muslims to regularly pay homage to mothers for their sacrifices for their children and to routinely ask God for blessing for their parents.

Respect, love, and kindness toward a mother should continue even after her demise, as the Holy Prophet (PBUH) encouraged Muslims to take care of their maternal aunts and friends in the same manner if the mother has passed away.

Interestingly, the revered position of a mother is not only for the biological mother but also for any women who have breastfed a Muslim. These women are called "Razaaee Mothers," and the Holy Prophet (PBUH) himself practiced exemplary love, kindness, and respect toward his Razaaee Mother, Bibi Halima Saadia (RA).

Daughter

A famous Hadith narrates the following:

> "Lucky is the woman whose first child is a daughter". Muslim fathers are promised heaven if they raise three or more daughters, treat them well and marry them off. This was an avant-garde concept presented by Islam, as it encouraged its followers to treat their daughters on an equal footing with their sons.
>
> The Holy Prophet (PBUH) set a commendable example with his love and kindness towards his daughters. He used to stand up at his daughter's arrival and used to spread his shawl (wrap) on the floor for her to sit on.

One of his other Hadiths states:

> Daughters are a blessing from God.

Such emphasis on the cardinal importance of the role of daughters empowered Muslim women in this role and solidified their importance in the Muslim family.

Wife

Contrary to the popular notion, Muslim women have a right to choose their partners. In fact the Holy Prophet (PBUH) disqualified a marriage contract because the woman was forced into the marriage by her father without her consent. A Muslim husband is required to give "Mehr," a mandatory gift to his bride at the time of the

marriage. The amount of Mehr is determined via collaboration between husband and wife. A husband is required to provide for her even if she is rich and has her own money. The woman has no obligation to give anything of her wealth to the husband. The husband must pay child expenses even after a divorce. If the wife is unwilling to breastfeed, the husband must pay another woman to nurse the baby. A husband also bears equal responsibility in raising children.

A Hadith narrates the following:

> Best blessing for a man is a loyal and righteous woman

Another Hadith states:

> A man has 3 fathers; his biological father, his wife's father & his teacher

In the instance of a divorce, the wife retains all the gifts acquired in the marriage, and the man is to abide by the prenuptial contract (if any), as well as to provide her with at least 3 months of the same standard of living to which she was accustomed during marriage. Men are strongly forbidden from harassing women during or after divorce proceedings. Muslim women are allowed to remarry after the "iddat" (4 months and 10 days). This timing was mandated to ascertain the presence of pregnancy from a previous marriage.

Although polygamy is allowed for Muslim men, the rules regarding this are strict, and God has urged men to practice absolute equality between wives should they decide to marry more than one woman. This includes equality in the time spent with each wife as well as other rights. The scrupulous rules serve to discourage polygamy as a casual practice. It is also worth noting that marriage in many cultures has symbolic meanings and is considered a gesture of respect and peace between families. Additionally, owing to loss of lives during and after wars, this allowance provided a means for widows to pursue marital life with dignity. It is worth noticing that according to some surveys [11, 14], polygamy is practiced less by Muslims as compared with other faiths.

Sister

Muslim men are encouraged to be mindful of their sisters' needs, to support them, and to treat them with kindness. Some scholars go as far as to say, "An unequivocal way to get rid of financial hardships is to take a small gift for your sister every time you go to her home" [12]. Muslim men are encouraged to support their sisters especially after the death of their father, and most Muslim societies reflect that collectivistic thinking.

Rights of Women in Islam

The passages above highlight Islam's contributions toward Muslim women's empowered existence. The following few paragraphs will narrate the unmistakable importance given to women and discuss rights often viewed as disparate by the

western world. The role obligations involved reflect variations in rights for each gender. As mentioned above, Muslim men are expected to take care of their mothers, wives, daughters, and sisters – accounting for the seemingly different rights in certain roles.

Inheritance

Islam recognized inheritance as a basic right for both genders. Daughters are entitled to half the share as sons in inheritance due to the differences in role obligations. Women are not obligated to provide any financial support to their male relatives. The rights of inheritance led to accumulation of wealth and development of sizeable assets for some Muslim women. In the mid- sixteenth century Istanbul (Turkey), 36.8% of the "aawqaaf" (charitable donations) were from Muslim women. Similarly between the years of 1770 and 1840 in Aleppo, 51% of charitable contributions were from Muslim women. Moreover, eighteenth century Cairo received 25.4% of its charitable contributions from Muslim women [13].

Work

Historically, Muslim women have been involved in business and many other lines of work. The first woman of Islam Bibi Khadija (RA), the first Muslim woman, and first wife of the Holy Prophet (PBUH) was a business woman and financially independent. In fact, the Holy Prophet (PBUH) used to work for her prior to their marriage. During the time of the Holy Prophet (PBUH) and tenure of the second Caliph of Islam Hazrat Umar Farooq (RA), a woman was the superintendent of the bazaar which provided subsidized food and other items for the society at that time. Muslim women also served as doctors, nurses, and soldiers at various times during history. Notably, in the USA, women were only given the right to fight on the front lines in 2015.

In modern times, Dr. Alaa Murabit [7] sets an outstanding example as one of the 17 global sustainable development advocates appointed by the UN secretary general and the UN High Commissioner on Health, Employment and Economic Growth.

Ibtihaj Muhammad [14] is another notable Muslim woman in the modern era. She is the first female Muslim athlete to earn a medal at the Olympics wearing hijab. She has also served on US Department of State's initiatives to empower women and girls through sports.

Hazrat Bibi Ayesha (RA) was a renowned Muslim scholar and active in political and social life of Muslim society at that time. In modern times, Fatima Jinnah, the sister of the founder of Pakistan, Muhammad Ali Jinnah, played a critical role in the Pakistani independence movement along with many other Muslim women of that time. Muslim women's involvement in political life in Pakistan is also considered to be above that in the UK according to some estimates, although the gender differences in employment do not reflect comparable gains.

Muslim women across the globe have held key political positions and have served as heads of state, which to date has not happened in the USA. In fact, at one point in

the 1990s, about 300 million Muslims had Muslim women as their state leaders. Dr. Almontasser [15] reports that in the last 40 years, nine Muslim women heads of state have served their nations, some of whom were elected more than once. Currently even some non-Muslim countries have Muslim women as heads of state, notably Singapore and Mauritius. In March 2017, out of the 15 female heads of state in the world, 2 were Muslim women [15, 16]. Notably, Ilhan Osman made history in 2016 by becoming the first Muslim Somali American woman legislator [17].

Education

Education holds a vital place in Muslim society as the first revelation of God was "Iqra," which means "read." The Holy Prophet (PBUH) had designated a separate day to teach women and encouraged women and men to seek useful knowledge. The gender differences in education seen in Muslim societies have no basis in the religious tenets as Bibi Ayesha (RA), wife of the Holy Prophet (PBUH), has narrated the largest number of Hadiths and holds a highly prestigious place among Muslim scholars.

Clinical Correlates and the Intergenerational Impact of Islamophobia on Muslim Women

Muslim women who can be easily identified due to their "hijab" or chaaddar (cloth covering the head) are at the receiving end of disproportionately high amount of Islamophobia experienced by Muslim women. This behavior may stem from many misconceptions and fears within western society toward the religion, along with pure gender and racial discrimination. Their choice of clothing is incorrectly perceived to be forced on them by men, and they are wrongly portrayed as submissive subjects of domestic violence in attacks carried out by Muslim men. Notably, Muslim women are also routinely a target of discrimination regardless of their dress preferences [18].

Unfortunately the fact that women across the globe, regardless of their religion or culture, are more likely to be subjected to abuse is conveniently overlooked. Hate crimes against Muslim women due to these prejudices result in isolating them by limiting social mobility and their opportunity to participate in social, occupational, or political life in the host culture, effectively impeding assimilation at all levels. Hate crimes are seldom reported due to fear and the risk of negative outcomes. The resulting psychological vulnerabilities are seldom addressed within the Muslim community or the larger western community. ENAR's project [5] has tried to address this issue, by gathering information and exploring solutions especially by coupling anti-racism activity with feminist movements. This study has shown that Muslim women are excluded from jobs due to their dress choice, which can be seen as threatening or representing unwillingness to assimilate into the European community. Ethnic and religious discrimination starts prior to employment, as surveys

have demonstrated that Muslim women are asked personal questions more frequently than their white counterparts and that Muslim women miss out on career advancement opportunities secondary to their religious adherence or sartorial preferences.

Intimidation by swearing and racial slurs is common on the streets. The media represents a very stereotypical image of Muslim women; those who are strong and independent are described as anomalous. The immense difficulties Muslim women face while living in a hostile environment place them at higher risk for developing PTSD, take a toll on their self-confidence, and hamper their ability to successfully assimilate into society. The hate crimes and constant negative rhetoric against Muslim women in the media not only adversely affect their quality of life and limit access to help but also affect their family functioning and child rearing capability. A depressed or anxious mother is usually disengaged and withdrawn. Maternal mental health issues directly affect children's behaviors, academic performance, capacity to assimilate, and overall sense of well-being.

While all Muslim women are at risk, second-generation immigrant Muslims are likely to experience worse outcomes, harbor anger, and feel increasingly misinterpreted, marginalized, and victimized. This victimization is likely to create vulnerability for mental health problems as this group is younger and, unlike their mothers who spent the developmental years of their lives in accepting Muslim cultures, has not previously experienced an accepting society.

Islam's View on Mental Health

Islam recognized the impact of mental health on social functioning more than 1500 years ago when mental illness was considered a curse globally. Long before McNaughten's rule was established in the western world, Islam uniquely proposed that individuals struggling with mental health disorders leading to decreased or no awareness of their deeds or diminished capacity to know the wrongfulness of their acts were exempted from punishment as well as from the performance of religious rituals like daily prayers. The first known psychiatric hospital was built in Baghdad in 705 AD [19]. Many historical Muslim medical professionals including Razis (860–932 AD) and Avicenna (980–1037 AD) worked at debunking superstition in Islamic society. They encouraged therapy-based treatment for psychological problems [20]. Empathic listening and supportive therapy are very natural extensions of Muslim social rituals.

While the stigma toward mental health exists globally regardless of faith preference, the current wave of Islamophobia detrimentally affects health-seeking behavior by worsening anxiety which in turn reinforces cognitive distortions, stigma, and shame. Muslim women can fall prey to overgeneralization and personalization of the negative encounters. Mistrust toward western providers due to their limited understanding of the underpinnings of religion and culture is a veritable barrier to establishing an optimal therapeutic alliance.

Additionally some treatment modalities might be culturally insensitive – especially individuation-based approaches [21, 22].

Case Examples

1. A 12-year-old second-generation Muslim hijab-wearing girl was called a terrorist and ugly by peers in school. She was also told that no one will marry her. The incident led to body image anxiety and symptoms of bulimia.
2. A 32-year-old first-generation immigrant woman presented with depressed mood. She reported discrimination in the workplace. Instead of reportable verbal assaults, she experienced being ostracized from social events. She stated that only the Muslims who bashed Islamic rituals were accepted by coworkers.

Recommendations for Providers

Muslims are unable to receive optimal care secondary to the limited understanding of Islamic practices in clinical settings [10]. This disparity is likely to promote dissatisfaction with medical care in the Muslim women and decrease health-seeking behaviors. As mentioned above, the impact of the stress of Islamophobia on Muslim women and poor mental health delivery has far-reaching effects on the Muslim communities.

The following recommendations primarily focus on proposals to provide better care to Muslim women, but most of these hold true for all genders in the Muslim world.

1. Medication: Avoiding alcohol-based medication or medication containing other prohibited ingredients (pork, non-halal items) is more likely to promote compliance.
2. Food: Halal food is a requirement for Muslims; they are prohibited from consuming any products containing non-halal items, alcohol, or pork products. These products are allowed only as lifesaving measures. Providers should be mindful of this key concept when they weigh psychopharmacological and other medical management options. During inpatient stays, refusal to eat non-halal food should be explored to avoid labeling it as oppositional behavior or food refusal.
3. Clothing: Muslim women across the globe dress in a variety of different ways based on cultural nuances. The foundation of Islamic clothing is conservative, and many Muslim women typically dress conservatively and fully cover their bodies. Hospital clothing on inpatient units which does not align with faith-based dress preferences is likely to engender resentment and mistrust of the medical system. Moreover, most Muslim women feel uncomfortable with male providers, so physical therapists and 1:1 sitters for suicidal Muslim women should preferably be females.
4. Physical contact: Islam prohibits open physical contact between men and women except in a marital relationship and certain blood relations. Therefore, something as simple as a handshake can be a boundary violation. Similarly, providers should be mindful and inquire about the gender preference for administration of injectable preparations prior to prescribing such medication.

5. Faith-based healing practices and the role of religious healers: Muslims highly revere the saints, popularly called "Wali Allah" meaning "friends of God." These are pious men and women whom Muslims, particularly Muslim women, routinely ask to pray for them. These saints often give them verses from the Holy Quran to recite and in some instances give them advice based on "Tib-e Nabwi" (PBUH) which is the medicinal practice of the Holy Prophet (PBUH) and is mainly food based. Honey and olive oil are staples in Islamic healing practices. Traditional Muslim societies used "Zavia," Khanqaah, or local community gatherings for support and to search for the real meaning of life. The Holy Prophet (PBUH) also stated "smiling is charity," which indeed has research-based positive effects. The recommendation of therapy is far more likely to be acceptable to Muslim women if it resonates with their social fabric and is presented in the context of their religious practice and promotes the therapeutic alliance.
6. Comprehensive case conceptualization: Due to the focus on the common good of the family and society, Muslim women often minimize or do not disclose their symptoms. The onus of responsibility lies on the providers to ask leading questions and explore:
   - Severity and frequency of Islamophobia
   - Resultant symptoms
   - Workplace discrimination
   - Social support systems or lack thereof
   - Discrimination secondary to adherence to Muslim tenets
   - Minimization of symptoms by family and friends
   - Effect on their offspring
   - Guilt
   - Safety risk

   It is critical to identify and monitor the role guilt and embarrassment secondary to perceived inability to carry out family obligations and the subsequent impact on their children.
7. Cognitive schema and its compatibility with therapy: Muslim women garner more respect and adoration as they age, and Muslim children defer to their mothers in many aspects of their lives regardless of their own age. Parents hold a revered position as mentioned earlier. Talking against parents and elders is considered inherently wrong and is incompatible with cognitive schema of most Muslims. This is of particular importance in the context of psychiatric or psychological evaluation of traits to avoid mislabeling these as dysfunctional.
8. Exploration of cognitive distortions like overgeneralization, over-responsibility, guilt, and labeling in the context of Islamophobia is pivotal. CBT is well suited to modify cognitive distortions in Muslims [23]. Therapy lends itself seamlessly to the Muslim society as the core social tenets of Islam promote empathic social conversations, Socratic questioning, and support. Rituals of death, illness, loss, and marriage all promote gathering together and kind words, reminding those who are suffering of the positive aspects of life.

9. Use of Islamic tenets to promote wellness: Five daily prayers provide structure and help patients with depression maintain their ADLs. Limiting use of hand-washing to the religiously prescribed times may help in the treatment of OCD if framed in religious terms.
10. Identification of risk factors for experiencing Islamophobia and its long-term adverse outcomes:
    - Conservative sartorial choices
    - Adherence to religious norms
    - Young age
    - Second-generation immigrant
    - Limited social supports
    - Low socioeconomic status
    - Symptom minimization by family and community
    - Marginalization by other Muslims
11. Avoidance of assumptions: Not all Muslim women adhere to the faith so different Muslims will have different needs. Substance use, sexual history, and effects of non-religiosity should also be explored.
12. Psychoeducation: It is notable that many symptoms of mental disorders like hypersexuality in mania, religious delusions in schizophrenia, blasphemous thoughts in obsessive-compulsive disorder, and suicidal ideation in depression can be interpreted as lack of belief by other Muslims. This might lead to isolation from family and Muslim community and promote guilt in the patient. Psychoeducation can help mitigate guilt and blame.
13. Provider bias: It is imperative for healthcare professionals to make conscious efforts to recognize their own biases and limitations and to uphold the highest ethical standards.
14. Mindfulness- and meditation-based therapies and recommendations: The five daily prayers, Darood Sharif recitation (prayers for the Holy Prophet PBUH), and other tasbeehaat (prayers using rosary beads) are widely practiced by Muslim women and promote mindfulness and meditation. Therefore therapies incorporating mindfulness and meditation are very suitable.

Conclusions

Islamophobia is increasing at an alarming pace. When experienced by Muslim women, it has major ramifications for them and their children. The long-term sequelae, although not yet well studied, result in adverse mental health outcomes in Muslim women and their offspring and can pose a substantial burden on society. Despite flagrant spread of Islamophobia, the healthcare community, in particular the mental health disciplines, has not yet established guidelines to screen, evaluate, and deliver faith-centered care. Since religiosity is a known protective factor against mental health problems in Muslims, faith-centered management strategies are likely to encourage adherence to treatment and promote resilience against Islamophobia. There is a need for research to narrow the practice gap for identification and management of adverse outcomes of

Islamophobia in Muslim women in order to prevent untoward mental health outcomes in Muslim women and their children.

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26 Muslim Youth in the Face of Islamophobia: Risk and Resilience

Madiha Tahseen, Sawssan R. Ahmed, and Sameera Ahmed

Bullying of Muslim Adolescents

A survey of Muslim adolescents in California [10] found that 53% of Muslim students have experienced religiously-based bullying in school—nearly twice the national average of bullying. The experience of bullying for Muslim adolescents is multifaceted, comprising direct and indirect forms of aggression, occurring across many contexts and from many different perpetrators [4, 8, 10, 21, 25, 45]. Verbal bullying is the most common form of direct harassment reported by Muslim youth; however, physical bullying is on the rise. From 2014 to 2017, rates of Muslim adolescents reporting physical harassment and assault increased from 9% to 19% [10].

> I was on the school bus and this…random guy…he was like 'Go back to your country you f-ing Afghan'… I felt horrible, I felt really bad, I mean I was only in 7th grade, what am I going to do?… I felt that, I mean how ignorant American society is, [and] at the same time why do they have a wrong image of us? And I wish that… all Muslims including me could stand up, because I think that then we can really show America that we're not a bad religion. We don't teach violence; we teach tolerance. – Female Muslim Student, [35]

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Perpetrators of Bullying Anti-Muslim bullying is perpetrated by a variety of individuals in adolescents' schooling and non-schooling contexts. Muslim adolescents are bullied by their peers [4, 8, 14], which is consistent with the bullying experiences of their non-Muslim counterparts [31]. However, contrary to what typically occurs for bullying of non-Muslim students, where teachers tend to serve as mediators during peer acts of bullying, school staff members are also perpetrators of bullying against Muslim students [5, 14]. For instance, 38% of the bullying incidents reported by Muslim students involved a teacher or school official, which is an increase from 20% in 2014 [10]. Anti-Muslim bullying is directly perpetrated by educators and school administrators, through verbal (*"This is the region of the peace haters"*) and physical acts of discrimination (e.g., teacher removing student's headscarf) [4, 14, 33, 35, 45]. In school environments, Muslim adolescents experience bullying while under adult supervision in the classroom (by both teachers and peers alike), in the cafeteria in the presence of lunch monitors, on the athletic field, and in afterschool programs [14]. Bullying also occurs in unsupervised settings, such as in school hallways, locker rooms, bathrooms, and while riding the school bus. Outside of school, Muslim adolescents also experience harassment from complete strangers. A young girl recalls that she was driving with her mother and both were wearing headscarves:

> A car full of teenage boys passed and made obscene hand gestures at them. When the car passed a second time, the boys rolled down the window and yelled verbal epithets about Muslims...The girls in the study unanimously agreed that they felt sad when people were angry and hateful toward them – [4]

Consequently, as Muslim adolescents move between various social settings in their lives, they may experience anxiety and feel unsafe due to the anticipation of possible discriminatory incidents.

Intragroup Bullying Another source of bullying that Muslim adolescents experience is from other Muslim adolescents, a process termed *intragroup bullying*. A key task in the adolescent developmental period is achieving a sense of belonging to social groups. Although these processes have not been empirically tested among Muslim adolescents specifically, prior works show that majority and minority memberships have distinct effects on a variety of intragroup processes, such as identification with one's ingroup (for a review, see [36]). Thus, past research can be used to guide our understanding of intragroup experiences among Muslim youth.

People are motivated to see their social groups as being positively distinct from other social groups and desire to clearly differentiate ingroup members from outgroup members [42]. Any group members who may blur the boundaries between the ingroup and outgroup threaten the integrity of the group's distinctiveness [43]. For instance, in the face of identity threats from the outgroup, ingroup members often reaffirm group boundaries [24]. They also evaluate prototypical members of a group more positively than peripheral members, such that divergence from the

prototype can result in being labeled deviant by ingroup members (e.g., [20]). Thus, as Muslim adolescents experience threats to their identity from the outgroup (i.e., American culture, media, non-Muslim peers or adults) as well as other subgroups within the broader Muslim group (i.e., other racial backgrounds), they may reaffirm qualities that they believe define being Muslim. Additionally, they may marginalize and discriminate against those adolescents who deviate from ingroup qualities and blur these reinforced boundaries, such as Muslim youth who engage in risky behaviors that are not accepted in Muslim circles (i.e., premarital dating, substance use) or Muslim youth from different racial groups (e.g., South-Asian youth versus Black Muslim youth). The marginalization experienced by peripheral Muslim youth may place them at risk for further engagement in risky behaviors and poor mental health.

Microaggressions Muslim adolescents are also the victims of indirect forms of discrimination. Microaggressions refer to brief and everyday slights or insults that communicate negative messages toward individuals of color; they may or may not be intentional [39]. Recent research suggests that microaggressions against Muslims are exhibited in much more complex and subliminal ways [29]. Verbal microaggressions may include asking Muslim adolescents questions, such as "Where are you really from?", which imply that he/she cannot be American. Microaggressions may also include misinformation in the school curriculum content or biases that portray Islam and Muslims as inherently villainous, uneducated, and in direct conflict with Western civilization.

> One Muslim parent explained that her son felt embarrassed when a student teacher explained to the class, in reference to the Kaaba, that Muslims worship idols. – [33]

Microaggressions may also include school practices or policies which make it difficult for Muslim youth to follow their religious obligations, such as not having time or a place to pray at school, not allowing Muslim students to make up assignments or exams that are scheduled on Muslim holidays, and/or the subtle exclusion of non-Christian holidays on school calendars [14]. Other examples of microaggressions in the school context include lack of support for Muslim student organizations and requiring fasting Muslim students to participate in strenuous physical activities during Ramadan.

Cyberbullying Muslim adolescents also experience religiously-based cyberbullying, which refers to posting or sending electronic messages aimed at harassing another individual through varying forms of social media [5]. From 2014 to 2017, rates of California Muslim students who reported being victims of cyberbullying increased from 19% to 26%. In addition, a majority (57%) also reported viewing their peers making offensive online posts about Islam or Muslims [10]. Though direct forms of bullying are often more apparent as identity-based discrimination, Muslim adolescents often do not report these offenses to adults because they do not feel doing so would make a difference.

Media is an important context that contributes to the bullying of Muslim adolescents. The negative rhetoric directed toward Islam and Muslims serves to perpetuate the message that hate and bullying are socially acceptable. Even if Muslim adolescents have not directly experienced Muslim-based bullying, the *perception* of anti-Muslim and Islamophobic rhetoric in the media can mimic the impact of direct experiences of discrimination. Vicarious discrimination, or discriminatory experiences directed at other same-religion peers and adults in the adolescents' life, are equally detrimental to mental health [28]. Consistent with research on other minority youth [44], Muslim youth also experience vicarious discrimination, particularly online as cited previously. However, there is no literature on the mental health impact of this form of discrimination for Muslim youth. Thus, it is also important to consider the secondary impact of media's messaging and vicarious discrimination on Muslim adolescents.

Intersectionality It is important to note that Muslim adolescents are a diverse group and vary in their racial, cultural, religious, and socioeconomic backgrounds [3]. Preliminary evidence indicates that the extent of discriminatory experiences of Muslim students may also vary by ethnic or racial group, thereby making some subgroups more vulnerable than others [1]. Thus, it is imperative to use an intersectional approach when dealing with youth who navigate multiple identities.

Impact of Bullying on Muslim Adolescents' Well-Being

> I've just blocked that day out. All I can remember was walking down the hall and I hearing a boy yell, 'The Mozlems are gonna be rounded up now!' Then kids started snickering and chanting, 'Make America great again!' I didn't look up, I just ran and hid in the bathroom before anyone could see me cry. No one came to help me. No one told them to stop. No one did anything about it. I don't feel safe there (at school). You can't make me go back there.
> – Omar, 9th grade

Although the impact of bullying on Muslim adolescents' well-being is a growing body of research, extant findings mirror those uncovered in the literature on their same-age counterparts. In the following section, the impact of bullying on adolescents' (1) mental health, (2) identity development, (3) academic engagement, and (4) civic engagement will be discussed.

Mental Health

The literature is clear that discrimination and identity-based bullying is related to an increase in internalizing (e.g., "I cry a lot") and externalizing (e.g., "I get in many fights") behaviors among Muslim adolescents [3, 4]. Hostility from peers and adults may contribute to Muslim adolescents questioning their self-worth and self-esteem. Adolescents may become conscious of being constantly scrutinized by peers, teachers, other adults, and the larger community [37], which can result in tremendous

internal conflict for Muslim adolescents. They may vacillate between ignoring anti-Muslim acts for fear of validating them but then also feel guilty about not reacting and thus contributing to perpetuating further acts. Dealing with such internal conflict may lead youth to blame themselves, and to isolate themselves from other adolescents in school, which may contribute to higher levels of depression and anxiety [9, 37]. Moreover, Muslim adolescents are less likely to divulge instances of bullying to their parents out of a need to protect them, which may result in increased psychological stress for these adolescents [4]. These findings are troubling as they suggest that Muslim adolescents may be experiencing increased vulnerability and decreased sources of support and coping in times of crisis [17].

Identity

Due to the *othering* of Islam and Muslims in legal policies, media dialogue, and educational institutions, Muslim adolescents' identity development has been referred to as "identity formation under siege" [18, 37]. The *othering* process refers to how various systems espouse cultural norms and laws which perpetuate the notion that all Muslims are aliens to American culture [23]. Despite the developmental need to belong and be connected to society, Muslim adolescents receive direct and indirect messages of rejection from their environment which can impact their identity development [37].

