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

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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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H. S. Moffic et al. (eds.), *Islamophobia and Psychiatry*,
https://doi.org/10.1007/978-3-030-00512-2_15

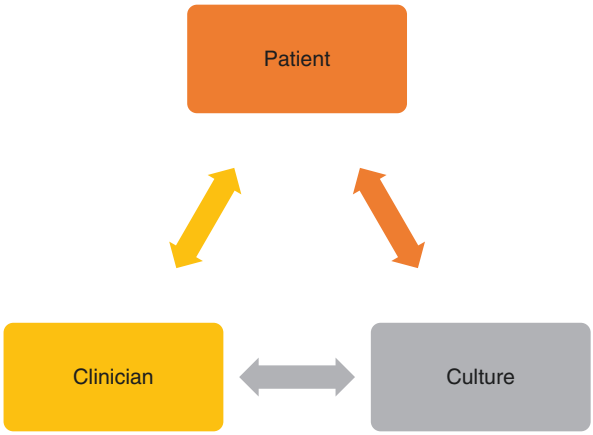

Fig. 15.1 Contextual categories of barriers related to treatment of Muslims

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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