Transference and Countertransference in Addressing Islamophobia in Clinical Practice

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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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H. S. Moffic et al. (eds.), *Islamophobia and Psychiatry*,
https://doi.org/10.1007/978-3-030-00512-2_12

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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