> I didn't understand what side you're supposed to be on or anything. Like, you know, on one hand, you're Muslim, and they're saying, 'You're Muslim, go this way'; on the other hand, you're American, and you have to be like this. Like, if you go to the American side, they're never going to think of you as American, but if you go to the Muslim side, you're not Muslim enough. – (Marina, 17-year-old girl; [15])

How young people cope with bullying and discrimination is dependent on individual traits, developmental context, and the interaction between these factors in their environment [3]. For some adolescents, their Muslim identity serves as a protective factor in the face of bullying and discrimination [12, 46]. As a coping strategy, these adolescents may engage in various identity-enhancing actions, such as wearing hijab (a religious marker) or speaking out against stereotypes or misinformation about Islam [35, 47]. In this way, Muslim adolescents may attempt to portray Islam in a positive light, and to normalize Islam and Muslims, as well as to show signs of solidarity with fellow Muslims [47]. Such actions may serve to channel their energy while relying on religious supports and coping methods to buffer the impact of psychological distress from discriminatory experiences [3]. Thus, a strong religious identity can provide Muslim adolescents with social support, a sense of belonging, and connection with ingroup members (i.e., other Muslims) and reduce the negative impact of bullying on developmental outcomes [17, 25].

Some Muslim adolescents who report experiences with prejudice and discrimination endorse lower levels of Muslim identity [27]. Muslim youth who accept discrimination as a "fact of life," and do not engage in religious identity-enhancing

behaviors, report higher levels of anxiety and depression [37]. In such cases, adolescents may feel unable to use their identity as a coping strategy because of potential negative responses from teachers and friends [4, 22]. These individuals often experience fear and/or feel ashamed and embarrassed to exert their religious or cultural identity [6]. They may develop what can be called a form of self-hate that results in Muslim youth trying to blend into dominant culture with respect to adolescent norms and behaviors (dress, values, leisure activities). This attempt at assimilation may result in becoming ostracized from their religious and cultural support group, which can in turn increase the likelihood of engaging in risk behaviors [3, 6].

Civic Engagement

The experience of discrimination and potential loss of religious and cultural identity can have impacts on adolescents' engagement in other aspects of their lives, such as the broader community (i.e., civic engagement). Although Muslim youth balance their various identities, including a strong American identity, few researchers have studied the impact of bullying on Muslim adolescents' national identities (i.e., American identity). Adolescents "learn what it means to be a citizen through everyday experiences of membership in their communities and opportunities to exercise rights and fulfill obligations" ([46]; p. 85).

> They are always telling us: 'Go back to your country!" [But] this is our country. We're obviously living here... Who are you to tell me to go back anywhere? I was born here. I should be able to live here. – [29]

Despite experiences with discrimination, a majority of Muslim youth endorse overwhelmingly positive attitudes toward all conventional forms of American civic and political participation [13]. In a large study of Muslim students in New York City schools, 90% of students reported that civic and political engagement were important, including efforts ranging from involvement in community service to walking with others in marches. Other researchers show similar trends, especially for Muslim girls and young women. Research shows that perceived discrimination sometimes bolsters community engagement for young Muslim women who may choose to engage with non-Muslim communities in an attempt to fight back against stereotypes and discrimination [38]. It is important to note that although this study concerned emerging adults, these findings show that negative experiences can be buffered by protective factors in later developmental stages:

> I try to calmly to explain to them they should get to know Muslims in the community and learn more about Islam before making offensive statements. – [10]

Preliminary research also highlights the possibility that bullying experiences can result in the civic *marginalization* of Muslim youth [45]. If Muslim youth experience harassment and constant attacks on their Muslim identities, then they are more

likely to feel separated from their American identity which may impact their role as productive citizens of this nation [8]. Such feelings of exclusion may result in reduced civic participation and little concern with local social issues.

Academic Engagement

Research on the negative impact of discrimination and bullying on the *academic* lives of Muslim adolescents is also emerging. Experiences with bullying in the school environment hinder Muslim adolescents' academic engagement. The lack of interest in students as individuals and the existence of anti-Muslim stereotypes in some school climates prevent students from feeling understood, safe, or included at school [6]. There is some indication that feelings of being misunderstood at school may be on the rise for Muslim students. For example, Muslim students report lower levels of feeling welcomed and respected in school (69%) compared to previous years (83% in 2014) [10]. In addition, Muslim students have a difficult time reconciling their self-image with the negative portrayal of Islam in curriculum materials [30, 40]. Indeed, findings show that negative portrayals of Islam and Muslims in school curricula result in negative self-perceptions among Muslim students, which in turn results in lower levels of GPA [41].

Muslim adolescents have also reported that prejudiced views held by school staff and peers undermined their academic success and resulted in difficulties maintaining their religious and cultural identity [6], which in turn, was associated with decreased academic performance. Intentional or unintentional inaction by school staff during bullying incidents under their supervision sends messages of rejection and fear to Muslim students, which in turn, undermines Muslim students' sense of trust and safety in the student-teacher relationship. Condoning and turning a blind eye toward Muslim-based bullying also send the message to onlooking peers that acts of bullying are permissible and indirectly encourage them to recur in the future.

> A Muslim student recalled how a Social Studies teacher who was talking about the Middle East once said, 'This is the region of peace haters.' This greatly embarrassed the student and he began fearing that his non-Muslim peers would have the same 'peace-hating' impression of him. – [33]

As a result, only 32% of youth in the California survey cited previously said reporting a problem to an adult made a difference, down from 42% in 2014 [10]. In fact, many Muslim students worry that reporting an incident may actually worsen the situation at school and hence fail to report incidents [35]. These underlying tensions between Muslim students and school staff disproportionately shift the power dynamics in the student-adult relationship. Muslim students may no longer trust that the adults in their schools will be there to provide protection, which can be more developmentally destructive than the peer bullying and may be as devastating as emotional abuse from a parent or guardian [14].

Protective Factors

The literature on protective factors that promotes Muslim adolescents' resilience in the face of discrimination and religious-based bullying is scant. Consistent with previous research on ethnic minority adolescents (e.g., [34]), preliminary findings on Arab-American adolescents show that cultural resources, such as religious coping, ethnic identity, and religious support, promote greater psychological well-being [3]. Muslim youth reported turning toward additional prayers or listening to the Qur'an (holy book) to deal with discrimination-related stress [13]. Thus, within the family context, parents can increase youth's access to religious support systems and support their ethnic and religious identities [19] by (1) supporting adolescents' personalized religious or spiritual practices, (2) encouraging their participation and volunteering in youth-centered religious community activities, and (3) ensuring that they have access to adult mentors and peers that they can talk to and use for support [3].

Interventions in school and broader societal contexts should focus on fostering ethnic identity and access to religious supports, which may help to reduce the negative impacts of bullying and discrimination. Indeed, in an innovative experiment on perceived equal treatment in school settings, researchers found that when minority (i.e., Muslim) and majority students perceived equal treatment in schools, minority students were protected from the negative effects of discrimination on academic engagement and, in turn, performed better on the experimental test in the study [7]. Based on developmental intergroup [26] and social identity perspectives [32], these findings suggest that fairness and equal treatment work as a buffer against exclusion and discrimination and should increase trust and commitment among minority group members.

Beyond policies and messaging of fairness, schools' appreciation and celebration of students' identities may also have protective effects for Muslim youth. A central tenet of multicultural education is the affirmation of students' diversity and identity [30]. Some researchers have theorized models of inclusion which may nurture Muslim students' identities and result in greater well-being. The model for modification, proposed by Sabry and Bruna [33], emphasizes a need for proactive and cooperative relationships between Muslims and the school system by (1) encouraging greater Muslim family involvement in school activities and decision-making, (2) redesigning school curriculum, (3) developing relevant and appropriate instruction, and (4) eliminating stereotypes among teachers and school staff. Through the use of these strategies, Muslim students' identities can be celebrated and strengthened, and the overall school climate can be enhanced [33]. School psychologists can collaborate with schools to develop targeted school-wide and classroom-based strategies to facilitate an inclusive school climate for Muslim students [11], including the consideration of religious and cultural values when working with Muslim families [16].

However, it is important to note that there is no current empirical support regarding the role of the aforementioned identity-promoting factors as curbing or

ameliorating the deleterious effects of bullying and discrimination in school or family settings. More research is needed to examine whether fostering ethnic and religious identity and a connection to religious supports does indeed buffer the negative effects of discrimination on Muslim youth.

The Case of Jamilah: A 13-Year-Old African American Muslim Girl Who Loves Playing Basketball

Jamilah is an extroverted and athletic 15-year-old African American female who was born and raised in Atlanta. Her grandparents converted to Islam, and she is a third-generation American Muslim. She was raised with a strong sense of community and attachment to the large African American Muslim community in which she grew up. Last year, Jamilah and her family relocated to a suburb in the Bay area due to her father's company moving. Although there is a small and active American Muslim in this new community, there are few or no African American Muslims. At her new school, Jamilah has had a hard time making friends. She does not feel as though she can relate to the other Muslim kids at school and has not felt confident to reach out to them or any other of her school peers. She tried out for her new school's basketball team and was accepted into the team; however she was told she could not wear her religious headscarf or cover her arms and legs and play on the team. Additionally, recently one of Jamilah's classmates tugged at her headscarf. Her parents have noticed that since moving, Jamilah has been withdrawn and quiet and are unsure what to do. They reached out to the school counselor who recommended that Jamilah's parents attend therapy sessions with a local private therapist.

Recommendations for working with Jamilah Clinicians working with Jamilah could explore any feelings of loneliness and isolation she may be experiencing. They could explore issues related to identity development and how she feels about both her ethnic and religious identity and the intersection between the two. Jamilah could be experiencing a sense of loss since the move especially due to the loss of community that has been her source of comfort and a place of grounding. Clinicians could work with Jamilah on strategies to find a peer group at school and community resources and centers with which she can connect. They could explore any intragroup and intergroup incidents of discrimination she may have experienced and how to cope with them. Clinicians could also explore with Jamilah's parents' ways to make Jamilah feel a sense of empowerment and ways she and they can advocate for Jamilah so that she can play on the basketball team wearing a uniform that is in accordance with her Islamic practices.

Recommendations

Despite the lack of research examining protective factors in Muslim adolescents' lives, the findings are clear that Muslim adolescents experience various forms of

bullying and discrimination, from different perpetrators and within varying contexts. These experiences adversely impact adolescents' mental health, identities, and academic and civic engagement. Thus, it is imperative that prevention and intervention efforts address different aspects of adolescents' lives. In the following section, we provide recommendations for researchers and clinicians to promote positive change for Muslim adolescents.

Research

Though research findings highlighted in this chapter provide insight into the impact of bullying and discrimination on Muslim adolescents, much more research is needed. Future research should consider the following:

- Research on the prevalence of bullying and discriminatory experience, including microaggressions, in a nationally representative sample of American Muslim adolescents
- Longitudinal studies using quantitative methods that explore the underlying processes and mechanisms of bullying, as well as the long-term impact of their experiences on developmental outcomes.
- Research on protective factors within various systems (individual, family, school, community, culture) which can be enhanced and promoted for this vulnerable yet understudied population.
- Exploration of the role of the intersectionality of adolescent's various identities (race/ethnicity, SES, religiosity, gender) on their bullying experiences and related outcomes

Clinical Recommendations

Clinicians working with Muslim adolescents can play a unique and crucial role in fostering the well-being of Muslim adolescents and helping these youth manage the negative effects of anti-Muslim discrimination. Clinicians should:

- Reflect on whether they hold biases or prejudices against Islam and Muslims, and how this may affect their work with Muslim youth, especially given the widespread prevalence of misinformation and negative perceptions.
- Attempt to learn and understand the American Muslim youth experience. They should in no way assume that by reading resources or attending trainings, they will be able to fully understand any individual American Muslim youth's lived experiences with discrimination.
- Provide a safe space for Muslim adolescents to relay their experiences of discrimination without minimizing or overemphasizing these experiences.
- Start any type of treatment with American Muslim youth by asking direct and indirect questions about these experiences, as some youth may feel uncomfortable bringing up the topic of discrimination or may feel that a clinician may not

be able to relate. Youth may be reluctant to share these experiences at the onset of treatment so this topic should be broached throughout treatment after rapport has been established.

- Work within one's individual scope of practice and expertise. If a clinician feels as though they cannot provide effective and culturally competent treatment for a Muslim adolescent client, then they should refer to another provider. This includes cases where a clinician's own biases and views on Islam and Muslims may impact treatment.
- Encourage culturally relevant resources and utilize them in treatment. Determine if religious coping, ethnic identity, and having a connection to one's religious or ethnic community can be utilized as assets in combating the negative effects of discrimination. This can be done by engaging in a discussion about the role of these potentially positive factors in the life of the adolescent and encouraging them to learn from authentic sources about their religious and ethnic heritage. *Note*: This must be approached in a delicate manner as youth are navigating both majority culture and their religious communities. In addition to youth feeling marginalization from the majority culture, they may also feel like outsiders in their own community, especially if they do not fit into what they perceive is acceptable in their religious circles.
- Consider encouraging Muslim youth clients to be involved in communal efforts toward eliminating discrimination and social justice in general. Clinicians can also themselves become involved in advocacy efforts to combat discrimination. Consider working outside the clinic or therapy room in systemic efforts to foster social justice.

Conclusion

American Muslim adolescents experience the process of *coming of age* in a divisive sociopolitical atmosphere characterized by bullying in various contexts (school, neighborhoods, social settings) and from both peers and adults. Although the pervasiveness of bullying places them at risk for poor outcomes, there are many protective and health-promoting factors that may buffer them from the impact of bullying—and more importantly, enable them to thrive in society. Any individual who works with American Muslim youth should strive to adopt therapeutic and preventive strategies targeted toward various areas of their lives to promote resilience.

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Children, Adolescents, and Islamophobia

27

Sana Younus and Ayesha I. Mian

Introduction

Islamophobia is an excessive fear of, or a prejudiced viewpoint towards Islam, Muslims and matters pertaining to them, which is characterized by hostility, ignorance, deep-rooted prejudice, and in some cases violence [1]. As a violation of fundamental principles of human rights, it may cause significant dysfunction both at an individual and societal level [2]. Since Islamophobia affects both Muslim and non-Muslim children in various ways, it is important to uncover its prevalence, etiology, and manifestations in order to propose potential solutions to this endemic condition [3].

Epidemiology

Schools are the most common platform for Islamophobia. Various surveys document that anti-Muslim incidents affect children in schools [4]: in a recent survey, 42% of Muslim parents reported bullying of their children in schools based on their religious affiliation, compared with 23% of Jewish and 20% of Protestant parents [5]. This is not just perpetrated by peers; one in four bullying incidents involving Muslim students have involved teachers and school officials [5].

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Etiology

Psychological theories that explain the development of Islamophobia range from the displacement of an intrapsychic conflict (psychodynamic models) to behavior that is learned (cognitive-behavior models) [6, 7]. Genetic factors play a role in specific phobias but are not well-established as relevant to Islamophobia. Social and geopolitical factors also have a major impact on the development of this phobia. Various historical theories have contributed to an understanding of the underlying causes of this social epidemic.

Below we describe these etiologies in detail.

Racial Identity Formation

The achievement of racial identity, like other developmental milestones, is an integral part of personality development. Each child goes through a personalized journey of learning. Many factors can hinder the optimal development of racial identity, leading to prejudice. Social scientists define prejudice as "an individual's attitude towards a group and its members based on faulty, inflexible generalizations that fail to appreciate differences among individual group members" [8]. The values and prejudices of adults in the child's immediate surrounding and in society play a significant role in shaping a child's values and belief system.

The development of prejudice in children has been described using a variety of paradigms. One uses Piaget's framework (see Table 27.1).

Some other theories which describe the etiology of prejudice are briefly discussed in Table 27.2.

Social Factors

Role of Significant Historical Events

The attack on the World Trade Center on September 11, 2001, brought Islamophobia into sharper focus. Adults and children were exposed to the traumatic experience through incessant news cycles and social discussions. This overnight change of perception about the "Muslims" was sudden and unexpected. The period following 11th September showed an increase in acts of aggression, changes in attitudes and opinions about Muslims, and attempts by parties, organizations, and movements to make political and electoral use of the fear of Islam [10]. This forced Muslim children and parents, sometimes in the face of considerable internal resistance, to adopt a new hybrid identity – i.e. "I am a Muslim, but I am not a terrorist."

Role of Media

Cartoons and animations are child-friendly platforms on electronic media. Negative stereotyping of Muslims is often seen in cartoons and animated movies by portraying Muslims as poor, thieving, or barbaric. Disney's popular movie "Aladdin" is one

Table 27.1 Developmental stages of racial identity and prejudice [6]

Age group	Stages	Characteristics	Racial identity	Prejudice
3–5-year-old	Pre-operational	Egocentric Matter-of-fact observations Personalized Difficulty understanding "being in a group"	No fully formed clear concepts of themselves or others	Exposure to racial discrimination is harmful at this age
5–8-year-old	Late pre-operational	Sociocentric Peer oriented Greater interest in cultural characteristics Sense of being in a group, with public expressions of their group cohesion An emerging concept of moral sense Develop pride in their identity and learn factual information about others	Awareness of racism against the individual is heightened Personal prejudice becomes an integral aspect of a child's attitudes and behavior	A common expression of personal racism at this age is racial name-calling
9–11-year-old	Operational	Begin to understand the concept of "ancestry" Achieve "reciprocity", i.e., understanding the interaction between individuality and group membership	Understanding of the various factors defining racial/cultural identity develops in this stage	A critical phase when racist attitudes and behavior can be consolidated Inaccurate information can be challenged and changed

example of such a prejudiced portrayal in which the original lyrics of the song "Arabian Nights" depict Muslims as cruel [11].

> From a faraway place,
> where the caravan camels roam,
> where they cut off your ear if they don't like your face.
> It's barbaric, but hey, it's home.

In other pictorial depictions, Muslims are often described in terms of the "3 Bs": billionaire, bomber, and belly dancer [12]. Even in recent years, movies like Iron Man 3 have portrayed Muslim women as oppressed [11].

The negative depictions of Muslims increased post 9/11 [13]. There is considerable evidence to show that people exposed to continuous representations of a certain theme start accepting them to be absolute facts. Even if the media is not purposefully propagating a negative image, insensitive reporting may increase this misperception.

Table 27.2 Other theories of prejudice [6, 7, 9]

Psychodynamic theory	Children in an environment that forcefully promotes submission to authority need to release their aggressive impulses. Due to suppression of their aggressive impulses against authority figures, children are thought to displace their anger onto people who are labeled by authority figures as different (racial or ethnic minorities in certain contexts)
Social learning theory	Children mimic, and then come to believe, what they are exposed to in their environments. If prejudice is in their environment, that is what they learn
Intergroup contact theory	Prejudice is a product of a lack of personal, positive contact among members of different groups
Cognitive developmental theory	Prejudice is inevitable among young children because they lack the skills necessary to view people as individuals. Children tend to focus on surface features and exaggerate differences between groups
Lay theories	Lay theories are often captured in everyday sayings, such as “A leopard never changes its spots”
	For example, children who believe that people can change harbor less prejudice and are more willing to help disadvantaged others than children who hold the lay theory that people cannot change their ways
Evolutionary theory	The roots of prejudice may have begun in hunter-gatherer tribes who showed favoritism towards some and not all of their group members. This may have fulfilled the purpose of favored gene transmission to successive generations
Integrated threat theory	Prejudice is the result of both realistic and symbolic threats. Realistic threats are tangible economic, political, physical, or material threats to a group, whereas symbolic threats are more intangible challenges to a group’s worldview, morality, and culture. One source of Islamophobia may be the perceived threat of the religious/cultural group to people’s tangible and intangible values
Self-categorization theory	Categorizing people based on social groups leads to an emphasis on intragroup similarities and intergroup differences, with a negative view of the other considered to be less powerful or dominant. This generates the phenomenon of “us” versus “them”

These negative views are transferred to children and adolescents through direct readership/viewership, dinner table discussions, and discussions at school. Adults are often not comfortable answering difficult questions that children may have, leaving them vulnerable to unintentionally acquired perceptions.

Clinical Manifestations

As enumerated above, children and adolescents exist, develop, and function in the context of their immediate and external context. Similarly, clinical behaviors and symptoms of Islamophobia manifest differently depending on the context. For the purpose of our understanding here, we will stratify their environments based on the ecological model of development suggested by Bronfenbrenner in 1979 [14], marked by the layers of microsystems, mesosystems, exosystems, and macrosystems. The microsystem consists of interactions between a child and his/her immediate

environment like school or home. The mesosystem consists of a relationship between two or more relevant settings and the developing child. The exosystem includes societal structures like neighborhoods and governments. Finally, the macrosystem consists of political and historical aspects of social ecology, beliefs, and customs [15].

The cases below will use theories of both development and ecosystems to explain the etiology, manifestations, and approach to prejudice that may be used in these specific contexts.

Case 1

Amna is a 15-year-old girl who was born and brought up in the USA by a Muslim family. Her parents migrated to the USA from Pakistan 20 years ago and are naturalized citizens. Amna visits her extended family in Pakistan every couple of years. She considers herself an American Muslim. Her parents have strong ties with the Muslim community in the neighborhood and frequently visit the local mosque for prayers and other religious activities.

Amna grew up in an environment which promoted "otherness" from a very early age. She used to bring lunch from home as she was not allowed to eat non-halal food at school. Her parents regularly reminded her that food can be shared with Muslim friends but not with "others." She was expected to take a shower on returning home to clean herself because of the unavailability of water in the school restrooms. Her parents told her that "others" could use toilet paper but not "us." She was encouraged to make same gender Muslim friends and would only visit *them* as playdates. She was friendly with "others" but with restrictions. Her parents believed in staying united with the Muslim community especially after 9/11. "Due to the wrongdoings of some so-called Muslims, the entire community is blamed and scrutinized," they told her frequently. They encouraged her to speak English at all times when in public as "we don't want to make them suspicious."

On approaching adolescence, Amna had many questions about these restrictions. She couldn't understand her parents' resistance towards mingling with "others." She blamed them for her not being able to make many friends in school. She also blamed them for her not being on the gymnastics team due to the dress code. She blamed them for making her "different" from the others. Simultaneously though, she failed to understand why the First Amendment and freedom of expression did not apply for her. She questioned why she was not accepted for who she was by everyone, why the school wouldn't allow her flexibility in dress code for the gymnastics class, and why each new teacher at the beginning of school year asked her where she was from even though she was as American as the rest of her class. Her parents wanted her to start wearing a head scarf but she wasn't ready to add another "difference."

Amna's racial identity began to form as early as Piaget's pre-operational stage from the time she joined school and her lunch was different from that of "others." This continued into late pre-operational and operational stages when her friends' circle was defined by her religion.

From an ecological perspective, Amna's relationships were significantly affected at multiple levels. Her microsystem, which included her school, was influenced as Amna was unable to develop a healthy interaction with her peers due to social differences. She did not "fit in" with the peer group, leading to social isolation. Her peers were also unable to develop a connection with her due to these differences. This distance not only compromised daily interaction between Amna and her peers but also made Amna vulnerable to bullying. At home, Amna blamed her parents for creating these boundaries and also blamed them for her social isolation. Her parents' inability to understand her conflictual situation made them believe that she is being recalcitrant, which led to stricter restrictions being imposed on her.

At the level of her mesosystem, her relationship with her neighbors and society in general (part of the exosystem) were also affected, reflected in her discomfort speaking her native language in public, and praying in public places.

Amna's case brings to light the importance of strategic measures in preventing the development of Islamophobia in children and adolescents. Educational, judicial, and public relations-based strategies later discussed in detail can prove vital in the prevention of Islamophobia.

Working with Amna would require inclusion of her parents and the school. It would be essential to initiate conversations with parents about their perception of the problem. Similarly it would be important to discuss the impact of Islamophobia on Amna. Parents may not be aware of the gravity of the situation and initiating a family dialogue would be a crucial step in aiding Amna with this struggle. It is essential that these conversations are kept open, nonjudgmental, and unbiased, approaching them in a culturally informed and sensitive manner. It would also be important to watch for conflicts arising within the family unit and addressing them using the principles of family therapy to ensure and facilitate communication. As an adolescent, Amna could initiate similar dialogues at school platforms like debates, class presentations, and social projects. An important role of the clinician would be to guide her in approaching these initiatives in a non-threatening and nondefensive manner so as to promote objectivity and a safe space for all viewpoints.

Case 2

Adam is a 16-year-old boy who was born and brought up in Australia by Muslim parents of Turkish origin. Adam's parents migrated around 18 years ago for better work-related opportunities. His parents have maintained limited interaction with the Turkish and Muslim communities in the neighborhood. Their only visit to the local mosque is at the time of "Eid," a biannual religious event. They introduce themselves using their nicknames which don't sound Muslim or Turkish. They are very active in the neighborhood which is predominantly "white" and take part in all local cultural activities and festivities in town.

Growing up, religion was not central in Adam's household. He knew he was a Muslim, but there were no restrictions on Adam based on religious observances. He was very well adjusted in his surroundings and his school. In discussions about events related to Muslims in the media, Muslims who initiated trouble were

considered to be "others," and their miscreant activities frowned upon. Adam was going through the usual adolescent identity-related conflicts.

The situation changed after a terrorist attack in which the terrorist was identified as a Muslim of Turkish origin. Adam went to the school the next day and felt some uneasiness among his friends. He couldn't identify the reason till he found "terrorist" painted on his locker at home time. Adam was shocked by this event. He went home in a disturbed state but couldn't tell his parents about the incident. He questioned why his parents denied their identity and whether that was for better or worse. He also questioned why his friends did not want to be associated with him anymore and why they became uncomfortable with his presence. He started questioning his identity – whether he was Turkish, Australian, or Muslim – and struggled with reasons for being blamed for an incident which had nothing to do with him. He questioned his own hypocrisy as to why it was okay for him to stereotype and judge other Muslims but did not want his friends to stereotype him based on his ancestry. He was deeply disturbed by the conflict and started being truant. His parents were concerned but Adam would not share his consternation with them. This continued for a couple of weeks until his parents decided to take him to a therapist.

