Psychiatric Cultural Formulation in the Islamophobic Context

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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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