Before the incident, Adam identified himself as "other" despite having a Muslim background. He did not face any conflicts associated with being a Muslim, but we can hypothesize that his racial identity formation was also affected leading to prejudice against Muslims. We do not find any evidence of development of prejudice in the early and late pre-operational stages, but in the operational stage and later, Adam became prejudiced against Muslims and became involved in bullying Muslim kids in school. A similar phenomenon can occur in non-Muslim children who develop prejudice against Muslims in their developmental years.

After the incident, the categorization of "us versus them" became prominent, pushing Adam to the opposite side due to his Muslim characteristics. For Adam, the disruption at the level of the macrosytem had a ripple effect on all the levels underneath including exosystem, mesosystem, and microsystem. Due to the terror attack, political and historical beliefs about Muslims resurfaced, with a grave impact on Adam. His neighborhood became hypervigilant about Muslims and "Muslim looking" individuals as the government started taking stricter measures related to security. His schools and peers started overtly wondering about his demographics, including his country of origin, his parents' occupation, and his religious affiliations. Adam started feeling isolated, feared expressing his opinion among peers, felt betrayed by his fellow mates, and was bullied by other pupils. His relationship with his family was compromised as a result of this, leading to fragmentation at the level of microsystem.

In working with both Amna and Adam, a clinician would need to focus on the developmental stage of the adolescent, including elements of race, identity, morality, and nationality. Where adults may have stable and fixed notions of belonging to certain groups, children and young adults are still trying to negotiate their ecosystem, and their rightful place in it; being "in" or "out" of their peer groups is of paramount significance to them. By contrast to their work with adults, a clinician must address these concerns and conflicts with adolescents, giving them space and permission to express themselves in relation to opposing viewpoints and stances. Management

must focus on all system levels; parents and schools must be the center point in treatment plans. Focused family therapy would address open communication around fears, intergenerational conflicts, and pragmatic ways of reaching consensus. A clinician must work towards confidence building of the adolescent so as to empower her/him in responding to situations at the school, neighborhood, and beyond.

For children to cope with challenging circumstances, attachment to at least one caring adult is critically important [16, 17, 18]. A study from World War II concluded that separation from family caused a greater strain among children than air strikes [19]. This highlights the importance of a comforting relationship between a developing child and a caregiver when dealing with a stressor like Islamophobia. From an ecological perspective, conflict at the level of microsystem can cause emotional and social strain which may lead to social isolation, behavioral issues, and poorer mental health outcomes.

Other outcomes of an impaired relationship with the environment at various levels which may contribute to the development of low self-esteem in children and adolescents include [20]:

- Bullying, racial comments, and acts of violence
- Microaggression in daily life encounters
- Restriction of freedom of religious expression
- Discrimination in educational provisions
- Targeted security surveillance
- Travel bans
- Discrimination in legal proceedings
- Health disparities

As a result of these factors and outcomes, Muslim children may begin to feel discriminated against, marginalized, and alienated from society and may believe that they are under constant scrutiny and surveillance [21, 22].

Adolescents are in the process of building their identity and as such face challenges unique to their age group. This is true for Muslim adolescents as well, who are equally influenced by their environment. They may face conflicts about their identity and may find it difficult to adjust to their surroundings. They may struggle internally about their religious beliefs and externally about the expression of religion. Exposure to Islamophobic acts and attitudes puts adolescents at a greater risk of developing lack of self-esteem, self-confidence, and a sense of belonging. Hence, additional dilemmas around their religious identity can have cumulative and long-term effects extending into their adult lives.

Effect on Mental Health

Much of the research on the mental health of Muslim adolescents points to the effect of Islamophobia on identity development. While growing up, Muslim adolescents can develop "hyphenated" identities, attempting to balance their Muslim and American identity [23]. This hyphenated identity was shown to be different for

Muslim boys and girls. In one study, 90% of girls showed fluidity between their Muslim and American identity, whereas 70% of boys showed "fractured" identities, highlighting the conflicts and struggles related to discrimination and stigmatization [23]. This conflict plays out with peers, teachers, and school systems leading to negative outcomes. Rates of bullying were seen in as many as 50% of students in one study in which participants reported incidents of name-calling in the presence of teachers, staff, and administrators. Rates of discrimination were reported to be as high as 80% in Muslim students [24].

Data on mental health disorders in children exposed to Islamophobia is very limited. One study reports lower level of psychological distress in Muslim adolescents as compared to other religious groups, though the study has limitations [25]. One can hypothesize that conflicts related to religious identity and poor self-esteem act as predisposing factors in the development of mental health disorders in adult life. This gap in literature also points towards the need for future research in this area [26, 27, 28].

Management

The detailed etiological framework described above highlights how the perceived threat associated with Islam shapes the thoughts, actions, and behaviors of our population. Each of these management strategies proposed here includes a myriad of aspects and would require a collective effort to achieve them.

Educational Strategies

Some educational strategies which can play a vital role in managing the Islamophobia include:

- Integration of multicultural, human rights, inter-religious, and anti-racist teaching into the basic academic curricula
- Education and empowerment of young people about critical evaluation of prejudice in the media
- Promotion of nonsectarian religious education
- Organization of theme days in schools about different religions
- Training of administrators and teachers on issues related to minority communities

Strategies for Local Authorities

Local authorities can be an integral part of dealing with the crisis related to Islamophobia. Some measures which can be taken by these authorities include:

- Development and initiation of international intercultural and inter-religious youth exchange programs

- Collaboration with schools/educational systems in promoting programs for prevention of Islamophobia and related discrimination
- Encouragement and helping local minority population to exercise their rights
- Creating alternative media or media control to counterbalance the negative impact of media

Strategies Related to the Judicial System

Support from the judicial system is vital for the implementation of abovementioned strategies. Judicial systems can also help by:

- Taking strict measures against hate crime
- Endorsing the knowledge and application of rights of minorities
- Monitoring the implementation of laws supporting minorities

Strategies for Public Relations and Policy Making

Policy makers are also an integral partner for holistic management of Islamophobia. Some of the strategies from a public relations perspective include:

- Development of strong and clear sanctions on all levels against employers for discrimination
- Empowerment of the population with the necessary tools to fight all forms of discrimination/intolerance/disrespect
- Organization of public awareness campaigns
- Adoption or enforcement of existing legal frameworks for combating discrimination on religious grounds
- Providing information to minority communities about existing legal tools and mechanisms protecting their human rights, particularly the right to free practice and expression of religion
- Ensuring and protecting the right of all children and young people to education
- Involving youth in political decision-making including those with minority backgrounds and religions
- Promotion of inter-faith dialogue
- Creating opportunities of religious/Muslim communities at the national level
- Implementation of strict ban on anti-Muslim/Islamophobic content in political election campaigns
- Establishing representative religious councils to examine relevant national policies
- Increasing the participation of minority leaders in political and governmental institutions

Here we demonstrate an example of how one school used educational strategies to manage Islamophobia. The Tanenbaum Center for Interreligious Understanding's Religion and Diversity Education program developed a curriculum to address Islamophobia in classroom [29]. The curriculum confronted Islamophobia in schools by teaching students concrete skills for living in a pluralistic and democratic society. The curriculum was designed and implemented in a developmentally appropriate manner, and the content was integrated into the academic program. It also trained teachers to effectively implement the curriculum in classrooms.

The Role of Clinicians

Clinicians can and must play a role in helping individuals exposed to Islamophobia. It is important for clinicians to inform themselves of the specific issues that a Muslim child may face during normal development. These must be addressed regardless of whether the issues are brought up by the patient or family.

Children and adolescents come across many milestones while growing up, such as the transition from elementary to middle to high school, going to the first prom, and engaging in romantic relationships and breakups. Similarly, the development of racial identity and the development of prejudices such as Islamophobia are important milestones in the lives of children and adolescents. Hence it is very important for clinicians to feel comfortable in asking patients and families about these developments and to provide safe environments for discussion of such issues arise in order to provide culturally sensitive care.

The Council on American-Islamic Relations (CAIR) has developed a guide for healthcare providers about Islamic religious practices which can help clinicians understand the Muslim practices pertinent to healthcare. Guides like these educate clinicians about practices like fasting, dietary requirements, clothing, touching, birth, circumcision, abortion, death, suicide, euthanasia, and other medical procedures [30]. The knowledge contained in these guides can help the clinician to approach a Muslim patient in a culturally informed manner. Some examples of questions which can be asked in the clinical setting to gauge the beliefs of a Muslim youth include [31]:

- How can I help you to be comfortable during this procedure?
- Are you fasting today? (If during the month of Ramadan, which is now marked on many European and American calendars). If so, do you wish to defer your blood work or vaccines until after your fast?
- Would you prefer speaking with me in your parents' absence? (Especially when inquiring about substance use or sexual activity, children and adolescents may not be comfortable in speaking about these in front of their parents.)

The Role of Parents

Parents have an important role in dealing with Islamophobia to which their children may be exposed. This can be extremely challenging for parents, who may already be facing difficulties with acculturation. In order to help their children, it is vital for parents to understand their own conflicts; to reflect upon their thoughts, behaviors, and actions related to Islamophobia; and to alter them if needed and possible. This can be a challenging task, but it is crucial to acknowledge it with children in a developmentally appropriate manner. As with other conversations with children, it is necessary to remain honest and empathetic, to provide necessary information, and to leave room for later questions.

While actively working on measures to manage Islamophobia, it is also important to give equal attention to building resilience in this population. Three important factors which lead to the development of resilience are (1) attributes of the individual child, (2) attributes of a child's family, and (3) characteristics of the larger social environment [32]. A study on children exposed to war trauma reported that these attributes promoted children's resiliency, sense of the future, hope and growth, and a connection to morality [33]. An important attribute of child's family which helps development of resiliency is the mental health condition of caregivers. Healthy parents or caregivers of children can act as a protective shield during adversity [34, 35]. Thus parents or caregivers' mental health can be a predictor for a child's mental health. Neighborhood and mentors within the community are also important components of a social environment which can sustain resilience [36].

Conclusion

Martin Niemoller once said [37],

> They first came for the communists; I did not speak because I was not a communist. Then they came for the Jews; I did not speak because I was not a Jew. Then they came to fetch the workers, members of trade unions; I was not a trade unionist. Afterward, they came for the Catholics; I did not say anything because I was a Protestant. Eventually they came for me, and there was no-one left to speak.

As a part of the International Bill of Rights, children and adolescents have a right to grow in a secure environment and a right to believe in the future. Islamophobia is a violation of human rights and a risk to social integrity. It is a global crisis affecting people from all walks of life, including children. Hence it is important to manage this situation by taking explicit measures on individual, familial, organizational, and societal levels. If not managed timely, it can have grave psychosocial consequences.

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28 Caring for Muslim Refugees

Omar Reda, Sara Maklad, and Rania Awaad

Introduction

The day Hasan received a call informing him that he was selected to resettle in the USA, he thought that fate had smiled upon him at last.

After fleeing the Syrian war and spending 4 long years in a refugee camp in Turkey, Hasan couldn't wait to start a new life in a country he believed would be a safe haven for his family. Little did he know that his destiny was to die of brain cancer 5 days after arriving in the USA.

Given his sudden and unexpected death, the resettlement agency handling his case would have been at a loss if it weren't for the Portland Refugee Support Group (PRSG), an organization led by five Muslim women. PRSG intervened, providing access to proper Islamic washing and burial for Hasan and support to his wife, Laila, through this difficult time.

As a young, traumatized, and grieving widow, Laila felt isolated because she knew nothing about her new home's language, culture, or traditions. She never expected to escape the horrors of an ugly war in her hometown of Aleppo only to find herself raising five children alone; seemingly running toward safety and finally arriving there, only to discover that it did not feel very safe after all. The outcome

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for Hasan's family and that of many others would have been very different had PRSG and similar refugee-specific organizations not exist.

Refugee Trauma

Immigration can leave people feeling alienated and alien, even if their stories are not as traumatic as Hasan and Laila's story. Acculturation has been defined as the change of culture that takes place when groups of individuals from different cultures come into continuous, firsthand contact with each other [1]. Psychological acculturation was later defined by Graves as changes in the individual whose cultural group is collectively experiencing acculturation. These changes can be noticed in five aspects:

- First is the physical change that can be attributed to effects of the new environment such as the type of accommodation, the level of pollution, and population density [2].
- Second, biological changes may occur in the form of a new nutritional status or new diseases [2].
- Third, the cultural changes that occur in the form of a change of political, economic, and social, and systems [2]. Leaving home is a very difficult decision to make even when one's life is at stake, and as such, it carries a very heavy emotional, financial, and even spiritual burden that can have far-reaching consequences. One of the existential themes found in narratives and stories of immigrants and refugees is that some tend to be torn as to what is considered "home," while others think that they need to relinquish certain aspects of their cultural or religious identity in order to integrate into the fabric of the host country, whereas others abandon these ties altogether.
- The fourth category of change refers to new sets of social relationships that may become established in the new environment [2].
- Finally, there are behavioral changes, and an alteration in mental health status that almost always occur as individuals try to adjust to their new milieu [2]. Escobar proposed that the risk for psychological maladjustment may increase as a result of exposure to acculturative stressors, and/or the loss of protective social resources (e.g., strong family relations, cultural values, and social networks) [3]. Finding safe havens is not the end of the journey for refugees. For many, it is the first chapter in a long storybook of trauma.

Acculturative stress is a term that describes the state brought upon the individual as a result of the acculturative process [2]. This form of stress has been found to be associated with a decrease in the health status of individuals. It encompasses physical, psychological, and social aspects. Lowered mental health status is usually observed, along with feelings of marginalization and alienation, heightened psychosomatic symptom level, and identity confusion [2].

Immigrants, especially refugees, face multiple challenges before, during, and even after their migration. And while migration represents salvation from war, poverty, and terror, or in the least, a new start with better opportunities, it can cause psychological distress that can be a prelude to psychopathology. The prospective effect of immigration on the mental health of a refugee is somewhat inevitable, but a number of moderating factors govern the relationship between acculturation and stress. They were identified by Berry et al. to be the nature of the acculturating society, the type of acculturating group, the mode of acculturation being experienced, and a number of demographic, social, and psychological characteristics of the individual [2].

It is important to keep in mind the difference between an immigrant and a refugee. They share the experience of leaving their homeland. However, the circumstances surrounding their immigration, their experience of acculturation, and their psychosocial profiles are very different. Immigrants leave their homeland of their own volition. They are usually driven by economic factors or the need to move closer to family and the decision to leave is, to some extent, well contemplated. On the other hand, refugees flee their homes out of fear or necessity. Reasons include but are not limited to natural disasters, war, and prosecution due to race, religion, or membership in certain political or social groups. Most of the time, refugees do not get to choose the country to which they relocate. Moreover, they do not relocate directly to that country, but first seek asylum in countries that border their own. They live in widely varying conditions, from well-established camps and collective centers to makeshift shelters or living in the open. Stories about refugee camps are usually ones of pain and terror.

Just arriving at the shores of a safe land can be a traumatic event, as it severs the ties of kinship and deprives survivors of their psychosocial support networks back home. Although the digital age makes it possible for families that have been torn apart to remain in communication, this can never replace the power of actual contact with loved ones. Immigrants and refugees lose the support systems they leave behind and generally experience adversity in the new culture in which find themselves situated. On top of that, according to the moderating factors identified above, the nature of the host society can intensify this experience of adversity.

Research suggests that mental health problems may be less among immigrants in pluralistic societies than in assimilationistic ones [3]. While the USA and Europe have always prided themselves on being multicultural societies, many would argue that a tone of intolerance has recently been sweeping across the USA and Europe.

Several studies have shown that migrants who fled from war and persecution in their home countries reported high rates of pre-migration trauma and high frequencies of trauma-related mental health problems. PTSD and depression appeared as the most common mental conditions in these populations [4, 5]. Even though most refugees eventually adjust to their new communities after displacement, they are reported to have high rates of pre-migration trauma and trauma-related mental health problems [6–9]. Compulsory migration leaves most with “invisible wounds” that need to heal to prevent future intrapsychic, interpersonal dysfunction and transgenerational transmission of the traumatic experience.

The Muslim Refugee

While episodes of forced migration are not new to the Middle East, the past couple of decades have witnessed a tremendous increase in the refugee crisis. The wars in Syria and Iraq contribute most to the refugee crisis in the Middle East. In 2018, the UNHCR reported that the total number of registered Syrian refugees is approximately 5.5 million. Many more refugees and asylum-seekers flee terrorism, war, and failed states in Yemen, Libya, Sudan, Somalia, Burma, and Afghanistan. These people flee the very vitriolic ideologies with which some people in the host countries associate them.

The experience of living in an over-crowded and squalid refugee camp where privacy hardly exists is a universally painful experience. This experience is exceptionally hard on Muslims to whom modesty and privacy are highly regarded virtues. Conservative families where genders do not mix can struggle with the conditions of the camp, leading to despair and pressure to look for any immediately available alternative.

Seeking refuge in a non-Muslim majority land brings other dynamics into play. Refugees sometimes have nowhere to worship, gather, or educate their children. Hence, they may feel threatened and decide to withdraw or isolate themselves. For others, fear could be expressed externally as a lashing out and aggression toward the new system that tries to understand and help them. The walls of isolation are sometimes erected by the very people who are most in need of the camaraderie with which a cohesive community can support its members.

After arriving in the host country, resettlement agencies try their best to help refugees with the limited resources at their disposal. However, most caseworkers are overwhelmed with heavy caseloads. In addition, the timeline set for refugees to master the language and find jobs is often unrealistic, leaving families feeling disappointed and abandoned by the very systems created to empower them.

Another observation that we have made while working with trauma survivors who have recently arrived in their host countries is that they tend to view people who are trying to help them through a lens of suspicion. This is not surprising since many of these people were taken advantage of during their immigration journey while they were at their most vulnerable point by the very agencies whom they were supposed to fully trust. Other factors contributing to this suspicion include people, neighbors, and coworkers who believe that refugees have to “assimilate” to their host country’s cultures and customs – which adds to the everyday stresses with which refugees have to deal.

Some refugees do not want to carry the label of being a refugee and prefer that it not be a part of their permanent identity. Others feel that such label constantly reminds them of their painful past. As a result, some may act aggressively toward uninvited interventions that seem intrusive and threatening to their identity and privacy and as a result turn away from good-intended suggestions and invitations.

In the case of Muslim refugees, one might ask whom can they trust in a world where Islamophobia is rife. Under the current sociopolitical climate, Muslims face increased scrutiny and backlash even if they are born and raised in the West. It is

understandable how difficult it is to be a newcomer from a war-torn country where groups like ISIS operate. Islamophobic hate crimes and discrimination against Muslims, regardless of immigration status, have made refugees relocated to the West even more fearful, isolative, and suspicious of members of their host country.

Refugee Youth

Questioning one's faith is a difficult moral dilemma for Muslims. Allah is regarded by Muslims as a loving and compassionate God. However, living in these trying times of continuous global massacres which at times are done in the name of their religion, it is only expected that some believers will question their faith or even deviate from the path of religion. This is even more prevalent in those who witnessed firsthand violence and displacement in the name of religion, of which refugee youth have been primary witnesses.

The way to win the hearts and minds of troubled youth and sway them away from dangerous ideologies is to involve and empower them – in other words, to make them part of the solution rather than only part of the problem. This can be done through comprehensive programs that at a minimum should address their physical and emotional safety and fulfill their basic needs of having a voice, freedom, housing, education, and decent living. Through linking youth to compassionate systems of education, health, and social care, we can use early prevention rather than late intervention avenues to guide them back to the path for which they were created, to worship God, serve His creation, and make the world a better place [10, 11]. Young refugees should never feel unwelcome or marginalized. Youth can draw strength from their culture while also utilizing the newly available resources of the host country. To be multicultural should be viewed as an advantage rather than a disability, and diversity is to be celebrated.

Caring for the Muslim Refugees

According to the United Nations High Commissioner for Refugees [UNHCR], rates of forced displacements due to political conflict and war around the world are at the highest levels since World War II [12].

Therefore, currently established therapeutic approaches must be considered judiciously lest they not be culturally congruent and relevant to current refugee populations. Psychological assessments should also be given the same due consideration. For decades, researchers have faced challenges in developing reliable, appropriately normed tests for use with culturally diverse populations of refugees. This is one of the hypothesized reasons implicated with underreporting the mental health needs of refugees [13, 14]. Other implicated factors include the possibility of confounding variables that might explain the cognitive deficits observed in some refugees. For example, physical illnesses such as malnutrition and head trauma have both been cited as potential causes [14, 15]. The lack of established trust between refugees and

mental health professionals is yet another reason that can lead to the disruption of the mental health assessment and intervention process. In protracted conflict situations like those in the Middle East and now involving the Rohingya, distress is also mediated by political and religious convictions, cultural beliefs, social circumstances, and previous experiences with adversity – not simply by the distressing events themselves. Therefore, it is recommended that the assessment process is broadened to include psychoeducational assessment, neuropsychological testing, and cognitive assessment [14].

Therapists need to understand the ways by which to acknowledge and validate the trauma experienced by refugees. Through culturally congruent interventions, they can help refugees search for meaning, purpose, and dignity in their painful ordeals so that they can make amends, work toward forgiveness, and eventually find closure. The focus should also be on making sure that their basic needs are met and that they feel safe in the here and now.

In choosing an approach to therapy, a delicate balance needs to be established. An intervention that focuses on the present while avoiding past trauma may exacerbate the dissociation symptoms and intrusive memories, while an approach that explores the trauma prematurely may worsen rather than relieve affective and somatic symptoms. Mental health professionals working with refugees naturally tend to focus on the "trauma story," often at the expense of the resilience that allowed these refugees to survive. This approach results in their strengths being overshadowed by a "deficit model" that depicts refugees as traumatized victims. Alternatively, a strength-based perspective draws on the "power" within the client and sees the client as an expert on his or her current situation [16].

Professor Richard Mollica, founder of the Harvard Program for Refugee Trauma (HPRT), reminds therapists to focus not only on the brutal details of the trauma story but also on the cultural context, the "behind the curtain" unspoken words, and the listener-storyteller relationship. He views healing as a shared empathic partnership between two people working together in a community to create a new worldview and suggests that healing occurs when the trauma survivors believe they can become whole again. In his 5H Model, Dr. Mollica indicates that the human connection breaks down walls of shame and humiliation and that such connection can bring joy not only to the client. As such, the therapist should not only absorb the trauma but the beauty of the client's culture, strength, and resiliency [17].

As many Muslim refugees hail from collectivist cultures, it is common for family members to want to be involved in the therapy process. While this may seem intrusive and enmeshed for therapists trained in Western modalities that share the vantage point of individualistic culture, welcoming a patient's family to partake in sessions, with the patient's permission, can go a long way to building rapport. Although different from the typical therapy process where the focus is primarily on the individual, this family therapy approach can be healing, so long as the patient's privacy and confidentiality are respected.

Disconnection from home is of great concern to those leaving loved ones behind, and refugees leave a piece of their heart behind when they flee their countries. It was vital for PRSG to petition to bring Laila's sister to the USA. They now live together.

The important role of family support cannot be underestimated when it comes to assisting Muslim refugees.

Trauma shatters the survivor's core beliefs that the world is a safe place in which to live and that people can be trusted. In the aftermath of trauma, it is therefore vital to help survivors recover that sense of safety and establish routines and structure that can help them feel empowered to regain greater control of their lives. Pointing survivors to their inner strengths and the available psychosocial resources in their community is of utmost importance. Ultimately, psychological recovery comes from improvements in their overall circumstances (political, economic, and societal) and from the meanings people find in their lives and not simply from resolving their traumatic stories. Altruism, work, school, and spirituality seem to be powerful social instruments of healing [16].

Psychotherapeutic skills that can be useful when counseling refugees include active listening, employing a calm and nonjudgmental approach, building trust and establishing rapport, purveying empathy and compassion, teaching coping skills and grounding techniques, and assessing risky behaviors including the use of alcohol and drugs which can trigger thoughts of harm to self and/or others and even precipitate suicidal and/or homicidal ideation or behavior.

Therapists have responsibilities toward the refugees they are treating. These responsibilities include keeping the patient's privacy and confidentiality, empowering the patient by making them part of the solution, and building a therapist/patient relationship based on honesty, consistency, and reliability. Therapists should also work to give gentle guidance about the host way of life, while giving the heritage of their patients' due respect. Additionally, they should work on ensuring the effectiveness of the treatment and continuous follow-up. Frequent, shorter checkups can be more effective than classic once-weekly therapy sessions. Working with refugees requires patience, and it serves the therapist well to know that a little means a lot, over a long period of time.

It is also important to note that working with refugees can introduce strong emotions into the therapeutic space. Some Muslim refugees would rather work with a non-Muslim clinician due to concerns of stigma and privacy, especially when dealing with sensitive and "shameful" issues like sexual violence or drug use. Therapists need to know their own boundaries and address their personal countertransference, especially if they themselves have a traumatic background. It is perfectly acceptable in these cases to ask for consultation, supervision, or even refer the client to another provider.

Likewise, transference from a Muslim refugee toward a Muslim clinician may be both useful and problematic. A potential downside of matching patient and therapist based on language, faith, or ethnic background is assumed overfamiliarity. It is important that therapists do not fall into the trap of assuming they understand what a patient meant because of shared beliefs or colloquial idioms used by the patient. Rather, they should inquire with respect and curiosity to ensure they fully understood what the patient meant.

Another important point to consider in caring for refugees is provider burnout and compassion fatigue. This is a real concern when working with survivors of

human violence and listening to their trauma stories. It is of utmost importance that care providers engage in consistent self-care. This is especially true for therapists who may come from the same country of origin or same faith background as the trauma survivor and who feel a sense of "survivor's guilt" that compels them to give all they can – sometimes at the expense of their own well-being.

There is also the problem of mental health stigma. As with many cultures, mental health stigma is a problem that is still deeply rooted within Muslim communities residing in Western countries [18]. Coupled with the problem of mistrust of Western psychology, this problem results in many Muslims suffering in silence, leaving a trail of pain and damage in their families and larger communities [16]. There are also a number of cultural beliefs about mental health that can deter people from seeking help for their mental health struggles. Examples include viewing mental illness as a sign of weak faith, a result of "the evil eye," an act of Jinn or black magic, or a punishment from God. These beliefs may affect the help-seeking attitudes of Muslims. Despite the severity of their symptoms, many Muslims first seek help from traditional healers and local imams before consulting a mental health professional. We can work to build trust by using psychoeducation, to normalize and humanize mental illness by comparing it with physical disorders, and to emphasize confidentiality which can strengthen the patient-therapist relationship. In addition, the Harvard Program in Refugee Trauma (HPRT) recommends using less jargon and more "benign" terms like categories of emotional distress and pathways to healing [19]. Therefore, culturally congruent psychoeducation is a much-needed service for Muslim patients. It is important for members of minority communities to be empowered in order to overcome stigma and change their help-seeking attitudes. Psychoeducation is a particularly important part of the therapy process in the aftermath of disasters. Survivors need to know that most of the symptoms they experience are a normal response to an abnormal situation. This is succinctly described by Philip K. Dick in his famous quote, "It is sometimes an appropriate response to reality to go insane."

One such example of culturally congruent psychoeducation efforts is the Oregon Muslim Medical Association (OMMA). OMMA inaugurated its Muslim mental health clinic in April of 2015 with a focus on psychoeducation in addition to clinical interventions. OMMA helped break barriers and address taboos associated with trauma-related anxiety, post-traumatic stress disorder (PTSD), depression, and drug use among their local refugee community. Similar psychoeducation and support efforts have been conducted by other organizations around the USA such as the Syrian Community Network in Chicago, IL. International efforts to assist the psychoeducational efforts of refugees include the train the trainers projects conducted by the Care Program for Refugees via the Alalusi Foundation in San Francisco Bay Area, CA. This team of psychiatrists, psychologists, and educators travel semiannually to areas of the Middle East with high populations of refugees in order to train those who work with and care for refugees on how to provide culturally congruent psychoeducation. The common thread in all of these important projects is that when listened to, refugees feel validated as part of the solution.

A sense of community is paramount to healing. It is not only therapists who help trauma survivors heal. Making the human connection, establishing rapport, and building bridges can be quite impactful. Humanity has no language. In the words of Queen Rania of Jordan, "The voice of the human heart needs no translation."

Humanizing Refugees

Empathy is defined as the ability to share feelings with other humans. It is the ability of human beings to melt the boundaries between them, recognize their feelings, and connect with one another on an emotional level. It is the ability of an individual to suffer because of another's suffering and rejoice for the happiness of the other. Human beings are by nature empathetic toward each other. When humans do not feel the suffering of other human beings or actually cause their suffering, this usually stems from not perceiving other people as fellow humans. It is not news that faceless statistics about the horrifying numbers of refugees don't beget the expected sympathy from people, especially in the West. People everywhere, especially in the West have been constantly bombarded by graphic pictures of bodies of refugees that have washed up on European shores. At the same time, they are subject to constant fear mongering and spreading of exaggerated rumors about the impending danger the influx of these refugees will bring to the Western world.

Winning over the public opinion is needed to save the lives of refugees. No longer being labeled as "the other" will help to alleviate their difficulties in relocating to their host countries. Humanizing these refugees would be the first step to accomplishing this goal. To this end, their names must be told, and their stories must be narrated to understand the amount of pain and suffering they have been through.

Conclusion

Our message to therapists working with this population is the following: though the work is draining and emotionally exhausting, it is rewarding in equal measure. It is important that we do not judge or assume. We should know that people can be anywhere along the spectrum of Islamic practice and spirituality. We should educate ourselves about and remain mindful of the widespread discrimination and the rampant rise of Islamophobia. We should be careful not to dismiss or propagate it. We should not psychopathologize human emotions. We should not take away hope or preach despair. And we should not dismiss internal resources, but rather use a strength-based approach that integrates rather than alienates refugees from their existing support system.

There is an unfortunate new trend in America to alienate and dehumanize newcomers, especially those coming from a Muslim background. The first executive order President Donald Trump passed when he assumed office was a travel ban, commonly referred to as the "Muslim Ban," to limit citizens of seven predominantly Muslim countries from entering the USA. Concurrently, there has been a sharp rise

in anti-Muslim hate crimes and violent incidents; examples include the execution-style killing of three young Muslim activists in North Carolina and the stabbing of three people who defended Muslim women in Oregon. For refugees relocating to the West in the current Islamophobic climate, there is an additional layer of struggle with discrimination, racism, profiling, and hostility based on their skin color, their accent, the way they dress, or how they choose to practice their religion [20]. It is important for psychiatrists and other mental health providers to be sensitive to the struggles shared by their Muslim clients. If we begin to doubt, question, or normalize any form of abuse that refugees have endured or call it by any other name, we risk quickly losing the rapport necessary in a therapeutic relationship.

The first author recently saw a young Syrian boy who witnessed his father become quadriplegic because of an air strike. In a split second, the boy became a silent witness to mass destruction and the dark side of humanity, as well as to the shattering of his image of his father as a superman and the image of the world as a place where children should always feel safe. The boy's story and his strength and resilience brought tears to my eyes. This brings another dynamic to gentle therapists who encounter horrific stories working with this population. We believe that showing emotions only means that we are humans and genuine and can bring more authenticity into the therapeutic space as long as we know our boundaries and are careful to not overwhelm our patients in the process. If our patients sense our distress listening to their trauma story, they will try to protect us, stop sharing, and instead "keep the secret."

We recommend that therapists offer refugees the best of what they have and believe in them; if they do, they will in return believe in themselves. Our hope is that people will put their perceived differences behind them and treat each other with dignity and integrity, knowing that we have much more in common than what divides us and are in this together. Violence is our common enemy, and the best way to heal ignorance is through education. We need to build bridges and not erect walls, literally and/or metaphorically.

The prophet of Islam, Muhammad peace be upon him, was a refugee and an asylum seeker himself. His immigration from Makkah to Medina is a highly celebrated event in Islamic tradition and was a watershed moment that heralded a new era for Islam. It is a strong belief in Islam that if one immigrates because of religious persecution that God will open doors for him and ease his way. We as care providers can use religion to our advantage when working with Muslim refugees.

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29 A Case Study of the Political Determinants of Division: Muslim Perceptions of British Combat Troops

Ahmed Zakaria Hankir, Frederick R. Carrick, Jamie Hacker Hughes, and Rashid Zaman

Introduction

Three Kings is a 1999 American satirical war film starring George Clooney, Mark Wahlberg, Ice Cube and Spike Jonze as four US soldiers on a gold heist that takes place against a backdrop of the 1991 uprisings in Iraq following the end of the Gulf War. *Three Kings* was described as *the most caustic anti-war movie of this generation* by *The New York Times* [1], received "universal acclaim" by film critics (indeed, the movie holds a 94% "Certified Fresh" rating on Rotten Tomatoes [2]) and was a box office success, grossing $107 million on a $48 million budget.

Mark Wahlberg played the role of Sergeant First Class Troy Barlow, an office worker with a wife and baby daughter back in the USA. Barlow is involved in a particularly poignant scene in the film when he is captured by members of the Iraqi forces and is held captive by them. A dialogue soon ensues between Barlow and Said, a bilingual Iraqi captain who interrogates and tortures Barlow to extract intelligence from him. During the interrogation, Said unexpectedly shows vulnerability and discloses to Barlow that his home was destroyed during a US airstrike. Barlow shows empathy to Said by describing the experience as horrible and the expression on his face and tone of his voice betray a congruous earnestness. However, Said

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immediately retorts with exasperation exclaiming that he has not revealed the horrible part of his story just yet. It transpires that Said's wife and child were in his home during the US airstrike and that they were killed consequent to it. The Iraqi captain goads his prisoner and asks him how he would feel if the same were to happen to him. Barlow does not respond verbally to Said's provocation; however, his silence belies the loudness of his thoughts, and, through the power of film, viewers are offered a visual and graphic insight into his mind as he imagines a bomb being dropped on his home in suburban America and detonating whilst his wife and child are inside it.

Although the film is fictional, we know that the deaths of Iraqi civilians in the Gulf War and the 2003 US- and UK-led invasion and subsequent occupation of Iraq were real. Indeed, Les Roberts and colleagues at the Johns Hopkins Bloomberg School of Public Health conducted two cross-sectional surveys on Iraqi mortality rates following the 2003 Iraq war. The studies estimated the number of excess deaths caused by the invasion and occupation, both direct (combatants plus non-combatants) and indirect (due to increased lawlessness, degraded infrastructure, poor healthcare, etc.). The first survey estimated 98,000 excess Iraqi deaths between 2003 and 2004 or about 50% higher than the death rate prior to the invasion. The authors described this as a conservative estimate, because it excluded the extreme statistical outlier data from Fallujah. If the Fallujah cluster of deaths were included, the mortality estimate would increase to 150% over preinvasion rates [3]. The second survey estimated 654,965 excess deaths related to the war, or 2.5% of the population, through the end of June 2006, 31% (186,318) of which were attributed to the US-led coalition. The causes of violent deaths were gunshot (56% or 336,575), car bomb (13% or 78,133), other explosion/ordnance (14%), air strike (13% or 78,133), accident (2% or 12,020) and unknown (2%) [4].

People who have experienced and endured the conflict of war can identify with films like *Three Kings* which can inadvertently trigger the resurfacing of traumatic memories. We invite readers who have not been subjected to such distressing atrocities to pause at this moment and to participate in a mental activity. We ask you to try to imagine the unimaginable: that is to contemplate how you might react if you were to wake up one morning to discover that your hometown was bombed and that your loved ones were among the dead. The purpose of this exercise, challenging and uncomfortable though it may be, is to encourage you to "slip into the shoes" of those who are at the receiving end of war and to develop an empathy for them. It is only through empathising with these people that we can truly begin to fathom the feelings, thoughts and emotions that humans experience in such extreme situations which can include, but are not limited to, despair, pathos, pain, powerlessness, anger, fear, hatred and hostility.

Unlike the deaths associated with natural disasters such as earthquakes, those attributed to war and terrorism have perpetrator(s), perceived or otherwise, towards whom victims and their loved ones can direct their feelings and reactions. They can thus attempt to assuage any negative feelings that they develop by avenging, extra-judiciously or not, the deaths of those who were killed with such impunity – i.e. exacting the proverbial "eye for an eye and tooth for a tooth". This can occur at the

level of the individual [i.e., the decapitation of a British serviceman (see below)] or on a governmental level. In relation to the latter, take, for example, the heinous and horrific September 11 terror attacks on the USA that resulted in the deaths of approximately 3000 people. Suspicion quickly fell on al-Qaeda as the perpetrator and the USA responded by launching "Operation Enduring Freedom", invading Afghanistan to depose the Taliban, which had harboured al-Qaeda. "Operation Enduring Freedom" began with an initial air campaign and has since claimed the lives of over 31,000 Afghan civilians. The Cost of War project estimated that an additional 360,000 people died through indirect causes related to war [5]. Colossal death tolls such as these do not endear the US and UK governments to the people of Afghanistan, most of whom are Muslim.

The foreign policies of the UK and the USA have led to the deaths of hundreds of thousands of innocent civilians in Muslim majority countries, and to presume that this is without consequence is, frankly speaking, naïve. Given that the ideology of Islam is such that it considers its adherents as members who belong to a single Muslim nation (Fig. 29.1) that transcends time [i.e. present-day Muslims have an impregnable bond with their brethren who were persecuted during the lifetime of the prophet Muhammad (Peace Be Upon Him-PBUH) several centuries ago] and space (i.e. Muslims in the UK and the USA consider themselves the "brothers and sisters" of Muslims in Afghanistan and Iraq), the remainder of this book chapter will explore the far-reaching impact that UK and US foreign policies have on those who were affected, specifically people who identify as Muslim – including "self-proclaimed Muslims" – residing in the West. Our book chapter contains data from the first survey of its kind on Muslim perceptions of British combat troops which was presented to military officials in Whitehall – the UK counterpart of the Pentagon.

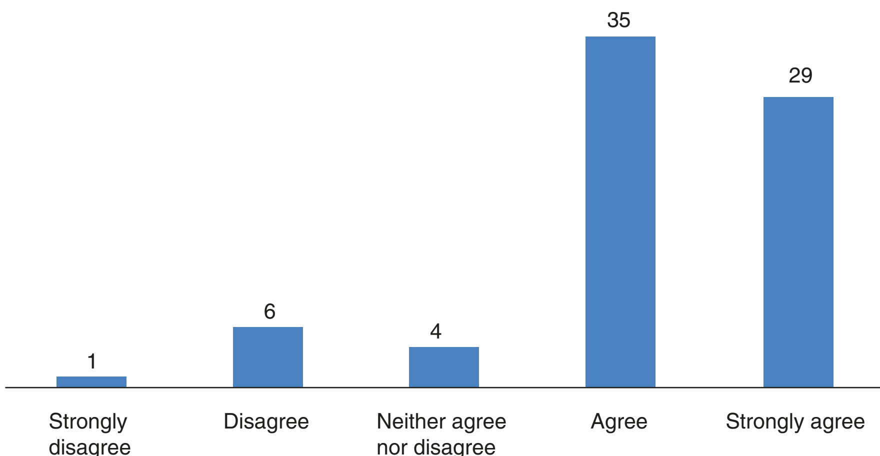

Fig. 29.1 Being Muslim can increase empathy towards civilian casualties and deaths due to British combat troops engaged in military operations in Muslim majority countries

Violent Extremism in the UK

On the 22nd of May 2017, suicide bomber named Salman Abedi, a British citizen of Libyan descent, callously detonated an improvised explosive device (IED) in a concert by American singer Ariana Grande in the Manchester Arena killing 22 people and injuring 500 others. The "massacre in Manchester" was the worst terrorist attack on British soil since the London suicide bombings in 2005 (also referred to as "7/7"). Muslim communities in the UK and throughout the world have resolutely rejected the multitude of absurd and apocryphal claims that such heinous and horrific actions have any place in Islam and have expressed their deepest condolences to the families and loved ones of all those who were affected by the explosion. Indeed, multiple members of the Muslim community in Manchester reported Salman Abedi to the British Intelligence Services on at least five separate occasions before he executed his barbaric attack due to their concerns about the extremist views that he was expressing and their forebodings that he posed an imminent threat to Muslims and non-Muslims alike [6].

Leaders of all the political parties in the UK suspended their campaigns for the general election following the cowardly Manchester bombing. The leader of the Labour Party, Jeremy Corbyn, however, controversially resumed electioneering soon after the atrocity. Corbyn, the former chair of the Stop the War Coalition, emphatically exclaimed in a general election campaign speech that: "Many experts, including professionals in our intelligence and security services, have pointed to the connections between wars our government has supported or fought in other countries and terrorism here at home [7]".

Corbyn's claims, controversial and contentious though they may be, are not unfounded, especially if one considers what the terrorists themselves have said, and indeed continue to say, about what motivates them to carry out their abhorrent activities. For example, British serviceman Lee Rigby was brutally attacked and decapitated by Michael Adebolajo and Michael Adebowale close to the Royal Artillery Barracks in London in 2013. The perpetrators told passers-by at the scene that they wanted to avenge the killing of Muslims by the British Armed Forces [8]. Indeed, militants of (and those inspired by) terrorist organisations such as Daesh (ISIS) repeatedly report that what motivates them to carry out their activities are British military operations in Muslim majority countries.

The Perversion of Islam

Daesh (ISIS) is a terrorist organisation founded by Abu Musab al-Zarqawi in 1999 and based in the Levant (Middle East), primarily controlling territory in Iraq and Syria. As of 2016, US officials estimate that there are between 15,000 and 20,000 listed militants [9]. Abu Musab al-Zarqawi promulgated a vitriolic ideology that has no regard for the sanctity of human life, Muslim and non-Muslim alike. Indeed, the United Nations has designated Daesh as a terrorist organisation and

holds its members responsible for a plethora of human rights abuses and war crimes [10]. Daesh's manifesto is anathema to the teachings of the blessed prophet Muhammed (PBUH). Succinctly put, Daesh does not represent Islam. Most of Daesh's victims are Muslim and most people engaged in combat against Daesh are Muslim.

Calling oneself a Muslim does not necessarily make that person a Muslim, a fact which was not lost on a bystander of the Leytonstone underground station knife attack in London in 2015. The bystander, a non-Muslim named by the media only as John, coined the phrase, "You ain't no Muslim, Bruv" in response to the fanatic Muhyadin Mire's ravings whilst he was being tasered and arrested by London Metropolitan Police (the term "bruv" is a colloquialism that is often used by Londoners in vernacular parlance). The phrase soon started to trend on Twitter, and David Cameron, who was the Prime Minister at the time, praised the commentator declaring that "[he] stated it all much better than I could have done" [11].

Recruitment of Foreign Fighters to Join Daesh

The British government has expressed deep concerns about Britons who have been recruited to join Daesh through their propaganda campaign. International Centre for the Study of Radicalisation and Political Violence reported that more than 700 Britons joined Daesh since the inception of this terrorist organisation in part due to their propaganda campaign [12].

The Quran explicitly prohibits the killing of innocent civilians and non-combatants as evidenced in the following passage:

> …If you kill one human life, it is as if you have killed the whole of humankind… (Quranic scripture, Chapter 5, Verse 33)

Muslims believe Muhammad (PBUH) to be the Prophet of God and that, as such, he was the keeper of prophecies. Muhammad (PBUH) prophesied that terrorist organisations such as Daesh would sprout and he issued the following clarion call about them:

> …They are the worst of the creation. Blessed are those who fight them and are killed by them. They call to the Book of Allah but have absolutely nothing to do with it. Whoever fights them is better to Allah than them. – (Sunan Abi Dawud 4765)

We, the authors, share the deep concern that the British government has about the youth from the UK who are vulnerable to recruitment by the so-called Islamic State (Daesh/ISIS) to engage in unlawful battle with them. We would like to make it absolutely and explicitly clear that Muslims residing in the UK do not "quietly condone" terrorism in any of its many forms, but rather we vociferously and vehemently condemn these flagrant crimes against humanity. The primary author (AH), who

identifies himself as a British Muslim, lamented inconsolably when he discovered that the British humanitarian, Alan Henning, was beheaded by his captor Mohammed Emwazi (known by the media as *Jihadi John*) in Syria on the 3rd of December 2014 [13]. We offer our sincerest condolences to the loved ones of Alan Henning whom we regard and revere as a valiant hero who selflessly served the most impoverished and destitute people in our world today.

MI5 Behavioural Sciences Unit Report

Thanks in no small measure to segments of the media, the myth that Muslims perpetrate and condone terrorism is rife. Moreover, isolationism and populism have fuelled recent political events such as the inauguration of Donald Trump as President of the USA and Brexit in Europe which, in turn, perpetuate Islamophobic narratives that caricature Muslims as heathen beasts who rejoice whenever a terrorist attack occurs. However recent research conducted in the UK has revealed that this couldn't be further from the truth. The MI5 Behavioural Sciences Unit conducted sophisticated in-depth analyses of hundreds of case studies related to Britons engaged in terrorism. They concluded that, "…*far from being Islamist fundamentalists, most [terrorists] are religious novices who do not practise their faith regularly… some are involved in drug-taking, drinking alcohol, and visiting prostitutes [all haram (forbidden) in Islam] …" MI5 reported that, "… there is evidence to support that a well-established religious identity actually confers protection against violent radicalisation*…" [14].

A leaked Daesh document verified as genuine by the US military's Combating Terrorism Centre was consistent with the findings of the British study. The document, which contained the personal details of 4188 militants who joined Daesh in 2013 and 2014, revealed that 70% of respondents described their knowledge of Islam as "basic". These findings suggest that Daesh has twisted the Quran to serve its own brutal and "un-Islamic" ideology [15].

Factors that Motivate Militants to Commit Terrorism

Professor Hamed El-Said is a consultant for the United Nations on violent extremism, and in his magnum opus, *Deradicalizing Violent Extremists: Counter-Radicalisation and Deradicalization Programmes and their Impact in Muslim Majority States*, he eruditely argues that those who are engaged in radicalisation aim to cause division and incite hatred. El-Said also reports that what motivates terrorists to carry out their abominable acts are military operations in Muslim majority countries. These assertions are consistent with what other experts on terrorism report [16, 17] and what the terrorists themselves have said. The acculturation process [18] and a myriad of other factors such as mental illness, poverty and unemployment have also been reported in the literature to contribute to the phenomenon of violent extremism [19–21].

Perceptions of British Combat Troops

Sir Simon Wessely is Regius Professor of Psychiatry at the Institute of Psychiatry, Psychology and Neuroscience at King's College London, immediate past President of the Royal College of Psychiatrists (UK) and Director of the King's Centre for Military Health Research. Wessely and colleagues report that there was evidence to suggest that although the public were less supportive of the UK's military involvement in the conflicts in Iraq and Afghanistan, their support of the Armed Forces themselves increased [22].

The social research institute, Ipsos Mori, conducted a study with King's College London entitled "Hearts and minds: Misperceptions and the military". This was an international survey on perceptions of the military compared with "reality". Five thousand and ten interviews were conducted between the 24th of April 2015 and 8th of May 2015 across five countries: Australia, the UK, the USA, Canada and France. This international survey revealed some "extraordinary" misperceptions on other issues. For example, the British respondents in the survey reported that they perceived 21% of the population in the UK to be Muslim (actual 5%). French respondents perceived 31% of the population in France to be Muslim (actual 8%) [23]. Interestingly, although the British government has expressed deep and grave concerns over Britons being recruited to join Daesh, and terrorism experts report that those engaged in violent extremism cite that military operations in Muslim majority countries motivate them to carry out terrorist acts, none of the participants selected from the UK for the Ipsos Mori and King's College London international survey were Muslim. As far as the authors are aware, there have been no studies to date that explore the perceptions that Muslims residing in the UK have towards the British military.

Muslims Residing in the UK and Their Perceptions of British Combat Troops

We conducted a cross-sectional, mixed-methods study on Muslims residing in the UK and their perceptions of British combat troops. Participants were selected by purposive sampling. We crafted a survey that explored Muslim perceptions of the British military and the government's foreign policy. Responses were indicated on a Likert scale and there was space for free-text comments which were subjected to thematic analyses. 75/75 (100%) of the participants recruited responded. [75/75 (100%) were Muslim participants, 43/75 (57.3%) were female, and 32/75 (42.7%) were male, mean age 20.5 years (Std. Dev. ±2.5).] 69/75 (94%) of respondents either disagreed or strongly disagreed that, "Being Muslim means that you cannot be British" (Fig. 29.2). 66/75 (88%) of respondents either agreed or strongly agreed that British military operations in Muslim majority countries have negatively influenced perceptions towards combat troops (Fig. 29.3). 65/75 (87%) of respondents agreed or strongly agreed that British military operations in Muslim majority countries have negatively influenced perceptions of the British government (Fig. 29.4).

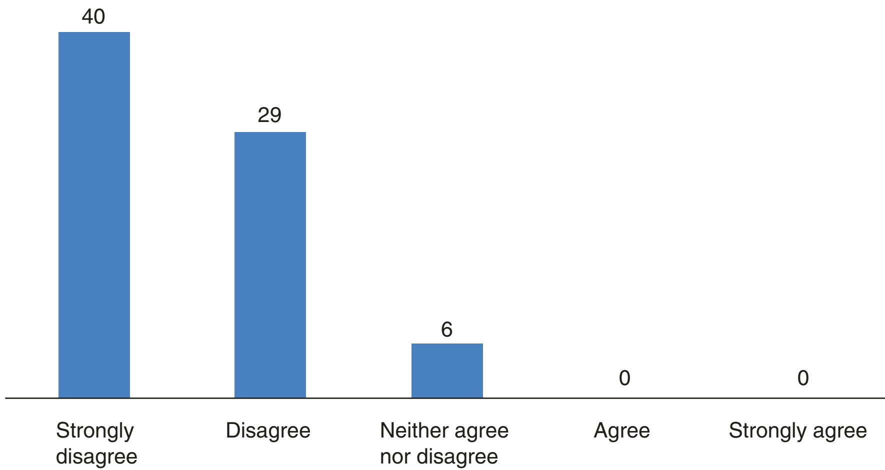

Fig. 29.2 Being Muslim means that you cannot be British

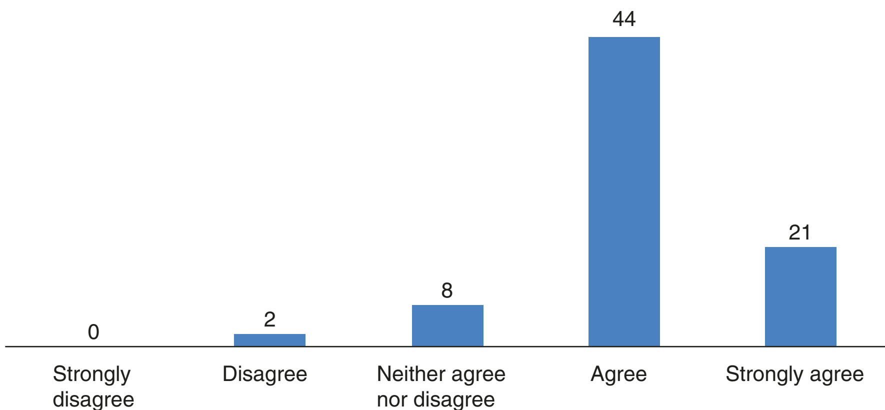

Fig. 29.3 British military operations in Muslim majority countries have negatively influenced perceptions of British combat troops

42/75 (56%) of respondents either agreed or strongly agreed that contact with service personnel or veterans would positively influence their perceptions towards them (Fig. 29.5).

Thematic Analyses of Free-Text Comments

Themes of free-text comments included the role that the media plays in demonising Muslims, the transcendental bond that Muslims around the world have for each other, "the brainwashing" of British combat troops by the government and the impression they are not primarily responsible for their actions.

> Are they sure they know what they are doing?
> **Participant 1**

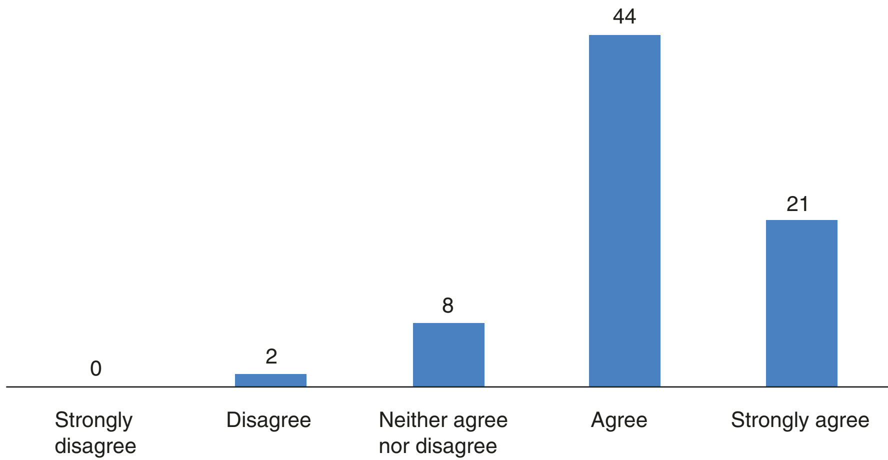

Fig. 29.4 British military operations in Muslim majority countries have negatively influenced perceptions of the British government

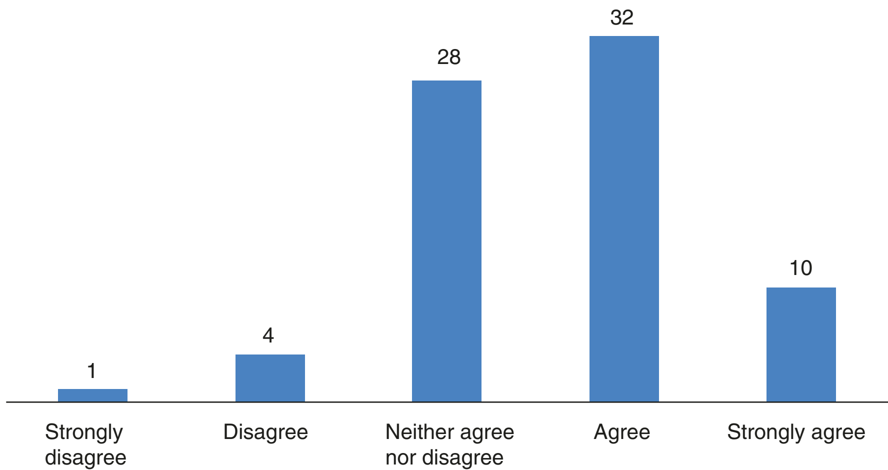

Fig. 29.5 Contact with British service personnel or veterans might positively influence perceptions towards them

> The soldiers are so brainwashed that they don't understand what they're doing. I think once they see the reality of what they're being told to do, most change their ways...
> **Participant 2**

> I don't believe the actual soldiers are to blame, they are led to believe that what they are fighting for is a worthy cause…
> **Participant 3**

> The troops are of course not primarily to blame. However, it is an obligation for every human being to research into the effects of their actions and the activities that they are participating in.
> **Participant 11**

> Undisciplined as reports and cases that come out show troops abusing, torturing and humiliating prisoners out of their own boredom…The military is over-extended and becoming seemingly unnecessary as they are causing more harm than good (attacking more than protecting).
> **Participant 4**

> From personal experience, there is a feeling amongst Muslims and Pakistanis that British troops **are** to blame for the dealings of the British military abroad/in Muslim countries. Although I agree that Muslims should avoid dealing with the British military due to their Imperial history and/or current military occupations, this should not decrease the empathy felt for the soldiers (and their families).
> **Participant 8**

> Perhaps if the media wasn't constantly attacking us from all angles and demonizing us we wouldn't be so defensive towards occupation of Muslim lands by Western troops. We'd perhaps give them more of a chance to hear why they are involved in what they do.
> **Participant 10**

> Thank you. Engaged in a war and suffering loss of life, paying a burden the troops should not pay. There is no benefit at all to the foreign or domestic countries in their military intervention.
> **Participant 13**

> Racist, Islamophobic, ignorant…
> **Participant 14**

> The love Muslims have for each other transcends words alone…
> **Participant 12**

Discussion

In this chapter, we have analysed and discussed the political determinants that have given rise to radicalisation in the West. The authors contend that Muslims residing in the UK hold stigmatising views towards British combat troops (and vice versa), thus promoting division as opposed to peaceful coexistence. The fact that many of the participants in our sample agreed or strongly agreed that social contact with service personnel or veterans would positively influence perceptions towards them (Fig. 29.5) is encouraging. Moreover, since most of the respondents in our sample reported that media and film portrayals influence empathy towards British combat troops (Fig. 29.6), commissioning the production of a documentary film about the role that British combat troops play in conflict zones, especially in Muslim majority countries, might improve Muslim perceptions of them. Such a "bespoke" documentary film that improves perceptions of British combat troops in the Muslim community in the UK seems necessary given that most respondents in our survey agreed or strongly agreed that being a Muslim can reduce empathy towards British combat troops engaged in military operations in Muslim majority countries (Fig. 29.7). The results of our survey lend support for future intervention studies investigating whether contact between Muslims residing in the UK and British combat troops

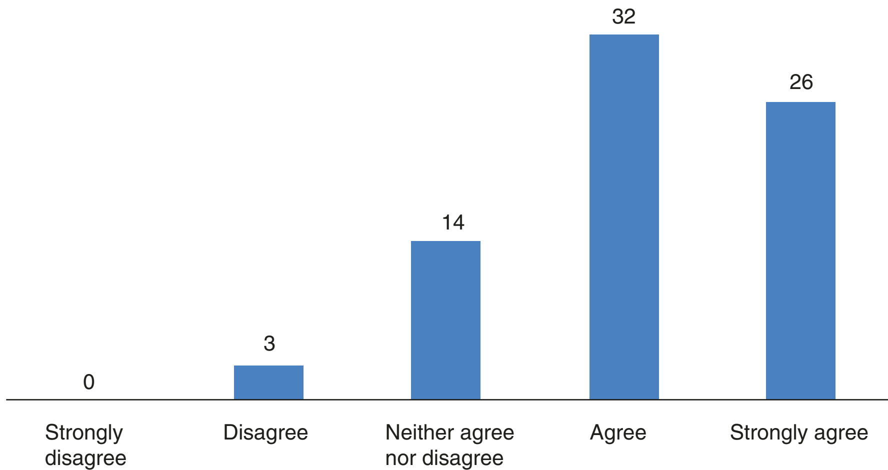

Fig. 29.6 Media and film portrayals influence empathy towards British combat troops

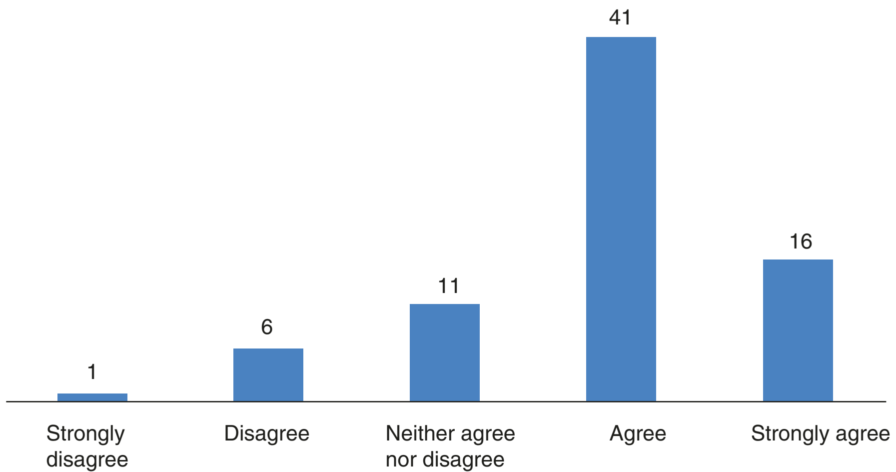

Fig. 29.7 Being Muslim can reduce empathy towards British combat troops engaged in military operations in Muslim majority countries

(and indeed Muslims residing in the USA and American combat troops) would promote unity.

The British government is exploring ways to recruit more Muslims to join the British Armed Forces since the latest figures revealed that of the 160,500 personnel currently serving, only 650 (less than 0.5%) are Muslim. However, as enumerated above, Daesh have already recruited more than 700 foreign fighters from Britain to join them since their inception in 1999. Figures such as these betray a worrying fact that authorities simply cannot ignore or dismiss and we must elucidate what the factors are that contribute to these alarming statistics.

Resistance for Muslims becoming servicemen has been reported to be partly attributable to the UK's involvement in conflicts in Iraq and Afghanistan, and the findings of our survey are consistent with this, with most (72%) of our participants endorsing the statement that, "*Muslims should not enlist in the British Armed Forces due to military operations in Muslim majority countries*" (Fig. 29.8). However, Imam Asim Hafiz, Islamic adviser to the chief of staff of the British Armed Forces, reported that, in his view, "*the values of the armed forces are fully compatible with the values of Islam as well as other faiths*" [24]. Interestingly, it appears that the Muslim respondents in our sample did not perceive that they would be discriminated against based on their faith if they wanted to enrol with the British Army (Fig. 29.9).

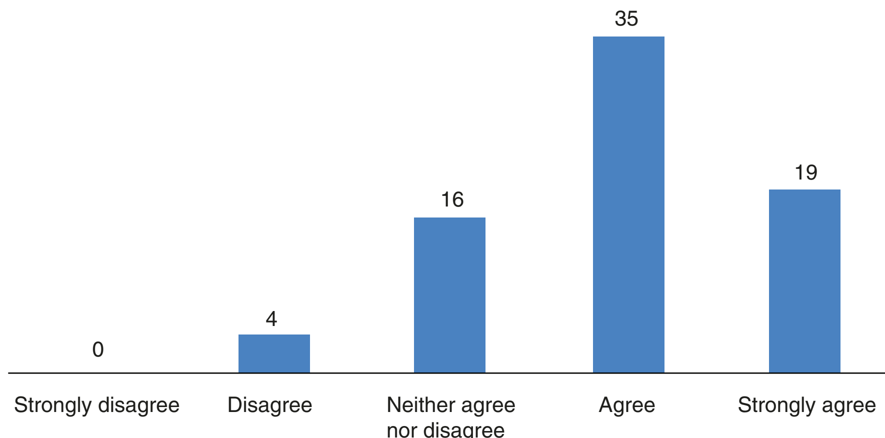

Fig. 29.8 Muslims should not enlist in the British Armed Forces due to military operations being conducted in Muslim majority countries

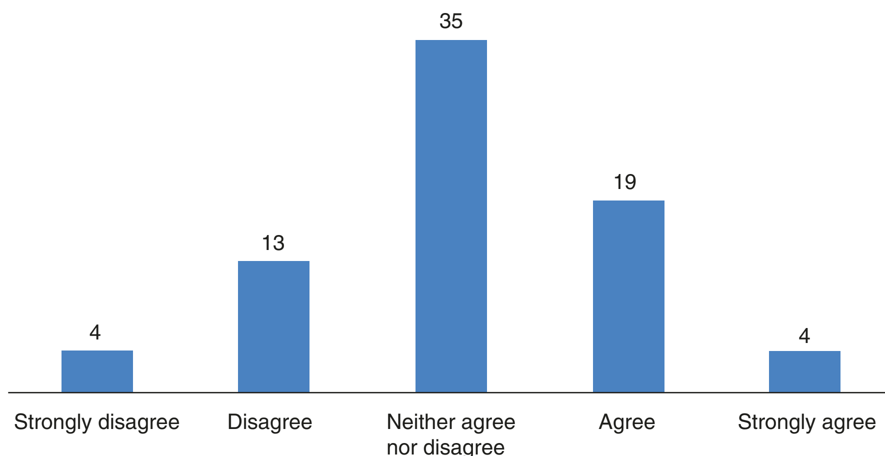

Fig. 29.9 The British Armed Forces are less likely to recruit Muslims

Conclusion

If the British government is serious about challenging radicalisation, it must take into consideration the perceptions that Muslims residing in the UK have towards them, their foreign policies and their combat troops. The British government and its Armed Forces need to increase and improve efforts to reach out and engage with members of the Muslim community domestically and abroad, particularly Muslim youth, by collaborating with organisations such as the Federation of Student Islamic Societies, the national umbrella organisation aimed at supporting and representing Islamic societies at colleges and universities in the UK and Ireland.

By addressing, and rectifying, the problems with UK foreign policy, the British Armed Forces might come to be perceived by Muslims as a legitimate branch of the government's Ministry of Defence and not as aggressors who occupy Muslim majority states. British Muslims may then feel duty-bound to protect their fellow citizens by joining the Armed Forces. Terrorist organisations have launched seductive propaganda campaigns to recruit foreign fighters. The British Armed Forces clearly need to enhance their recruitment strategy to enlist more Muslims in the effort to defeat terrorism than the number of militants Daesh enrolls for its cause.

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30 Community Resilience

Andrew J. McLean

Intro

> We're going to kill every one of you (expletive) Muslims!

This year, in my hometown, a racially charged incident occurred involving a Caucasian woman and three female Somali immigrants arguing over a parking situation. The back and forth included personal insults to the Caucasian woman, with the subsequent retort above. The incident became public and viral on social media. The occurrence could have been left at best, to smolder, and at worst to become more incendiary.

Instead, the chief of police, at the request of his deputy chief, inserted himself into the process, not in an authoritarian or punitive manner but in an invitation for dialogue and mediation. He invited the women to meet in his office and discuss. It turns out that the woman who yelled the anti-Muslim comment had lost her father during the war in Iraq. The Somali-Americans (two of whom were sisters who attended the meeting) had become frustrated in their struggle to be seen as part of the community. The police department's social media page showed a picture of the three women with their arms around one another. The story was also covered by local media [1].

As diverse as my own community (a small metropolitan area in the upper Midwest US, with over 40 dialects spoken) has become, I have seen it consistently come together during challenging times. Yet like most societies, we still struggle with the issue of who is "us" and who is "other." How do we define our communities and how do we keep them healthy? How have communities of Islamic faith maintained resilience? Trauma of individuals and communities is a public health matter.

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As a citizen, physician, and educator (of many Muslim physician trainees), how do I ensure that I advocate for the well-being of all?

Definition of Community

Interestingly, one Latin root translation of the word "community" is "the gift of togetherness," "Cum" (together) and "munus" (gift). Communities can be defined both narrowly and broadly. The family unit is often considered the lowest common denominator and the global community the greatest. Some argue that family is actually much more inclusive and expansive if one subscribes to the concept of genetic Adam and Eve (Y-chromosome Adam, mitochondrial Eve) in which all male and female descendants trace their ancestry to two specific individuals who lived less than 200,000 years ago [2]. (The Quran is replete with references to human beings as "the children of Adam.") Within the history of Islam, the global community of believers has been known by the term "Ummah." Yet, there are multiple branches of Islam across the world. And, as with all major religions, there can be significant intra-faith differences as well as interfaith ones. The publication "Campaign 2012, Muslims in the United States" [3] noted, there is no "one" Muslim population. This is not news to the world, given the notorious rift between Sunni Muslims and Shiite Muslims.

In the United States, there is a significant cultural contribution from Muslims from 77 countries, with various ethnicities and sects. While there is diversity within Muslim populations, a 2011 Pew study [4] noted that Muslim Americans mirror the US population in economic and educational categories. The survey also indicated that the self-rated importance of religion/religious practice is very similar between American Muslims and Christians. A 2009 Gallup poll found that Muslims had the second highest education level among major religious groups in the United States. This was echoed in a round-table discussion held with young Muslim professionals – the frustration of stereotyping that occurs in the media, talk radio, and other venues, the labeling of entire populations, and the downplaying of positive contributions by highly educated individuals.

Definition of Resilience

Resilience has been a buzzword of significance as of late. There are many definitions – a popular one being that of Bonanno [5], "the human ability to maintain stable, healthy levels of psychological and physical functioning following a potentially highly disruptive event." While the term "resilience" has implied adjusting to environmental stress (i.e., positive adaptation), there have been reinterpretations of the definition. One is the thought that by learning skills of resiliency, individuals can proactively reduce the impact of stress and thus reduce the need for adaptation. Another consideration in resilience literature is that of post-traumatic growth – a reactive yet positive outcome. Over the course of history, all the great religions have

found a way to survive both internal and external strife. And they continue to deal with such challenges to this day.

During heightened levels of Islamophobia, Muslim individuals and communities experience and respond to stress. Many years after “9/11,” Arab American Muslims and immigrants continue to be affected – some “traumatized threefold” [6] (affected by the tragedy itself, by the response by certain non-Muslim individuals and communities, and by perceived legislative backlash). A 2009 *Traumatology* [7] article on hate crimes noted that up to a quarter of New York Muslim respondents acknowledged verbal assaults and 19% experienced physical assaults. A year earlier, the *Journal of Muslim Mental Health* [8] had noted increased fear, stigma, isolation, and loss of community within a cohort in Brooklyn. This same study noted the significant impact Imams played in the promotion of mental health both pre- and post-9/11. Dr. Osman Ali notes that there needs to be greater research in the area of Imams addressing the mental health needs of Muslims [9].

With threats of, or implementation of, recent travel restrictions aimed at specific Muslim-majority countries [10], numerous stories have come forth pertaining to actions based on fear, taken by Muslims residing in the Unites States. I have known of young Muslim professionals who postponed their out-of-country wedding, who did not accompany their spouse on their honeymoon abroad, who did not reapply for visas, etc. A high-ranking applicant to a regional residency program chose the “pre-match” selection elsewhere due to the fear of waiting for the general “match” process and the potential for lack of visa renewal.

Yet, these individuals carry on and find ways to bounce back. A hallmark of resiliency is finding opportunity in challenges. According to Powley [11], resilience is “activated” through three main mechanisms, each of which depend on communication and information: liminal suspension (alteration of relational structures and the emergence of new relational patterns), compassionate witnessing (noticing and feeling empathy for others), and relational redundancy (how interpersonal connections intersect and span beyond immediate social reference groups); these actions occur in parallel among individuals and across functional or organizational boundaries.

Community Resilience

Community resilience has been defined by Pfefferbaum and colleagues [12] as “the ability of community members to take meaningful, deliberate, collective action to remedy the impact of a problem, including the ability to interpret the environment, intervene, and move on.” Norris et al. [13] noted that resilient communities share similar traits – they have strong leadership, engage their citizens, utilize resources wisely, and attend to psychosocial supports. As above, the great religions of the world share early stories of survival with sparse resources. Since the foundation of Islam, there have been examples of such communities.

A review of multiple studies on resilience indicates that two of the most impactful variables are resource availability and social connectedness – the latter is

typically more controllable. There are multiple examples over the centuries (the best known being the Hijra) [14] of persecuted Muslim groups being received by their brethren in other regions and treated as family. As one can see, community resilience implies a shared purpose and a positive impact on population wellness.

As members of civic communities, religious groups frequently come to the assistance of the community at large. In our own region after a disaster event, a group of VOADs/COADs (Volunteer/Community Organizations Active in Disasters) joined government entities, healthcare professionals, and others to develop a community resilience group. Initially called "The Spiritual and Emotional Well Being Subcommittee of the Red River Recovery Group," it became "Red River Resilience" [15].

Immigration and Community Resilience

Community resilience in adaptation to change is reflected also in response to immigration into communities at large. Some civic communities navigate these changes deftly. Many struggle, attempting to maintain the myth of the status quo against the reality of a changing ethnic landscape. My home state borders Canada, and I attended a meeting in Manitoba on human rights [16], sponsored by the Islamic Social Services Association. One of the presentations came from the Canadian Mounted Police. What was striking to me was their attitude that the first consideration in the interaction with individuals trying to cross the border for refuge (in mid-winter) was that of safety – for the refugee. Theirs was not a naïve consideration (they are expert in security issues), but a humanitarian approach. Empathy is an incredibly powerful force. The ability to understand (and experience) another's thoughts, attitudes, and emotions is key to building healthy relationships.

Religion, Ethnicity, and Communities

Studies on religious communities in general indicate they are a source of significant social support to their members. Many religious social networks provide enormous emotional and tangible benefits including subjective well-being, physical health, and so on. Mochon et al. [17] have indicated that this benefit primarily falls to those strongly committed to their faith. In discussions with young Muslim physicians, these findings appear supported. Some, particularly more devout individuals, have found significant solace in their religious communities. Others who are less religious admit that after increased backlashes against the Muslim community (whether nationally or locally), they may be more likely to avoid the mosque, in part due to fear of being a target of hate.

Abu-Raiya and colleagues [18] found both religious and nonreligious means of coping among US Muslims experiencing discrimination and harassment. Nonreligious coping included resilient behaviors such as social connectedness with Muslims and non-Muslims alike, resulting in post-traumatic growth in areas such as individual strength and appreciation. As with findings from numerous studies on

resilience after traumatic events, those who were isolated had greater levels of anger and depression. Positive religious coping, identified by feelings of support from Allah or mosque members, resulted in benefits similar to the above (i.e., post-traumatic growth). Though navigating one's religious practice (five daily prayers, fasting during Ramadan, Friday prayer services, etc.) within a typical US work setting can be challenging, in doing so most Muslims experience a heightened sense of community.

In our city, the sole mosque is located only a couple of blocks from our community mental health center, where many of our psychiatry residents train. I can attest that on Friday afternoons, particularly during times of heightened reports of Islamophobia, the cars of devotees are parked along the streets for many blocks.

Negative religious coping, noted in part by feelings of punishment from Allah, were reflective of higher levels of depression. However, as a "negative cognitive set" is pathognomonic of depression, it is uncertain as to whether negative religious coping was a result of, versus a contributor to, depression.

Younger Muslim Americans have been a particularly interesting group for study. Those who are able to maintain a sense of "Americanness" (a majority, in a study by Sirin [19]), despite being discriminated against, are more resilient. I have witnessed Muslim physician trainees dealing with the insults that inevitably come from patients in the throes of mania or psychosis. These practitioners have also discussed the surprised look from a patient as they appear abruptly in a telemedicine visit or the frustration that occurs with greater numbers of patient appointment cancellations than occur with their cohorts with names of Northern European heritage. Yet, they report honing skills and becoming more adept at managing the interactions. They utilize the support of their peers, clinic colleagues, attendings, etc. They practice self-reflection, as well as empathy for "the other."

What do individuals or groups do with their frustrations when they are ostracized, labeled, etc.? What do they do when they feel trapped, when they have no voice? While some may violently rebel, most respond in other ways. Oppressed communities do not always assimilate, nor is the "pushback" necessarily direct or aggressive. Actions are often taken in more subtle ways by individuals or groups to protect what they value. These may come in the form of civil disobedience, boycotts, etc. In the past few decades, such adaptation has come through religious organizations, social movements, athletics, and other networks. A classic individual example is that of the actions of Cassius Clay/Muhammad Ali. Sonn and Fisher [20] warn against overlooking the alternative settings/activities by which such groups survive.

Media

Many young Muslim professionals have voiced their frustration with media reporting. This includes the consistent reporting of terms in one context only. As an example, many think of the term "jihad" as referring to their own internal struggle to be the best Muslim they can be, and not reflective of "holy war," though that is the

context in which the term is most often reported. Even the term "radical" has been usurped. As my colleague Shahina Siddiqui of the National Council of Canadian Muslims notes, radical thinking is not necessarily a bad thing – we want our youth to "think outside the box," to question, and to be independent thinkers. It can be argued that most advances in civilization have come from the creative minds of "radical" thinkers. If the term "radical" is always yoked to extremism or terrorism, its positive, historical aspects are ignored. Ms. Siddiqui and other Muslim leaders make themselves readily available to the media during events of import in order to allow for balanced discussion. In democracies, it is not only vital to have a strong press (i.e., the "fourth estate,") but a strong citizenry able to articulate facts. This is particularly important in our current climate of social media.

In psychiatry, we have assisted in best practices for media reporting around issues impacting public well-being. The best example is reporting of death by suicide. If it is believed that prejudice is a social/public wellness issue, we need to ask the media to be responsible in its reporting on such issues. The dilemma is that many "news" entities rely heavily on the reporting (or enhancement) of discord as a means of financial viability. Controversy sells. War is exciting. Peace is dull. In a Gallup poll conducted this summer [21] on the question of safety, two-thirds of adults listed being stressed about crime, particularly terrorism, gun violence, and hate crimes. It is interesting that concerns of terrorism are greater than those of gun violence and hate crimes in the United States, despite the latter two events being significantly more prevalent.

Consistently, our discussion group members felt that while there is bias in how Muslims are portrayed, the response against their community "is not as bad as the media indicates." They gave examples of others (majority/Caucasian) being concerned with how they (individually and as a group) are doing, apologizing for the media portrayal and showing considerable empathy for their members. One young woman stated that she hopes that "mainstream" Muslims will utilize social media to shift the bias. She believes that if there is a consistent, unified effort, over time this may shape attitudes.

Identity: Other or Not

The late contemporary philosopher John O'Donohue once said, "Tradition is to community what memory is to the individual" [22]. How does a community identify itself? By default, if you are not part of the community, you are foreign. You are from elsewhere; you are "not us." What are the essential elements of "us"? Much of bias has to do with protecting identity. Resources from the outside are often seen through the lens of emotion, not rationale [23].

There have been numerous articles on the concept of "other" and "otherness." However, from an object relations standpoint, no one is "same," and developmentally it is healthy and important to learn "self" vs. "nonself." Key in this notion are "relations"; differentiation, but not rejection; and examination of how the particular might contribute to the universal without losing identity.

A healthy way of viewing "other" is that the individual or group is separate from me/mine yet more similar than different. And those differences can be of value. The

other individuals or group members are seen as people and linked to me/us in various ways. An unhealthy way of viewing "other" is as object, with differences to be belittled. Rather than linkages, barriers (physical, social, psychological, other) are placed so as to avoid contact/interaction.

Much of the resiliency literature has to do with responsiveness to disasters – that during those times, healthy communities "come together." The unifying factor is the rallying against an external foe (natural disaster, etc.) and that all who do so are of the same tribe. However, this cohesion typically does not last. As Myers and Zunin [24] point out, there usually occurs a later disillusionment. The recovery process depends on multiple factors, many of which are found in Norris et al.'s research on community resilience noted above.

History

The civil rights era was a watershed time in our nation where we attempted to address fairness not only as it pertained to US citizens but also to "foreigners." The Immigration and Nationality Act [25] changed the rules of national-origins quotas and sought to categorize and prioritize immigration slots with an emphasis on unifying families, assisting refugees, and bringing in individuals with skills beneficial to the United States. Immigrations shifted from Northern European populations to Southern, Eastern European as well as Asian, African, and Latin-American peoples.

In Hobfoll's Conservation of Resources [26] theory, people act to obtain, retain, and protect their resources. Significant stress occurs when there is threat of loss, actual loss, or no sufficient gain, despite investment. Extrapolate this stress model to encompass not only tangible resources but intangible, such as culture, historical memory, etc., and one can see the power of perceived threat to certain communities. Stating the obvious, ethnicity is frequently tied to discrimination. Often it is religion – many times it is difficult to tease apart the actual "rate-limiting factor" chosen. In the United States, the most recent religious group discriminated against has been those who practice Islam – in the last century, it was those of Jewish faith. Prior to that, bias against Catholic immigrants. Another group of citizens persecuted due to their faith in the nineteenth century was the Latter Day Saints.

Humans developed the need for categorization as a means of simplifying our world. In part this came about for reasons of safety – the ability to quickly lump someone/something as "safe" or "dangerous." Regarding relationships, the default assumption was that in-group is safe and out-group is dangerous. Quickly reacting to a potential threat was self-preserving, but at the expense of lost opportunities for new information and resources, new allies, and so forth.

As noted above, there needs to be caution regarding overgeneralization. Labels can be helpful in general categorization. However, when labels are no longer symbolic tools but seen as truths, they become problematic. The world is not binary, nor are individuals or groups "all good" or "all bad." Using game theory language, individual rights are not a zero-sum game – one's social character, group, or tribal existence need not diminish or preclude another's. Insistence on ownership of

indisputable self-evident truths and continuation of unhealthy competitive relationships lead to no resolution of conflict [27].

Figuratively, the world is not black and white; however today's humans struggle with gray – with enduring seemingly contradictory concepts. We do not tolerate cognitive dissonance (where beliefs and behaviors are at odds) very well. Being in a space where two truths exist at the same time is often more than discomforting. What are the options for individuals when this occurs? They can choose to re-evaluate their stance and potentially change either their belief or behavior. Or they can deny/ignore information that conflicts with their set belief/behavior and continue to justify their stance. A recent book, *Mistakes Were Made (But Not by Me)* [28], addressed these dilemmas well. Choosing to ignore or blindly support such dissonance can result in confirmation bias – with a wonderful example by Lord Molson, British politician of the twentieth century who stated, "I will look at any additional evidence to confirm the opinion to which I have already come."

It is said that orthodoxy stifles debate. Over the centuries, from the Greeks to the present day, societies have participated in "the Long Debate," a philosophical review and discussion of all things important, including nature, governance, and the meaning of life. Major religions have both stalled and advanced such discourse. Ibn Sina (Avicenna) and al-Farabi were two Muslim philosophers whose works in the Middle ages advanced Jewish, Christian, as well as Western thought at a critical time in history (the Dark Ages). We would do well to foster an openness to dialogue.

Islamophobia: Prejudice Toward Muslims

Cinnirella [29] combines models of identity theories and posits a new model called the Identity and Representations Model (IRM) of Islamophobia. The concept is that threats to identity principles of both individuals and groups result in prejudice. In 2005, Abrams and Houston [30] found Muslims to be the least accepted minority in the United Kingdom, though gay individuals were similarly targeted. What is the threat to the community at large that results in such prejudice? If the facts indicate that the odds of a material threat by minority groups ("other") is extremely limited, it is not the actual threat but the symbolic threat that pervades. To paraphrase one participant in a round-table discussion, "They (biased individuals) don't label and marginalize the entire white male population when someone in that group engages in mass murder (such as the Oklahoma bombing, Las Vegas shooting, etc.) but they stereotype those who practice Islam (when there is an "event")."

External foes allow for not only unifying the in-group but diverting attention from real differences. When we don't have an external enemy, or even an external focus, our view narrows to potential threats in the immediate milieu, and we become adept at finding scapegoats. History is replete with examples of those in power deftly deflecting ownership of an issue and subsequently positioning groups against one another. One does not need to look far to see such illustrations today.

While on the one hand, there is ample evidence that immigrants contribute socially, culturally, and economically as new members of communities, if communities aren't

healthy, including economically stable to begin with, immigrants can be seen not as contributors but competitors. They become the blame for many ills. Historically, the "slowing" of immigration has occurred at particular episodes in US history, such as during wartime or economic downturns. At times this included restricting individuals who "looked" like the majority (i.e., those of Northern European descent) and those who did not.

There is the perception that, rather than mitigating conflict, it is being inflamed in a "divide and conquer" fashion. One counterapproach for those marginalized is a "coalition of the oppressed." Not unlike coalition governments – parties that would seem to have less in common, by joining forces, acquire more power. As an example, at the aforementioned human rights conference in Canada, mutual support came from such disparate but equally marginalized communities including LGBTQ, Muslim, and Indigenous peoples.

Definitions: Foreign-born or immigrant is someone born outside of the United States to non-American parents. Native-born is someone born in the United States or outside the United States to an American parent. A naturalized citizen is a foreign-born individual who has become a US citizen. An undocumented immigrant is a noncitizen who is not a legal resident of the United States. A refugee is someone who has left his or her country due to persecution or fears of persecution. One group that is particularly targeted is comprised of those individuals who are "undocumented." Again, facts may cloud the issue, but the number of undocumented individuals in the United States has actually declined and stabilized since a peak in 2007 [31].

Bias

We often fail to recognize the significant impact emotions play on our cognitions. We may think and behave in biased ways unconsciously. Malcolm Gladwell gave an example of this in his popular book, *Blink* [32], referencing a test (with numerous subtypes) called the implicit-association test (IAT) [33]. When choosing the test on implicit bias toward European Americans or African Americans, as of 2015, almost 70% of participants show bias favoring European Americans, with only 18% neutral and less than 15% bias favoring African Americans. There is an IAT measuring religious biases between Jews and Muslims. While some question the validity of tests such as these, they do offer opportunities for reviewing our own potential biases.

Other exercises that are intended to assist people in gaining insight into relationships with themselves and others include simple diagrams such as the Johari Window and the "Cone in the Box."

Religion and Politics

Two of the more emotionally charged topics (and as such, not often discussed at family gatherings) are religion and politics. According to a Pew Research Center article noted above by Lipka [34] in 2002, the perception by Republicans/leaning

and Democrats/leaning who felt that a majority of Muslims in the United States held anti-American sentiment was very similar: Republicans,47%, and Democrats, 42%. By 2016, this had changed to Republicans, 63%, and Democrats, 41%.

Jonathan Haidt, in his book, *The Righteous Mind* [35], theorizes how progressives, conservatives, and libertarians prioritize particular values. Further work by Haidt and colleagues within moral foundations theory [36] elucidates how all three politically minded groups share a similar "weight" on the importance of fairness but that progressives strongly support the concept of caring, libertarians liberty, and conservatives foundations of loyalty, authority, and sanctity. It would appear that this articulation might afford an opportunity for joining around the "fairness" concept and expanding to agreed-upon examples of the other shared values. It would be difficult to argue the importance of any of these values.

It is apparent that facts alone do not sway opinions or deeply held beliefs. It is important that we recognize our own biases and not feed them. Our vigilance should not necessarily be about who is different and how, but in discerning when and in what ways this is relevant. Challenging our own beliefs and those of our in-group is not without risks to our own identity as delineated in the discussion on cognitive dissonance.

Leadership

A 2011 White House Paper entitled "Empowering Local Partners to Prevent Violent Extremism in the United States" [37] noted, "…but we must remember that just as our words and deeds can either fuel or counter violent ideologies abroad, so too can they here at home. Actions and statements that cast suspicion toward entire communities, promote hatred and division, and send messages to certain Americans that they are somehow less American because of their faith or how they look, reinforce violent extremist propaganda and feed the sense of disenchantment and disenfranchisement that may spur violent extremist radicalization."

Studies show that people are less biased against other cultures and religions when they personally know an individual from that group. Our community's mosque has held two open houses for the community in the recent past in order to enhance relationships. The members served ethnic foods and shared their literature, and the Imam answered questions from the audience about their religious community and beliefs. The events were very well-attended, and guests commented on how appreciative they were to learn more from their Muslim neighbors.

In speaking with young Muslim physicians, they have shared the positive impacts within their own communities when these efforts have occurred. There is also significant pride in their own contributions to society. We are at a point where the leadership within and outside of Islam is incredibly important. As a young Muslim physician noted, "It comes down to leadership, not just in the U.S., but in Muslim countries…" To paraphrase, US leaders must not speak in a way that emboldens others to discriminate. Muslim leaders must call out terrorism when it occurs, and their actions should match their words.

These young professionals also cite the benefits of dialogue in countering misconceptions. When civil discussions are able to take place, changes in attitudes and beliefs on both sides often occur. The examples of positive leadership noted within this chapter are given not to imply that there are easy solutions to complex problems but to show that leadership and civil dialogue can make a significant difference.

The Responsibility of the Psychiatric Community

Section 7 from the American Psychiatric Association's *The Principles of Medical Ethics With Annotations Especially Applicable to Psychiatry* [38] states, "A physician shall recognize a responsibility to participate in activities contributing to the improvement of the community and the betterment of public health." One of our resident physicians noted that this is not simply a religious issue, but a political and socioeconomic one as well. I would add that it is a public health issue. From a societal wellness standpoint, it has significant implications, as articulated in the book, *The Spirit Level: Why More Equal Societies Almost Always Do Better* [39].

In public health matters, we know that it is much more effective (including cost-effective) to focus on primary prevention. Hebling, in *Islamophobia in the West* [40] calls on the educational system to play a role in dialogue on matters of discrimination and prejudice. Others [41] have made the same clarion call.

Conclusion

The First Amendment to the Constitution of the United States [42] protects freedom of religion and freedom of speech and expression. When looking for a rallying point for mutual agreement on why Islamophobia is harmful, this should be front and center. From the standpoint of the American standard of individual liberties, individuals residing in our country should not have to fear harassment and discrimination because of their religious practices or choice of appearance or dress.

All citizens can continue to enhance resilient communities by:

1. Agreeing to commit to a space for civil discourse
2. Using commonality as the default mode in our relationships and tolerating (if not accepting/celebrating) differences
3. Considering an inclusionary vs. exclusionary stance
4. Admitting that we may not be able to see our own biases
5. Remembering that any relationship takes nurturing and work
6. Seeing prejudice as a social/public health issue

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31 Islamophobia and Public Mental Health: Lessons Learned from Community Engagement Projects

Sara Ali and Rania Awaad

Effects of Islamophobia on Muslim American Mental Health

Likely fueled by the political discourse surrounding the US 2016 presidential elections, Muslim communities throughout the US felt a noticeable spike in anti-Muslim incidents. The Council on American-Islamic Relations (CAIR), the nation's largest Muslim civil rights and advocacy organization, reported a 57% increase in anti-Muslim incidents in 2016 compared to 2015 [12]. Anti-Muslim sentiments take different forms, e.g., stereotyping, profiling, verbal abuse, physical aggression, burning of mosques, and bomb threats [28, 32]. Those sentiments were not attributed with specific locations or settings. In fact, incidents were reported in schools, campuses, offices, mosques, and even recreational areas. Institutional Islamophobia includes aggrevated forms of surveillance, interrogation, detention, and deportation, among other violations of civil rights [5]. What makes the problem even more complex is that some Muslims experience racial discrimination in addition to the religious harassment [28] resulting in double or even triple stigma as will be further explained in the chapter.

The damaging consequences of Islamophobic incidents extend to different age groups, cultural backgrounds, and genders [12]. Due to the unpredictability of the time, place, and circumstances of Islamophobic incidents, Muslims tend to be in a continuous state of hypervigilance and insecurity. This alarmed state of mind has detrimental effects on the psychological well-being of Muslim Americans. Most of the literature documenting the adverse effects of Islamophobia on health and well-being draws from studies done on the effects of racism and discrimination on

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minority populations, with the exception of few studies that focused on Muslim Americans [28]. These studies have unveiled new dimensions for the Islamophobia problem as it impacts individuals, social relations, and communities at large, as we explain next.

On an Individual Level

Discrimination and anti-Muslim sentiments contribute to the development, exaggeration, or progression of mental illness of Muslim Americans [2]. Discrimination-related stress is a known pathway for triggering multiple psychological problems including anxiety and depression [26].

Muslim youth who are easily identifiable by their appearance (e.g., wearing a hijab for girls or a kufi for boys) often are the target of bullying at schools. According to the 2016 report published by CAIR on Muslim students residing in California, there has been a decline in the safety of the school environment for Muslim youth [14]. Findings also showed that 53% of the respondents have experienced verbal or physical harassments at their schools. Thirty-seven percent of girls wearing the hijab reported being exposed to physical assaults in the form of hijab tugging, pulling, or touching.

This early exposure to harassment affects the developmental well-being of Muslim youth, which is further explored in a separate chapter in this book. In addition to increased risks of anxiety, depression, and sleep difficulties, bullying has also been positively correlated to poor school adjustment and decline in educational attainment [14].

On an Interpersonal Level

Fear of stigma and stereotyping results in social marginalization that deprives Muslims of the health-promoting effects of social engagement [34]. Anticipation of harassment in the public arena negatively affects how Muslims engage with other people, making it challenging to develop a community life. Belonging to a stigmatized group can result in internalizing Islamophobic stereotypes and identity concealment [34].

On a Community Level

Islamophobic incidents that happen to Muslims in any part of the United States perpetuate a sense of insecurity and could result in trauma by proxy. In 2015, three visibly-Muslim youth were murdered in their apartment in Chapel Hill, NC, by their Islamophobic neighbor. This tragic hate crime resulted in widespread fear, anger, and anxiety in Muslim communities across the United States and the world.

Applying the Socioecological Model to Examine Factors Affecting Vulnerability and Resilience to Islamophobia and the Development of Psychosocial Problems

To protect Muslims from the adverse effects of Islamophobia, there is a need for creative prevention measures that consider the multifaceted aspects of the problem. Islamophobia should be conceptualized as a public health threat to Muslim Americans. Risk and protective factors are best captured using a socioecological model, which can serve as a framework for understanding factors that influence the development of a health problem. A socioecological model seeks to understand the influence of the interactions individuals constantly have with their naturally surrounding ecosystems on the development of health status or emergence of a health problem. The model is often depicted in the form of four nested hierarchical levels: individual, interpersonal, community/organizational, and policy/enabling environment.

In the next section, we will examine risk factors that make Muslims more prone to the negative psychosocial effects of Islamophobia and the protective factors that buffer these adverse effects, at each of the four levels of the aforementioned socioecological model.

Individual Factors

These refer to personal modifiable and non-modifiable characteristics that influence the development of a health problem. They include personal beliefs and attitudes, resilience, gender, ethnicity, religiosity, and socioeconomic and educational status. Drawing from the literature on racism, studies have shown that resilience is a protective factor against psychosocial stressors and a buffer against the effects of racism [13, 20, 38]. Resilience is the inherent ability of individuals to adapt and handle life-changing situation and stressors [6].

Gender is another important factor determining the risk of exposure to Islamophobia. Both females and males are at risk of different forms of harassment, with veiled females being more vulnerable due to their visible identity [32]. Historically, the image of veiled Muslim women has been negatively represented by the media to justify anti-Muslim sentiments. Muslim women who are veiled are the target of different forms of verbal and physical abuse, while men are more prone to being profiled in institutions and stigmatized as being terrorists, or violent.

In addition to religious discrimination, race plays a role in aggravating or buffering this effect. The interplay of race with religious affiliation puts Muslims at risk of double or sometimes triple stigma, depending on the presence of other risk factors [32].

Muslim religiosity has been reported to have protective effects against psychological distress. Several studies have found that religiosity was positively correlated with life satisfaction and optimism [1] and was linked to lower anxious and depressive symptoms [19]. The effect of religiosity on Muslims' well-being in the context of Islamophobia is unclear, however. In the light of the previously mentioned

studies, religiosity acts as a buffer to distress. On the other hand, a religiously visible identity puts Muslims at risk of Islamophobic encounters.

Immigration status plays a role in vulnerability as well. Immigrants and refugees, particularly those who experienced trauma in their country of origin, are at higher risk of psychological distress [2]. According to some studies, people who migrated from countries that are politically unstable are more likely to suffer from mental health problems than those who came from stable countries [9, 25].

Interpersonal Factors

Individuals who have previous experiences of discriminatory interactions are more likely to suffer from continuous anticipation of harassment that puts them at a higher risk of developing psychosocial problems [2]. Because family is an important asset to Muslims, a history of abuse to any family member is a risk factor to others in the family, feeding their state of hypervigilance [31].

Fear of stigma by mental health providers acts as a barrier to seeking mental health care [8, 23]. Lack of spiritually and culturally sensitive mental health services aggravates this challenge [23]. Studies show that Muslims are concerned about being misunderstood by their providers [4, 8] which make them less likely to talk to a professional. In general, Muslim and American community-grown stigmas form barriers to seeking professional help [4, 8].

Community Factors

In this context, a "community" is generally defined as a collection of groups or organizations, that have a direct or indirect influence on health problems. In the case of Muslim Americans, this typically means Muslim community centers, mosques, schools, colleges, hospitals, etc. It also includes groups, network ties, neighborhoods, and geographical locations. The influence of these entities on the well-being of Muslim Americans could be positive or negative depending on ideological and political views held by members of these organizations, their recognition of diversity, and their degree of cultural and religious sensitivity. For instance, public schools that are located in diverse neighborhoods are more likely to be "culturally friendly" and less Islamophobic compared to schools with less diverse populations.

Muslim community centers play an important role in the lives of religiously observant Muslims [24, 27]. They not only act as a place of worship, but they also provide a space for socialization, communal, and pastoral support. Some Muslim community centers provide social and mental health services. The presence of these services can provide culturally sensitive psychosocial support that can buffer the adverse effects of Islamophobia and thus be considered protective factors for those

who utilize them. These services can also prevent the progression of psychological problems through appropriate screenings/referrals or even management depending on the degree of services provided [10]. Several studies have documented the role of imams in providing psychological support to Muslim Americans [2]. Inability of imams to make appropriate mental health referrals, and the lack of mental health resources within Muslim community centers, leaves Muslim Americans with unaddressed psychological problems vulnerable.

Organized anti-Muslim hate groups also exert negative effects on the well-being of Muslim Americans. According to a report released by Southern Poverty Law Center (SPLC) in 2017, there has been a dramatic increase in the number of these organizations [37]. It is estimated that the number of hate groups tripled from 2015 to 2016 and has continued to rise to reach 114 chapters in 2017.

The widespread level of hateful rhetoric in media portals has provided an ongoing stage for Islamophobia to grow and shape public opinion [31, 32]. Negative portrayals of Muslims in TV shows and movies, whether overt or subtle, feed into serotyping and discriminatory attitudes toward Muslim Americans [32, 39].

Policy Factors

Over the last three decades, laws and policies have provided a platform for the growth and progression of Islamophobic sentiments [32]. Legislation such as the Patriot Act passed in 2001 has increased the risk of detention, unjustified arrests, and interrogations of Muslim Americans [3, 7]. The Executive Order 13769, titled "Protecting the Nation from Foreign Terrorist Entry into the United States," which is known as the "Muslim ban" suspended the entry of foreign nationals from seven majority Muslim countries: Syria, Iran, Sudan, Libya, Somalia, Yemen, and Iran. According to a report issued by CAIR in 2017, the timing of the executive order coincided with heightened levels of hate crimes toward Muslims, estimated to be increased by 67% compared to 2016 and an immensely anxiety-laden time for Muslims worldwide [11].

A summary of the interplay of previously discussed risk and protective factors is illustrated in Fig. 31.1.

The interplay between risk and protective factors affecting the development and progression of psychosocial stressors for American Muslims requires mental health interventions to act on multiple levels (personal, interpersonal, community, policy).

Other chapters discuss how to address Islamophobia in clinical settings by providing interventions on individual/interpersonal levels. In this chapter, we use a wider lens to address the mental health effects of Islamophobia, with attention to the community level and using community engagement as an effective approach.

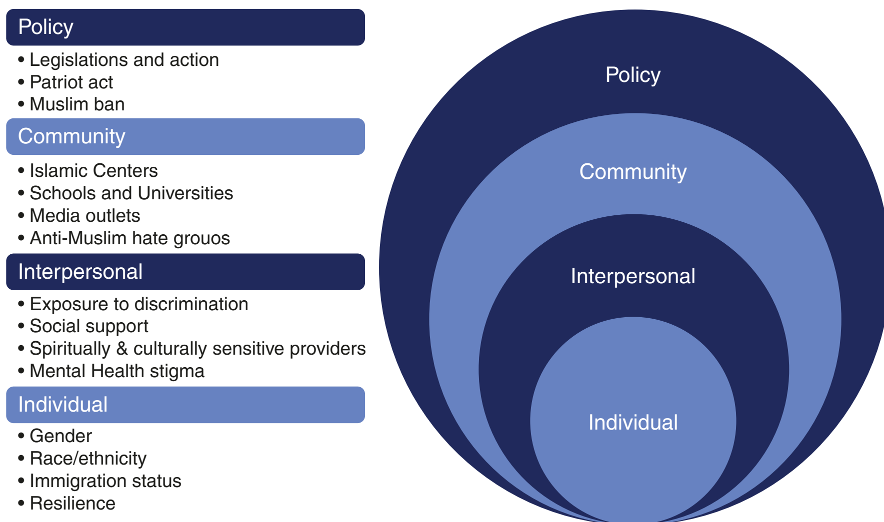

Fig. 31.1 Socioecological model depicting factors affecting vulnerability to Islamophobia and the development of psychosocial problems

Community Engagement: A Bottom-Up Approach to Address Complex Problems

Traditionally, health promotion projects were led by professionals with little or no input from the targeted communities [21, 29]. This top to bottom approach resulted in interventions that were ineffective and insensitive to the culture and needs of communities. Minority populations are more vulnerable to being negatively affected by this approach since they have long suffered from underrepresentation and misrepresentation in public health activities, research, policy, and interventions [22, 35]. This, consequently, contributes to the rise in health inequalities among minority communities.

A community engagement approach to health promotion stems from the idea that health is shaped by social and physical constructs. To improve the well-being of a community, an ecological view has to be employed to capture the culture, religion, lifestyles, behaviors, ethnicities, and other social determinants of health of that community. Thus, bringing the perspectives of community members on improving the well-being of their own community becomes a necessity.

Community engagement strategies have the potential to reduce health disparities by providing community members the opportunity to advocate for their needs and participate in designing interventions that are sensitive to their social, cultural, and political contexts [29, 30].

Studies have shown that interventions which use a community engagement approach are likely to be well-received by targeted populations, resulting in self-sustainability, better health behaviors, and perceived social support. Enlisting new

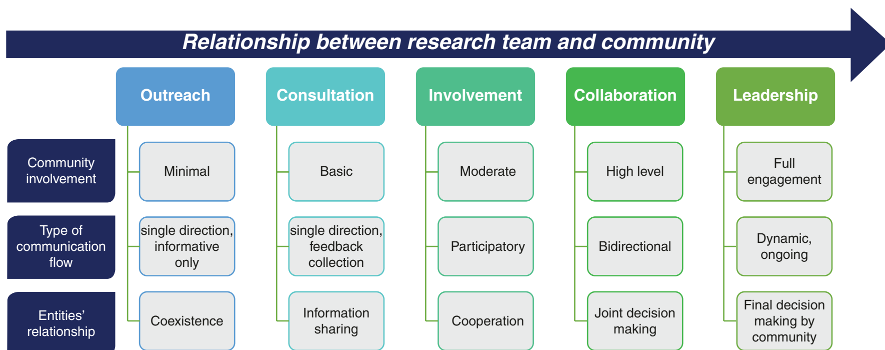

Fig. 31.2 Community engagement continuum

resources, building trust, establishing allies, and improving health outcomes are some of the goals that community engagement projects seek to achieve [15, 36, 40].

To understand more about community engagement, let us start by explaining what we mean by that term. Community engagement is defined as "the process of working collaboratively with and through groups of people affiliated by geographic proximity, special interest, or similar situations to address issues affecting the well-being of those people" ([15], p. 9).

In light of the above definition, community members could refer to those affected by the health problem being targeted. More broadly, they could also be stakeholders such as professionals, researchers, policy makers, or expert by personal experience who are from or involved with the targeted community in any capacity.

Engagement is usually described as a continuum of community involvement. The continuum starts with "outreach" which focuses on establishing communication channels with the desired community. It is a one direction process, in which information is partially shared with the community without eliciting feedback. As we move along the continuum, the partnership and sharing of information start to become bi-directional. The role of community members grows to include sharing decision making and finally co-leading the projects. A summary of the continuum of community engagement modified from CDC [14] is illustrated in Fig. 31.2.

In the next section, we discuss Muslim mental health promotion projects conducted in California which used community engagement strategies. Community members were involved in a multitude of tasks ranging from consultation roles to designing and delivering interventions.

Case Studies

Stanford-MCA Partnership

Overview

In 2016, the Stanford Muslims and Mental Health Lab (SMMH) was awarded a pilot grant from the Stanford Center for Clinical and Translational Research and

Education (SPECTRUM) to enhance an emerging research partnership with the Muslim Community Association (MCA), the largest Muslim community center in the Bay Area, California. Initial goals of the grant included (1) establishing a community advisory board of Muslims to lead the partnership, (2) conducting research focus groups to explore barriers and facilitators to utilization of mental health services among religiously observant Muslim Americans in the Bay Area, and (3) identifying strategies to improve access to mental health services.

Method/model of community engagement used: The project used a community-based participatory approach. The first phase of the project focused on developing the community advisory board that represent the large and ethnically diverse Muslim population residing in the Bay Area and served by the MCA. The recruitment process started by consulting key stakeholders from the MCA community who in turn suggested names of community members who could represent diversity in gender, age, professions, ethnicities, and cultural and religious ideologies. Once the first cohort of stakeholders was recruited, they in turn suggested other community members for recruitment. The Community Advisory Board (CAB) members participated in monthly meetings through which they were engaged in the research process, discussed their leadership roles, and received training on principles of CBPR.

The second phase of the project was to conduct focus groups to explore barriers and facilitators to utilization of mental health services in the Muslim community. CAB members participated in designing the focus group case scenarios, and they led the recruitment process. They were responsible for running the focus groups under the supervision of the principal investigator, Dr. Rania Awaad, from their academic partner, Stanford University.

Outcomes Outcomes of the CAB meetings were fivefold: Over a renewable 1-year term, CAB members (1) served on the community advisory board, (2) conducted four focus groups (for men, women, youth, and religious leaders) that explored barriers and facilitators to utilization of mental health services, and (3) based on feedback from the focus groups, determined the mental health needs of Muslims residing in the Bay Area in order to guide future mental health activities and research. (4) CAB members helped develop a database on Muslim mental health practitioners who practice in the Bay Area and (5) developed a mental health crisis response team that is culturally and religiously sensitive to the needs of the Muslim community.

The partnership was built on the principles of community-based participatory research (CBPR), which seeks to create an equitable relationship between researchers (academia) and community members. Based on the importance of co-learning, CBPR encourages communities' participation in the co-construction of knowledge [41] and in shaping the research agenda.

The Stanford-MCA partnership started with the consultation phase in which community members were providing feedback for developing the focus groups and recruiting participants. Then the involvement increased when they co-led the focus groups. Now the partnership is taking this blossoming collaborative relationship to

the next level in which community members are shaping future research questions, identifying mental health needs of the community, and taking a leading role in developing new projects.

Bay Area Muslim Mental Health Professionals

Serving a minority population can be a lonely journey that requires considerable sincerity and dedication. Adding to that, the lack of evidence-based practices contributes to the uncertainty and stress of the work of health professionals. In 2014, a group of Muslim mental health professionals joined forces to build upon previous grassroots efforts to organize Muslims MH providers, breaking this loneliness by meeting regularly for peer support, networking, and mentorship. The group, now known as the Bay Area Muslim Mental Health Professionals (BAMMHP) network, has grown from a handful of mental health providers to over 100 interdisciplinary MH providers and trainees. The monthly meeting of the BAMMHP has been hosted by Muslims and Mental Health Lab at the Stanford School of Medicine, Department of Psychiatry and Behavioral Sciences. The group meets to share expertise, and resources, develop culturally and spiritually sensitive trainings, establish research and professional collaborations, and mentor young professionals interested in serving the Muslim community.

A major outcome of these meetings was the formal establishment of the Bay Area Muslim Mental Health Professionals as a network of Muslim-identified mental health providers and students whose focus is to link the local Muslim community with psychological support and resources. The network includes an interdisciplinary group of licensed Muslim psychiatrists, psychologists, social workers, and marriage and family therapists, professional counselors, and psychiatric nurses. The combined expertise of this group has facilitated outreach and education to the Bay Area Muslim community regarding topics on mental health and well-being, including but not limited to parenting support, depression, anxiety, youth issues, substance use, trauma, marital and premarital counseling, and personal development, among others.

Another outcome of the BAMMHP has been aiding the CAB in the development of a directory that lists mental health providers in the Bay Area who are Muslims or who have experience working with Muslims. The directory allows users to search by location, gender, religious affiliation, language spoken, type of the provider, and qualification of the provider. The directory is hosted at www.BayAreaMuslimTherapists.org which has an easy-to-read guideline that explains the differences among mental health disciplines and basic information about types of therapists. The network provides a platform for the emergence of several projects including the crisis response team (CRT) that will be discussed later. Participants from the network participate in ongoing research projects in the Bay Area including helping the Muslim Community Association and Stanford Muslims and Mental Health Lab develop and recruit for the Muslim Community Advisory Board.

Degree of Community Engagement

This is an example of an organically developed community-based project in which mental health professionals who belong to a certain community acted as a catalyst for social change and health equity. Driven by the professional needs of minority serving providers and the needs of their own community, BAMMHP created a platform for the exchange of ideas and for innovative projects to emerge and grow. Although not intentionally designed, the fashion by which ideas were exchanged and developed by the group could be best explained by the diffusion of innovation theory. According to the theory, for an innovation to come to light, ideas are first generated and communicated among members of groups through multiple channels [33]. In addition to the preplanned lectures that were presented in the monthly meetings, BAMMHP dedicated time slots for social networking and random discussion. This created a natural channel for participants to freely exchange thoughts and opinions. The interdisciplinary nature of participants played a role in enriching the discussions and bringing different perspectives to emerging projects. BAMMHP had a flexible framework that allowed some of these projects to become stand-alone entities.

Challenges and Future Directions

As with other volunteer-based projects, time availability and lack of funding are some of the challenges that face the BAMMHP network. Building a stronger infrastructure for the network is becoming an imminent need. Future directions include seeking grant funding to ensure financial stability and conducting trainings for BAMMHP leaders. The network also might be hosted at the newly opened Khalil Center Bay Area headquarters, a spiritually integrated psychotherapy center, to help the network grow and provide needed trainings and resources for sustainability.

MH Crisis Response Team

Overview The Bay Area Muslim Mental Health Crisis Response Team initially developed informally in the aftermath of the Chapel Hill shootings. Muslim communities around the United States were shocked to the core. Individuals and families were reporting various psychological stressors ranging from anxiety, fear, anger, and depression. A group of Muslim mental health therapists and counselors lead by a psychiatrist came together and initiated a crisis response team. The team utilized the network that was being formed under the Bay Area Muslim mental health professionals to recruit volunteer therapists and launch their initiative.

The main goal of the team was to reduce the significant emotional distress that Bay Area Muslims were experiencing through providing education, empowerment, and support activities. The team focused on providing intervention on an individual level and on a community level. On an individual level, the team developed a crisis hotline which provided free counseling sessions over the phone and in-person to

distressed individuals. If participants needed further assessments, counseling, or medications, they were referred to appropriate mental health services. On a community level, the MH crisis team was able to partner with Islamic organizations such as Council on American-Islamic Relations (CAIR), Ta'leef sisters support group, Muslim Students' Associations on multiple university campuses, and mosques (including MCA, Muslim Community of the East Bay, Masjid al-Huda, Berkeley Masjid, Islamic Center of Alameda, Oakland Islamic Center). Furthermore, they partnered with legal organizations serving minority groups such as the Stanford immigration law clinic, ACLU, and the Asian Law Caucus. Through these partnerships, the MH crisis team was able to provide support groups, community events, and informational workshops.

Outcomes The crisis response team had a formal launch in 2016 in which they developed a website and started to recruit mental health professionals to serve leadership roles in the Crisis Response Team (CRT). Now the CRT has six individuals forming the team core and serving as co-chairs, regional coordinators, a communication coordinator, and a resources coordinator. The team also includes a list of 20 professionals who pledged to volunteer running and leading activities in times of crisis.

Challenges and future directions for the crisis response team include further developing their infrastructure through strategic planning, recruitment, and professional trainings. So far, their work has been based on volunteerism, and their next steps include seeking grants funding for sustainability. Furthermore, they are expanding their partnerships to include organizations serving other targeted minority groups including the Sikh Coalition and Services, Immigrant Rights and Education Network (SIREN) to exchange expertise and design common projects. They are also seeking partnership with well-established non-mental health organizations that serve Muslims and provide trainings in disaster response and media communications such as Islamic Relief Disaster Response Team and Islamic Networks Group. Another type of partnership in progress is connecting with local officials such as chiefs of police and mayors to educate the Muslim community about city and county resources available at time of crisis.

Reflections

The CRT team realized during their formal and informal launch that addressing mental health crises in the Muslim community has to always adopt an interdisciplinary approach that leverages community assets and addresses the social, legal, and spiritual needs of the community at time of crisis. Integrating spirituality into their individual and community interventions was one of the successful strategies utilized by the CRT. One of the spiritually sensitive approaches used was the involvement of religious leaders and scholars early in their educational and awareness initiatives. Involving legal organizations such as CAIR in the crisis discussion was crucial in educating the Muslim community about their legal rights and ways to be involved in civic engagement.

MAS-SSF

Overview To meet the growing mental health and social needs of Muslims residing in Sacramento, a group of community members established a nonprofit organization named Muslim American Society-Social Services Foundation (MAS-SSF) in 2007 as a separate project from its parent organization, MAS-Sacramento Region. One of the main goals of MAS-SSF was to provide Muslims with spiritually, culturally, and linguistically sensitive mental health and social services. The organization started with training a group of dedicated community members in providing peer counseling. MAS-SSF chose a peer counseling model because of its client-centered approach based on a recovery model that promotes health and wellness and encourages self-directed recovery.

Outcomes Over 10 years MAS-SSF has trained 20 peer counselors. They have provided peer counseling services to Muslims residing in California in 15 languages. During this period, services have expanded to include workshops, awareness events, lectures, and support groups. MAS-SSF now has its own youth hotline, called AMALA, which provides phone counseling to youth and refers them to appropriate services. MAS-SSF has partnered with local clinics and organizations for referrals. All the services provided are offered for free, or for a minimal fee.

Degree of community engagement This is a unique model of community engagement in which the organization was developed and led by community members side by side with mental health professionals. MAS-SSF succeeded in keeping community members at the heart and soul of the organization which guaranteed that their interventions deeply reflect community needs. This success was achieved by continuous recruitment of community members and establishment of partnerships with key stakeholders in the community.

Reflections and Future Directions

Since the inception of MAS-SSF in 2007, the organization has earned the trust of the local Muslim community. Throughout the years, strong connections have been built with local Islamic centers, mosques, and key stakeholders. The organization has been part of the Racial and Ethnic Mental Health Disparities Coalition (REMHDCO) which is a California statewide coalition that includes state and local organizations working on reducing mental health disparities for racial and ethnic communities. Through this continuous participation, MAS-SSF has been a strong advocate for the underserved Muslim communities in California.

In 2016, the organization was awarded a grant from California Department of Public Health—the office of health equity as part of California Reducing Disparities Project. The grant will be used to build the organization's infrastructure and hire more staff and peer counselors. The grant will also be used in refining their peer

counseling model and evaluating its effectiveness through a participatory evaluation led by Stanford Muslims and Mental Health Lab.

Khalil Center

Overview

The lack of spiritual and culturally sensitive mental health services acts as a barrier that prevents Muslim Americans from seeking professional help. Responding to the growing mental health needs of the Muslim community, a grassroots organization named the Khalil Center was launched in 2010. The Khalil Center is a social and spiritual community wellness center that addresses the widespread prevalence of social, psychological, familial, relational, and spiritual issues of Muslim communities. The first site opened in Chicago, Illinois. The organization has since expanded, opening two other offices in Chicago, three in California, and one in New York over the course of 7 years. Furthermore, their tele-counseling and tele-psychiatry services reach Muslims across the nation that do not live near a Khalil Center site. Khalil Center's staff are made up of an interdisciplinary team of licensed mental health providers of different racial/ethnic backgrounds. To address the need for linguistically sensitive care, services are offered in multiple languages including English, Spanish, German, Urdu, Hindi, Farsi, Pashto, and Arabic. To address the need for spiritually sensitive care, all of the Khalil Center therapists are Muslim and undergoing specialized didactic training to integrate psychotherapeutic techniques from Islamic spirituality into their therapy with Muslim clients.

Outcomes

To date, the Khalil Center is the largest mental health agency serving Muslims in America. The centers have collectively served nearly 2000 clients across the country. Over 1500 appointments were scheduled in 2017 in California locations. To exchange resources and build partnerships, the organization has expanded its outreach efforts to include local hospitals, mosques, police departments, and congress offices. The Khalil Center holds regular lectures and workshops in Islamic centers, schools, and university campuses to educate community members on mental health and counter stigma. Believing in the value of research in driving clinical work, the Khalil Center is partnered with the Urban Youth Trauma Lab at the University of Illinois-Chicago and the Muslims and Mental Health Lab with the Stanford Psychiatry and Behavioral Sciences Department. Through these academic partnerships, the Khalil Center participates in conjoint research projects that aim at assessing the growing mental health needs of the Muslim community and developing spiritually and culturally sensitive psychotherapy models.

Reflections and Future Directions

As the largest and longest serving institution serving the Muslim American community, the Khalil Center's success partially arises from its three-pronged model of direct services, community outreach, and academic research backing. The Khalil

Center found that in order to build trust within the Muslim community and for their clinical services to be truly effective in addressing the mental health needs of the Muslim community, their work had to be coupled with educational initiatives and their therapeutic offerings guided by research. Future directions for the Khalil Center put them on track to open up branches in other metropolitan cities with large Muslim populations such as LA and Boston. The leadership structure of the Khalil Center includes clinical directors of each branch who are dually trained in mental health as well as in the Islamic sciences. This has given it credibility within a faith community that often looks to their spiritual leadership for guidance. Its financial model has also facilitated ease of accessibility for Muslims from all walks of life. The Khalil Center takes private insurance, offers a sliding scale based on household income, and offers a financial assistance program that draws from zakat (earmarked alms-charity funds collected by the Muslim community).

Conclusion

Islamophobia has negative impacts on the psychological well-being of Muslim Americans. Recognizing the interplay of individual, interpersonal, and community factors on the well-being of Muslim Americans is crucially important in providing culturally sensitive mental health care and establishing rapport with Muslim clients. Involvement in community interventions is one of the ways providers can utilize to counter mental health stigma and encourage Muslim Americans to seek professional mental health care. For community interventions to truly address the needs of Muslims, engagement strategies should guide all steps of interventions, taking into consideration community beliefs, resources, and social and political constructs.

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Psychological Determinants and Social Influences of Violent Extremism

32

Ahmed Zakaria Hankir and Steven Hassan

Section 1

Terrorism in the West

People from all walks of life commit violent extremist acts, from followers of the "free love" Rajneesh destructive cult movement responsible for perpetrating bio-terrorism in the United States [1] to members of the doomsday terrorist organization Aum Shinrikyo who orchestrated the sarin gas attacks in Japan [2]. In the United States, it is estimated that over 90% of terrorist acts are committed by non-Muslims [3]. However, over the last decade, violent extremisms carried out by self-proclaimed Muslims in the United States, United Kingdom, France, Australia and elsewhere in the West have dominated the collective consciousness of the public on a global scale [4].

On 22nd of May 2017, Salman Abedi, a second-generation immigrant born and raised in the United Kingdom, entered the foyer of the *Manchester Evening News* arena during a concert and detonated an improvised explosive device killing 23 people and injuring over 500 others [5]. What propelled Abedi to carry out the deadliest terror attack on British soil since the London suicide bombings in 2005 [6]? Jomana Abedi, Salman's sister, reported that her brother had said he had been driven by a desire to seek "revenge" for US and UK military attacks in the Middle

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East [7]. Yet, although Western foreign policy has often been cited as a "political pathway" to violent extremism and radicalization, the vast majority of British Muslims who disagree with the British Government's military interventions in Afghanistan and Iraq do not condone or commit terrorist attacks in any way, shape or form. (The so-called "political pathways" to terrorism are beyond the scope of this chapter but can be explored further in a separate chapter in this book entitled "A Case Study of the Political Determinants of Division: Muslim Perceptions of British Combat Troops".)

Acculturation, Mental Health and Terrorism

Mental health experts suggest that acculturation may be a contributory factor in the case of Salman Abedi and those like it [8]. According to Kamran Ahmed, a consultant psychiatrist based in Sydney, in an article published in *The Guardian* [9], the acculturation process can be a stressful one: trying to meet the cultural expectations of parents while trying to fit in with peers, dealing with experiences of racism and balancing religious and Western values. Ahmed argues that the acculturation process poses a challenge for many disaffected Muslim youths living in Western countries today [9]. Ahmed then cites a study that shows that for those who find themselves at odds with the culture of their parents, and yet are met with hostility from the culture of the society in which they live (despite their best efforts to be accepted by them), exiting the acculturation paradigm to embrace a third culture that provides them with a sense of belonging may be a seductive option [10]. Ahmed surmises that in this case their (i.e. disaffected Muslim youth) minds become fertile ground for radicalization [9]. Indeed, potential recruits for terrorist groups are more likely to feel angry, alienated or disenfranchised, believe political involvement cannot instigate change, identify with perceived victims of social injustice and feel a need to act. They believe violence against the state is justified, have friends or family sympathetic to the cause, and benefit psychologically from a sense of adventure, camaraderie and heightened identity [11, 12].

In an interview for Al-Hayat Media Centre – an organization that has been producing recruitment videos for Daesh – UK-born terrorist Abu Bara al-Hindi stated that he knows what it feels like for Western Muslims and that the "cure for depression is jihad" [13]. Abu Bara al-Hindi's statement might resonate with disaffected Muslim youth who are vulnerable to being recruited by terrorist and cult organizations since it is an established fact that Islamophobia is associated with psychological distress [14]. We argue that this would be an opportunity for authorities and agencies to intervene to prevent people from being drawn into terrorism. However, the current counterterrorism strategy *Prevent* that the British Government has launched has received criticism from reputable organizations such as the Royal College of Psychiatrists who argue that it treats Muslims as a "suspect community" [15]. This is discussed further in the book chapter, "Islamophobia: A British Muslim Experience".

"Lone Wolf Terrorists" Should Be Called "Fringe Actor Terrorists"

Mark Hamm and Ramón Spaaij, under the auspices of the US Department of Justice, conducted the largest and most comprehensive study on "lone wolf terrorism" in the United States. Hamm and Spaajj revealed that there is no standard profile of terrorists in this category. Characteristics that many of them did share, however, were being unemployed, single, Caucasian, male and having a forensic history. Compared to members of terrorist groups, "single-actor" terrorists are older, less educated and more prone to mental illness. The radicalization model formulated by the study authors indicates that "lone wolf terrorism" begins with a combination of personal and political grievances *which form the basis for an affinity with online sympathizers* [16].

In relation to Salman Abedi, the UK Home Secretary Amber Rudd adamantly argued that Abedi was not a "single actor" but rather that he was part of a broader network. Experts in the field of terrorism not only assert that there are almost no true "lone wolves" but that there are few examples of individuals who have succeeded in making a lethal explosive device by themselves [7]. We argue, based on these assertions and the research findings of Hamm and Spaajj (and that of many other authorities and academics in the field of violent extremism and radicalization), that "lone wolf terrorist" is in fact a misnomer. Given that we are living in the digital age and that social media is seemingly ubiquitous, radicalized individuals seldom, if ever, operate in total isolation but rather function as part of a broader "virtual" network. The term "lone wolf" glamorizes a terrorist and may be a factor that perpetuates violent extremism. A term that SH coined and which we feel should replace "lone wolf" is "fringe actor" (see Fig. 32.2); we will use this term hereafter.

The Mental Health of Fringe Actor Terrorists

On the 22nd of July 2011, Norwegian far-right terrorist Anders Breivik detonated a van bomb outside a government building in Oslo claiming the lives of eight people. Within a few hours of the explosion, Breivik travelled to Utøya island, the site of a camp for a Workers' Youth League, and, posing as a police officer, started firing his weapon intermittently and indiscriminately for more than an hour killing a further 69 people. On the day that the 2011 Norway attacks were launched, Breivik used digital technology to disseminate his manifesto entitled "*2083: A European Declaration of Independence*", which explicitly outlines his opposition and hostility towards Islam and stipulates that all Muslims should be deported from Europe with immediate effect. Breivik confessed that the motive behind his terror attacks was to promulgate his fascist ideology [17]. Breivik's case illustrated how Islamophobic sentiment can be deadly for both Muslims and non-Muslims.

As in the case of other more recent fringe actor terror attacks, speculation was rife that mental illness had a prominent role to play in the atrocities that Breivik

committed. Two teams of court-appointed forensic psychiatrists assessed Breivik before his trial and agreed that he was experiencing some form of psychopathology. However, they were unable to reach a consensus about his mental health status, the first team diagnosing Breivik with paranoid schizophrenia and the second with narcissistic personality disorder [18].

This does beg the question, is mental illness associated with fringe actor terrorism? Academics at University College London researched 119 fringe actor terrorists and a matched sample of group-based terrorists to test if there was any difference in the rate of mental illness between the two cohorts. The study showed that the odds of the former having a mental illness are 13.49 times higher than the odds of the latter. The study also showed that fringe actor terrorists with mental illness were more likely to have been recent victims of prejudice and to have experienced acute and chronic stress [19]. Since fringe actor terror attacks are on the rise (there was a 19% increase in terrorism fatalities due to "unaffiliated actors" from 1955 to 1999 [20]) and since people in this group have been linked to psychological disturbance [19], arguments have been made that better provision of mental health services may represent a more productive prevention strategy than simple counterterrorism [21].

There are many "life cycle" events that make people *situationally* vulnerable to undue influence (see Section 2). As human beings, we all go through young adulthood and seek to develop our sense of personal identity, so it is quite normal for there to be curiosity and experimentation regarding new experiences, people and ideas. However, cult recruiters are experts at finding out about a person's background and their potential situational vulnerability such as "moving to new city, state or country", bereavement of a loved one, illness, graduation, loss of job and divorce or breakup of a relationship. These are examples of the situational factors that make people more vulnerable to undue influence [22].

Other personal and dispositional factors that can make a person more susceptible to undue influence include sleep deprivation; past trauma; anxiety disorders; insecure or disorganized attachment; being highly hypnotizable, highly compliant, highly suggestible and prone to dissociation; and having an autism spectrum disorder. A common and spurious misconception is that people who are recruited into destructive cults are unintelligent, uneducated, weak or "losers". In fact, as will be discussed in Section 2, many people who are recruited to join destructive cult organizations are highly intelligent, successful and talented but were deceptively recruited at a vulnerable moment in their lives [22].

Section 2

Section 2 *of this chapter will focus on the unethical psychological techniques that cult organizations like Daesh use on their members, namely, undue influence and mind control.*

What Are the Differences Between Ethical and Unethical Social Influence?

Ethical influence empowers a person to have an internal "locus of control" concerning their personal, authentic identity, which includes their conscience, creativity, free will, volition and ability to make independent decisions. Undue influence or destructive mind control is any ideological authoritarian system of influence that promotes radical personality change. It is any act of persuasion that overcomes the free will and judgement of another person and makes that person compliant and obedient to direction. People can be unduly influenced by deception, flattery, trickery, coercion, hypnosis and other unethical techniques. Undue influence confuses and assaults an individual's authentic identity and creates a synthetic, alternative cult identity that suppresses it. It is a pernicious phenomenon that can infect peoples' minds to such an extent that it can create a "programmed cult identity". The "virus of undue influence" can stealthily invade its host and infiltrate his or her thoughts altering their words, values, behaviour, character and modus operandi [22].

Mind control and undue influence overlap; both refer to the process of controlling people by mentally hijacking their normal thought processes. Moreover, mind control and undue influence can both violate personal boundaries and human integrity as well as ethics and, often, the law. In a legal context, undue influence primarily refers to mind control and is the better term since exploitation forms part of its definition [22].

This process of social influence to recruit and indoctrinate people can be achieved through digital media. Deception (lying, withholding vital information or distorting information to make it more palatable) short-circuits and undermines informed consent. Former cult members all report that they would never have joined if, from the outset, they understood the processes used on them and the acts they would ultimately be directed to commit [22].

It must be clear that the practice of mind control is not entirely nefarious or unethical. Indeed, mind control, when conducted by a regulated and licensed practitioner in a controlled environment can be beneficial. Mind control spans a continuum from an entirely ethical practice to a grossly unethical one that flagrantly violates the rights of humans. For example, in clinical practice, it is acceptable for a licensed healthcare professional to use hypnosis to achieve a positive therapeutic outcome [22].

Lifton's Eight Criteria of Mind Control

Robert Lifton is an eminent American psychiatrist who is regarded by many as a foremost authority on mind control and thought reform. Lifton is a member of the Collegium International, a global organization of leaders with political, scientific and ethical expertise whose goal is to pioneer innovative approaches to promote world peace, prosperity and security.

While Lifton was a psychiatrist with the US Air Force during the early 1950s, he interviewed American servicemen who were prisoners of war (POWs) during the Korean War as well as priests, students and teachers who had been held captive in prisons in China. Lifton also interviewed Chinese students who had fled after having been subjected to indoctrination in Chinese universities. Lifton published the findings of his research in his 1961 book *Thought Reform and the Psychology of Totalism: A Study of "Brainwashing" in China*, in which he describes his Eight Criteria of Mind Control and the coercive techniques used in the People's Republic of China that he labelled "thought reform" or "brainwashing" [23]. In 1999, Lifton wrote *Destroying the World to Save It: Aum Shinrikyo, Apocalyptic Violence, and the New Global Terrorism* and applied his model of unethical influence to the Japanese sarin gas cult [24].

Lifton's Eight Criteria of Mind Control are listed below and forms the basis of SH's BITE model influence continuum (which Lifton himself has endorsed):

1. *Milieu Control*. This involves the control of information and communication both within the environment and, ultimately, within the individual, resulting in a significant degree of isolation from society at large.
2. *Mystical Manipulation*. The manipulation of experiences that appears spontaneous but is, in fact, planned and orchestrated by the group or its leaders to demonstrate divine authority, spiritual advancement or some exceptional talent or insight that sets the leader and/or group apart from humanity and that allows reinterpretation of historical events, scripture and other experiences. Coincidences and happenstance oddities are interpreted as omens or prophecies.
3. *Demand for Purity*. The world is viewed as black and white, and the members are constantly exhorted to conform to the ideology of the group and strive for perfection. The induction of guilt and/or shame is a powerful control device used here.
4. *Confession*. Sins, as defined by the group, are to be confessed either to a personal monitor or publicly to the group. There is no confidentiality; members' "sins", "attitudes" and "faults" are discussed and exploited by the leaders.
5. *Sacred Science*. The group's doctrine or ideology is the ultimate truth, beyond all questioning or dispute. Truth is not to be found outside the group. The leader, as the spokesperson for God or for all humanity, is likewise above criticism.
6. *Loading the Language*. The group interprets or uses words and phrases in new ways so that often the outside world does not understand. This jargon consists of thought-terminating clichés, which serve to alter members' thought processes to conform to the group's way of thinking.
7. *Doctrine over Person*. Members' personal experiences are subordinated to the sacred science, and any contrary experiences must be denied or reinterpreted to fit the ideology of the group.
8. *Dispensing of Existence*. The group has the prerogative to decide who has the right to exist and who does not. This is usually not literal but means that those in the outside world are not saved, unenlightened and unconscious, and they must be converted to the group's ideology. If they do not join the group or are critical

of the group, then they must be rejected by the members. Thus, the outside world loses all credibility. In conjunction, should any member leave the group, he or she must be rejected also [23].

Festinger's Theory of Cognitive Dissonance and Mind Control

To truly fathom mind control, we must go further back in history to the horrific events that occurred during World War II. Atrocities such as the Holocaust led to a multitude of social psychological experiments, including Milgram's landmark study that yielded both fascinating and frightening insights into the numerous ways that people are influenced, unduly or not, both as groups and as individuals. The findings of these studies revealed a consistent pattern of the remarkable power of *behaviour modification techniques*, *group conformity* and *obedience to authority*. These three factors are known in psychological terms as "influence processes" and demonstrate that circumstances often determine human behaviours, overriding the values and beliefs of the individual [25]. These insights from social psychology can be used to identify the basic components of mind control.

Cognitive dissonance theory, which was first described by American psychologist Leon Festinger, can also be used to identify the basic components of mind control. Festinger argued that the three principal components of cognitive dissonance theory are *control of behaviour*, *control of thoughts* and *control of emotions*. In 1950 Festinger famously summarized his basic principle as follows: *"If you change a person's behaviour, his thoughts and feelings will change to minimize the dissonance"*. In basic terms, he was referring to the conflict that occurs when a thought, a feeling or a behaviour is altered in contradiction to the other two. A person can tolerate only a certain amount of discrepancy among his thoughts, feelings and actions which, after all, construct different components of his identity. Festinger's theory states that if any one of the three components change, the other two will shift to reduce the dissonance [25].

How does this kind of shift apply to the behaviour of people in cults? In 1956 Festinger published a book entitled *When Prophecy Fails*, about a Wisconsin flying saucer cult, whose leader had predicted the end of the world. The cult leader claimed to be in telepathic communication with aliens from another planet. Ludicrous though this may have seemed, followers of this destructive cult believed their leader and soon sold their homes, donated their money and stood at the appointed date on a mountainside awaiting flying saucers to rescue them from oblivion (the leader of this cult "prophesized" that an apocalyptic flood was imminent and that it would destroy the entire world) [25].

When morning arrived with no saucers and no flood – just a spate of satirical news stories ridiculing the group – the followers might have been expected to become disillusioned and angry. And a few did – but they were fringe members who had not invested much time or energy. Most members, however, developed even deeper convictions about their beliefs and stronger allegiances to their leader who proclaimed that the aliens had witnessed their faithful vigil and decided to spare the

Earth. Cognitive dissonance theory helps explain how and why this heightened commitment occurred. According to Festinger, people need to maintain order and meaning in their life. They need to think they are acting according to their self-image and their own values. If their behaviour changes for any reason, their self-image and values change to match. The crucial factor to recognize about cult groups is that they deliberately create dissonance in people in this manner and exploit it to control them [25]. A huge failing of governmental agencies and the mental health community is to have underestimated how psychologically astute destructive cult organizations are.

Introduction to the Founder of the BITE Model Influence Continuum

SH is an expert by professional and personal experience and is one of the world's foremost authorities on cults and mind control. Since 1976, SH has helped thousands of people who were victimized by cult-related mind control. He has led many workshops and seminars for mental health professionals, educators and law enforcement officers, as well as for families of cult members [22].

SH was deceptively recruited into Sun Myung Moon's Unification Church at the age of 19 while a student at Queens College. He spent the next 27 months recruiting and indoctrinating new members, fundraising and organizing political campaigning. SH ultimately rose to the rank of assistant director of the Unification Church at National Headquarters. Following a serious automobile accident, he was deprogrammed by several former Moonies, at his parents' request [22].

In 1999, SH founded the Freedom of Mind Resource Center, Inc. (freedomofmind.com), a consulting, counselling and publishing organization dedicated to upholding human rights, promoting consumer awareness and exposing abuses of undue influence, mind control and destructive cults. SH has codeveloped a groundbreaking curriculum, Ending the Game, to help victims of sex trafficking to understand psychological coercion used by pimps [22].

SH pioneered an innovative approach to help victims of mind control called the Strategic Interactive Approach (SIA). Unlike the stressful and media-sensationalized approach known as deprogramming, this noncoercive approach is an effective and legal alternative to help cult members. It teaches family and friends how to strategically influence the individual involved in the group [22].

The BITE Model Influence Continuum

SH, from his extensive personal and professional expertise on destructive cults, added an extra element to Festinger's tripartite theory of cognitive dissonance to explain mind control: *control of information*. SH argues that if you regulate the information someone receives, and use information to manipulate a person's experience, you restrict his ability to think for himself. These four components of

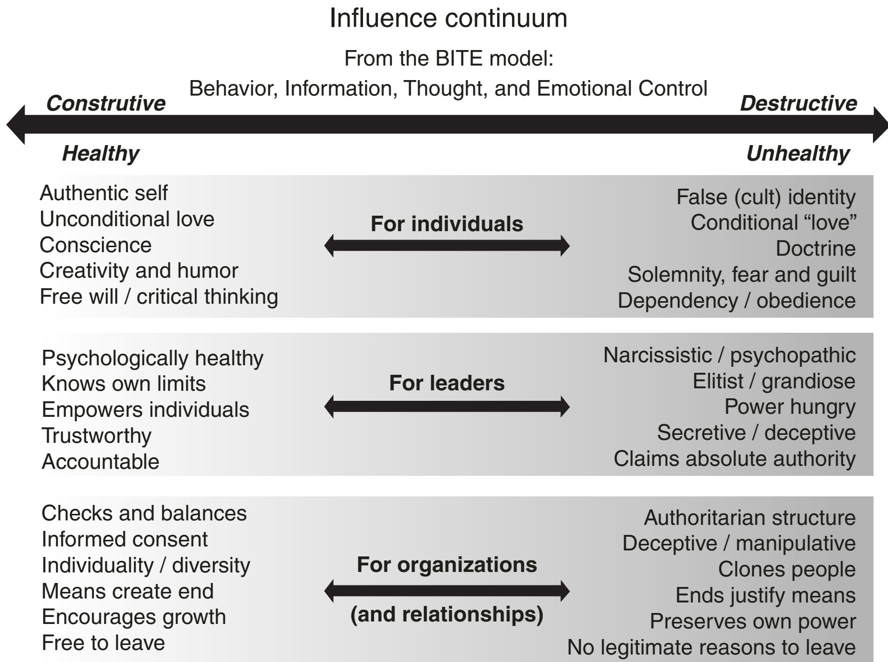

Fig. 32.1 The BITE model influence continuum. (Used with permission from Hassan, S. Combating Cult Mind Control)

mind control, behaviour, information, thoughts and emotions, form what SH calls the BITE model of mind control that destructive cults employ over their members (see Fig. 32.1).

Cult organizations distinguish themselves from normal and healthy social or religious groups by subjecting its members to systematic control of behaviour, information, thoughts and emotions to keep them dependent and obedient. The BITE model of mind control that cult organizations use over their members describes an extensive list of strategies in these four overlapping categories. These include deceptive recruitment, controlling sleep, controlling time, loaded language, thought-stopping techniques and many other variables to induce phobia indoctrination [22]. More recently, Daesh has been reported to use drugs like Captagon in their control of its members [26]. The influence continuum uses the extensive list to help people understand destructive situations as summarized in Fig. 32.2.

Mind Control and the Mental Health Profession

The 5th edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5), a nosology of mental disorders compiled and published under the auspices of the American Psychiatric Association, defines other specified dissociative

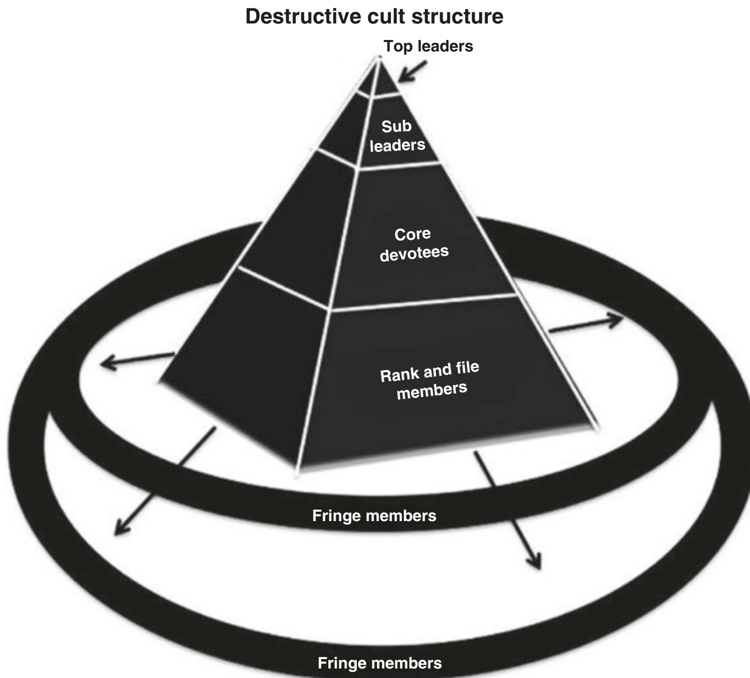

Fig. 32.2 Destructive cult structure. (Used with permission from Hassan, S. Combating Cult Mind Control)

disorder 300.15 as an: *"Identity disturbance due to prolonged and intense coercive persuasion: Individuals who have been subjected to intense coercive persuasion (i.e. brainwashing, thought reform, indoctrination while captive, torture, long-term political imprisonment, recruitment by sects/cults or by terror organizations) may present with prolonged changes in, or conscious questioning of, their identity* [27]*"*.

Mental health practitioners and therapists, however, are largely unaware that mind control meets the diagnostic criteria of a psychiatric disorder, let alone are they familiar with the specialized approaches that have been pioneered and developed to treat it. There was an occasion in recent history when the situation could have changed. Former President of the American Psychological Association (APA) Professor Philip Zimbardo, who conducted the now-famous Stanford prison study, recognized that the APA had largely neglected the mental health needs of victims of mind control. In 2002, Zimbardo solicited Alan W. Scheflin, then a professor at Santa Clara University School of Law, to chair a panel entitled Cults of Hatred, at the APA's annual convention [22].

In his opening remarks, Scheflin said that the mental health community had not addressed the needs of two different populations: those who accurately believe that their minds have been controlled in cultic and other situations and those who mistakenly believe they are the victims of mind control and may be suffering from delusions or paranoia. The event brought together academics like Scheflin and

Zimbardo, therapists who work in the field of mind control and former members of cult organizations. It was ostensibly a watershed moment in the recognition of how destructive mind control could potentially be for victims and the APA's commitment to addressing this [28]. Professor Zimbardo wrote in the President's column of the *APA Monitor* [28]:

> A basic value of the profession of psychology is promoting human freedom of responsible action… and supporting an individual's rights to exercise them. Whatever we mean by 'mind control' stands in opposition to this positive value orientation… mind control is neither magical nor mystical, but a process that involves a set of basic social psychological principles. Conformity, compliance, persuasion, dissonance, reactance, guilt and fear arousal, modelling and identification are some of the staple social influence ingredients well studied in psychological experiments and field studies. In some combinations, they create a powerful crucible of extreme mental and behavioural manipulation when synthesized with several other real-world factors, such as charismatic, authoritarian leaders, dominant ideologies, social isolation, physical debilitation, induced phobias, and extreme threats or promised rewards that are typically deceptively orchestrated, over an extended period in settings where they are applied intensively. A body of social science evidence shows that when systematically practiced by state-sanctioned police, military or destructive cults, mind control can induce false confessions, create converts who willingly torture or kill 'invented enemies,' engage indoctrinated members to work tirelessly, give up their money—and even their lives—for 'the cause' [28].

Zimbardo hoped that APA board members would wake up to the reality of mind control. That, unfortunately, did not happen. The promise contained in previous editions of the DSM and in the current edition of the DSM-5 remains unfilled and, indeed, unrecognized [28]. We are hopeful, however, that this will soon change, through the concerted and sustained efforts of enlightened mental health professionals and, importantly, the growing number of former members who are raising awareness of mind control by sharing their stories with the mental health community and, indeed, anyone else willing to listen to them. Zimbardo taught a course at Stanford University for 15 years, entitled "The Psychology of Mind Control", and material for the course included two chapters of SH's book (*Combating Cult Mind Control*). SH conducted a video in 1997 in which Zimbardo cites the BITE model as the tool he thinks is most useful to think about how to control human behaviour [29].

Destructive Cult Structure

Webster's Third New International Dictionary defines a cult as *"a usually small or narrow circle of persons united by devotion or allegiance to some artistic or intellectual program, tendency, or figure (as one of limited popular appeal)* [22]*"*. A destructive cult is a pyramid-shaped authoritarian regime with a person or persons occupying the helm that impose absolute dictatorial control over their members (see Fig. 32.2). Examples of organizations that employ unethical mind control include religious cults, political cults, psychotherapy/educational cults and commercial cults. Religious cults are the best known and most numerous and focus on religious

dogma. Daesh, Boko Haram, the Unification Church and Scientology are all examples of religious cults. Scientology is unusual, as it began as a psychotherapy cult. It now functions as a commercial cult and operates under the guise of religion [22].

Recruitment into a Cult Organization: How It's Achieved

There are many ways that people can be recruited to join a group through unethical mind control. Cults often deliberately seek out and recruit people who are intelligent, talented and successful. As a result, its members are often powerfully persuasive and seductive to newcomers. Indeed, the sheer number of seemingly sincere and steadfast members whom a newcomer meets is probably just as convincing, if not more, than the actual doctrine or ideology behind the cult itself [22].

Large cults use slick propaganda and know how to train their "salespeople" well. They indoctrinate their recruiters to reveal only the best sides of the organization. Recruiters are taught and trained to assess each newcomer and to formulate a psychological profile (which includes identifying any factors that might render the newcomer vulnerable or resilient to undue influence and mind control) and to package and "sell" the cult in whatever way is most likely to succeed [22].

In the Moonies, SH was taught and trained how to use a personality model comprised of four "gates" to recruit new members. People were categorized as thinkers, feelers, doers or believers. Thinkers approach life with their minds and identify themselves as intellectuals, feelers are led by their "heart" and emotions, doers are action-oriented and fixated on "bravado and brawn", and believers are spiritually oriented who invariably believe that they are on a "holy mission" for a noble cause, i.e. social justice. Once SH assessed a potential newcomer as thinker, feeler, doer or believer, he would adjust his approach accordingly. For example, when SH met someone who he assessed as a feeler, he would adopt a loving and caring approach with that person. SH would emphasize and boast that members of the Moonies had exceptionally elevated levels of emotional well-being and that they all belonged to "one big happy and loving family". SH would then state that he only experienced true love when he joined the Moonies movement. Since feelers often yearn to be accepted and loved [22] (and in many cases may experience the adverse effects of social exclusion and ostracization if they possess a stigmatizing attribute like mental illness [30]), they would be vulnerable and succumb to this recruitment strategy [22].

With this one simple personality model to guide recruiters, the Moonies organization cast a broad recruitment net that captured a diverse range of people. Indeed, Moonies like members of many legitimate Christian organizations regarded themselves as "fishers of men", a term taken from Jesus' metaphor for describing his disciples in the New Testament [31].

With the creation of the Internet, and the incredibly powerful social media reach, online destructive cult recruitment has largely replaced in vivo recruitment. Hundreds of "front groups" can set up, for example, matchmaking web sites or blogs that put out ideas. Recruiters of cult organizations monitor the comments that

are made on these Internet sites. Potential recruits can be "love-bombed" online and surrounded by multiple members of the cult and socially influenced. People are quickly told to be careful and not tell their parents or families and to "keep the secrets" of what God or Allah is doing on Earth now. They use current movies, video games, books and Hollywood style videos to attract and indoctrinate people. Personal information about recruits is often easily accessible or available for purchase on the dark web that can be useful to know how to manipulate and blackmail specific people. Members can be kept up all night (thus depriving them of sleep and rendering them even more vulnerable to mind control) on discussion boards, watch endless videos and be exposed to hypnotic influence all on their own computer in the comfort of their own domicile.

A Case Study of a Terrorist Group Using Mind Control and Undue Influence

Tarek Mehanna is an American Muslim who was convicted of conspiracy to provide material support to Al-Qaeda. Mehanna was subsequently sentenced in April 2012 to 17 years in federal prison. SH was invited by CNN to comment on a voice recording of a conversation that Tarek had with a recruiter for Al-Shabaab, a militant group based in Somalia. The recordings, which were broadcasted by CNN, provide a compelling insight into the unethical techniques that destructive cult groups use to unduly influence and control the minds of potential recruits. Below are excerpts of the transcript of the voice recording and SH's comments (we recommend readers to view the clip to gain a better understanding of the mind control process) [32]:

The recruiter initiates by aggressively exhorting Tarek *"…to come now"* and refers to Tarek by using the Arabic term *"akhi"* which translates as "brother" (adherents of Islam consider themselves to be members of a Muslim family, and they would often refer to other Muslims as their brothers and sisters). The recruiter continues to passionately attempt to seduce Tarek by stating *"I'm telling you, this is the life. There is no other life except this"* which appears to be working since Tarek responds by saying *"Is it still good?"* to which the recruiter states *"It's wonderful akhi, 100%. 100%, akhi. It's more than you even think it is"*. Tarek states that *"he just wants to be somewhere where he can pray 5 times per day"* to which the recruiter replies *"Do you know where I am? You can't even smoke cigarettes, it's illegal"*. The recruiter implores Tarek to *"come here now, you don't even have to have a dime in your pocket. I will set you up with everything. I'll have people pick you up I'll have a place for you to stay and heck if you want I can even have a wife waiting for you"*. Muslims believe that marriage is half of their religion, and the recruiter identified Tarek's vulnerabilities through the Four-Gate Personality Model that was previously described in this chapter (namely, that he is a believer and a feeler). The "hard sell" is laced with religious words and ideas attempting to reel in the recruit. Indeed, according to SH, Daesh is a political cult using religion and a perversion of Islam as the shield to systematically create an army of tranced-out followers [32].

It is noteworthy that there was no explicit mention of beheading someone or detonating a bomb to kill people; the recruiter merely stated, "just come hang out with us". SH describes what happened with Tarek as "deceptive recruiting", in that potential recruits like Tarek are not making informed choices, that they are being lied to, that information is being withheld and that they are incrementally being asked to change their behaviour [32].

Al-Shabaab and Daesh, like other destructive cult organizations, control behaviour, information, thoughts and emotions to create a new identity that is dependent and obedient on the authority figure. However, SH offers hope by stating that *"the human spirit wants to be free"* and that people can *"get out"*. SH asserts that former members of cult organizations are the best tool we have for inoculating the public from mind control and undue influence [32].

Recommendations

There are many millions of victims of undue influence worldwide. Combating destructive mind control requires a holistic, multisystem approach involving policy makers, health and social care providers, faith leaders (such as Imams) and educational providers. "Inoculation" programmes (facilitated by ex-cult members) in workshops and online can protect people from being infected by the mind control virus by teaching them about the techniques that destructive cult organizations use.

Below is a list of recommendations to help raise awareness of mind control and how to combat it:

- Ex-cult members who have received specialized counselling and training are uniquely suited to share their stories of indoctrination with others and should feature prominently in inoculation programmes.
- An educational programme that trains mental healthcare practitioners, religious leaders and educational providers to identify what makes people vulnerable to undue influence should be launched and rolled out nationally and internationally.
- The media has an important part to play in combating mind control. They must not only cover the sensational aspects of the ex-cult member's narrative but must also elucidate the process of how cult mind control is perpetrated.
- Online activism must be put into place to counter the cult recruitment process as well by engaging recruiters and exposing the flaws and weaknesses of what they believe and do.
- Many ex-cult members are misdiagnosed by mental health professionals who prescribe mind-altering psychotropic medications which fails to address the underlying problem. Mental health professionals must receive specialized training on formulating a management plan that takes into consideration the upbringing of their patients as well as psychosocial and political influences exerted on them.

Conclusion

Terrorism, be it the type inspired by neo-Nazi ideology or that espoused by Daesh, is a spectre that is on the rise in the world. There are multiple factors, including "political pathways", that contribute to this vitriolic phenomenon. Several studies have shown that fringe actor terrorists often have mental illness. Moreover, Islamophobia is associated with psychological distress; this can render disaffected Muslim youth impressionable and vulnerable to being recruited by destructive cult and terrorist organizations.

Mental health professionals need to be aware of the social influences and psychological determinants of violent extremism and the unethical techniques that cult and terrorist organizations use to recruit people to join their ranks. Although reputable organizations such as the American Psychiatric Association and the American Psychological Association recognize that mind control is a criterion for other specified dissociative disorder in DSM-5, many mental health practitioners are not aware of this.

If we want to truly counter violent extremism, politicians, faith leaders, educational providers and mental health practitioners must make a sustained and concerted effort to raise awareness of the egregious effects of undue influence and mind control and to organize and commission events and workshops in schools, mosques, churches and synagogues and at primary and secondary health and social care settings, as well as through online programmes. The more that members of the public understand how undue influence works and how to exercise their own free will to preserve their integrity, the more resilient they will be against mind control.

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Editors' Conclusions

Over the course of the year, from July 2017 to July 2018, as this book was initiated and completed, Islamophobia, at least in the USA and the UK, seemed to continue to flourish and adversely affect the mental health and well-being not only primarily of Muslims but also of those assumed to be Muslims and even the perpetrators of Islamophobia. For example, witness this Twitter comment by the renowned US television star Roseanne Barr on May 29: "muslim brotherhood & planet of the apes had a baby = vj", vj referring to Valerie Jarrett, an American citizen with Iranian heritage who previously worked as senior advisor for the Obama administration. This vulgar Tweet, like many other online posts loaded with anti-Muslim sentiment, resonated with a digital community of Islamophobes who "liked" and re-Tweeted them. To its credit, ABC Network, despite her huge popularity, immediately cancelled the Roseanne show in response. An example of Islamophobia in the UK in 2018 was the vile and vitriolic "Punish a Muslim" campaign that was launched on the 3rd of April. "Punish a Muslim Day" encouraged citizens to "accumulate points" by abusing and harming members of the Muslim community by, for example, throwing acid on their faces (50 points) and burning or bombing mosques (1000 points).

If Islamophobia represents the dark side of the human condition, then the reaction towards it illustrates that humanity has not lost its light. For example, in May, a positive media story was a powerful and informative feature in the National Geographic on the resilience of "Being Muslim in America". In the UK, communities up and down the nation united in a show of solidarity for "Love a Muslim Day" which precipitated a Twitter storm (the hashtag #LoveAMuslimDay, as well as #WeStandTogether, trended with more than 42,000 tweets sent).

Unlike the previous year, the 2018 Annual Meeting of the American Psychiatric Association did not include a session on Islamophobia and Muslim mental health. This was clearly not an indication of "a need having been met" since authors repeatedly noted when searching for material for their chapters that there was a paucity of literature and research findings on the subject matter.

This volume attempts to augment other anti-Islamophobia endeavours; however it does so uniquely through an extensive psychiatric analysis of its definition, history, recognition, prevention and treatment. Formulating conclusions about a

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comprehensive book which is perhaps the first of its kind is a daunting task. Perhaps the only firm and simple conclusion is that the book is desperately needed, and we hope it will stimulate further study that will lead to improvement in the mental health of those who are adversely affected by Islamophobia.

Beyond this essential conclusion, we have selected some summary highlights of the book which hardly do justice to the richness, depth and breadth of its chapters but may illustrate what they have to offer. Readers will identify their own highlights but here are some of ours (NB. These take-home messages do not necessarily refer to specific chapters):

1. No matter how Islamophobia is defined and operationalized, and there are almost as many definitions as there are chapter writers, all point out that it is a major psychological and social problem for both perpetrators and victims.
2. The use of the term Islamophobia may itself be reinforcing the misguided fears and discrimination. Mental health practitioners must engage in introspection and be mindful of how unconscious bias may infiltrate their minds and their clinical consultations with Muslims.
3. As with all discriminated against cultural groups, Islamophobia can also be internalized via identification with the aggressors within some Muslims, where it also needs to be identified and addressed.
4. Although there has been a burgeoning rise in Islamophobia over the last two decades, its antecedents can be traced back centuries.
5. Whereas the principles of Islam are clearly delineated in the Qur'an, how they are interpreted and lived varies from Muslim to Muslim although "general trends" do exist in certain cultures and countries. Islamophobia can have unique manifestations and challenges in different communities and countries.
6. The rich and glorious history of Islam regarding mental health care has been essentially unknown and/or ignored by mainstream psychiatry. Examples include the early establishment of psychiatric hospitals and Freudian-like theories of the mind.
7. A holistic approach that integrates Islam and psychiatry is usually the most effective way of treating Muslims with mental health problems.
8. Though traditional psychoanalytic and Jungian psychiatry has tended to ignore or misinterpret Islam, these perspectives potentially have much to contribute, such as a new theory on the Islamic normative unconscious.
9. Cutting-edge research on the neurobiology of intergroup conflict can provide valuable insight into conflictual group relationships.
10. To provide sensitive cross-cultural care to patients who are Muslim, a respectful, humble and caring attitude is essential, allowing the patient to teach the clinician about their beliefs and values.
11. Whereas stereotyping may be based on a kernel of truth, there is much more to learn about the people being stereotyped, including the real risks and psychological aspects of extremism mistakenly branded Islamic. Islam is synonymous with moderation and is antithetical to fanaticism.

12. More attention needs to be paid to the intersectionality of such subgroups as African American Muslims, the Rohingya and other Muslim refugees and people who identify as homosexual and as Muslim.
13. Art and images can communicate and express in ways that words cannot.
14. There are various expert cultural guidelines and formulations to enhance cross-cultural psychiatric care and assessment of those who are Muslim.
15. Islamophobia can be reduced by paying attention to all its manifestations at all levels: individuals, families, institutions and communities.
16. There are thriving models of community care that are Muslim-based, from which to learn and which we can try to replicate.
17. Teachers are critical to reducing bullying of Muslim youth.
18. Preliminary research suggests that new therapeutic techniques, such as virtual reality, may be helpful to reduce Islamophobia by taking on a Muslim persona.
19. The editors and authors, coming from a variety of religious, non-religious, primary language and cultural backgrounds, model an example of how intergroup and intragroup conflict can be overcome in meeting the goals of this book.
20. Islamophobia can literally kill people.

It is as if we editors and authors have spent a year relentlessly searching for a hidden treasure. We have excavated through centuries of strata, and we encountered many obstacles that attempted to thwart our way. We initially discovered items which, on the surface, appeared precious but on further inspection were in fact paltry. We continued to dig deeper through the layers, and when we could not locate what we were looking for, we retreated, changed direction and adopted different approaches. We finally found a chest of treasures within which was a variety of valuable jewels, each one representing a chapter of this book. We hope that sharing these treasures with our readers will help each of you to recognize, prevent and/or treat Islamophobia.

Concluding Image: Within Our Reach

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