

# Islam 101: Understanding the Religion and Therapy Implications

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How familiar are you with the religion and cultural aspects of Islam and with Muslim clients? As a psychologist, you likely will work with a Muslim client, given the growing number of Muslims in America. Yet very little psychological research or literature discusses Muslim clients or their experiences. This article provides some foundational information psychologists will need to work effectively with Muslim clients. An overview of the Muslim American community, including cultural values, gender role expectations, behavioral prescriptions, and immigration issues relevant in counseling and therapy, is provided. A case example illustrates how clinicians can effectively incorporate cultural aspects of Islam in their work in order to be culturally competent when working with Muslim clients.

Since September 11, 2001, many Americans have found themselves asking, “Who are Muslims?” and “What is Islam?” Media outlets attempted to address questions regarding Muslims and the Islamic faith but have not been able to clarify the numerous assumptions and misunderstandings about this diverse community. Because many questions are still unanswered, assumptions and misunderstandings may affect the work of non-Muslim psychologists and mental health professionals with Muslim American clients. Therefore, it is important for psychologists to understand who Muslim Americans are, the service and practice implications for psychologists in working with Muslim clients, and how to provide culturally congruent mental health services to this community. To provide some guidance in working with Muslim American clients, this article addresses (a) basic demographic information about Muslims in the United States, (b) historical background and the Islamic tenets and practices, and (c) culturally appropriate therapy demonstrated through a case vignette.

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## Introduction to Islam

Islam is the religion of between 6 and 8 million people in the United States. Its followers, called Muslims, are growing in numbers and are projected to soon be the second largest religious group in the United States by the year 2010 (U.S. State Department, 2001). Despite the growing number of Muslims in the United States, many Americans remain ignorant or largely suspicious of this group of people. A Roper poll showed that more than 50% of people in the United States who were surveyed endorsed the view that Islam is “inherently anti-American, anti-Western, or supportive of terrorism” (Blank, 1998, p. 22). However, only 5% of those who were surveyed had ever come into personal contact with a Muslim. In the aftermath of the 9/11 tragedies, there has been a growing need to understand the religion of Islam and to gain insight into the followers of this faith perceived as mysterious and Far Eastern.

The post-9/11 climate in the United States has also made many Muslim Americans highly concerned about discrimination. Since the terrorist attacks, the Council of American–Islamic Relations (CAIR) has logged over 700 discriminatory acts against Muslims (CAIR, 2002). Many of these have been violent attacks or threats against Muslims or those perceived to be Muslim. Along with violent attacks, Muslim Americans also face discrimination. A CAIR civil rights report (CAIR, 2001) showed a wide variety of discrimination, such as denial of religious accommodations (37%), job termination (13%), verbal abuse (8%), unequal treatment (8%), denial of employment (7%), denial of access to public facilities (5%), and other concerns. Of the discrimination cases against Muslims, 50% occurred in the workplace, whereas 15% occurred in schools. Perceived ethnic origin of Muslims was also associated with 25% of the discrimination cases, and praying according to Muslim tradition was related to 18% of discrimination cases. Anti-Muslim activists have also threatened internment of Muslim Americans who do not demonstrate their loyalty to America (McMillan, 2003). Research suggests that some Muslim Americans may actually change the religious practices that target them as Muslims (e.g., women choosing to remove the traditional head-

scarf) to avoid potential conflict or because they have experienced hostility from non-Muslims (Cole & Ahmadi, 2003; Inayat, 2002). With the increasing anti-Muslim sentiment, Muslim Americans may choose to seek mental health help to cope with anxiety, fear, and concern for friends, family, and partners.

Because of space limitations, this article does not discuss all aspects and variants of Islam (e.g., Sufism), Muslim extremism, terrorism, or global sociopolitical matters. This article is not a comprehensive review of Islam or Islamic history. Instead, this article is intended to provide a basic overview that may aid non-Muslim psychologists in designing more effective interventions to meet the needs of their Muslim clients and provide a foundation for future learning by non-Muslim psychologists. In this article, the term *Muslims* will be used to denote the followers of Islam globally and *Muslim Americans* to denote those who live in the United States.

### *Who Are Muslims?*

With nearly 1 billion Muslims, Islam is the second largest religion in the world, preceded only by the Christian faiths (Esposito, 1998). Indonesia is the largest national Muslim population with approximately 170 million Muslims, and Pakistan follows with 136 million identified Muslims (Ash, 1997). In the United States, there are between 6 and 8 million Muslims (U.S. State Department, 2001). The U.S. population of Muslims is divided between immigrants and nonimmigrants (Haddad & Lumis, 1987). Muslim immigrants in the United States are comprised of Arabs (26.2%), South Asians (24.7%), Middle Eastern non-Arabs (10.3%), and East Asians (6.4%). Nonimmigrant Muslims are comprised of African Americans (23.8%) and Caucasian and Native Americans (11%; U.S. State Department, 2001). More than one third of Muslim Americans live in large urban centers concentrated in the Northeast and the East Coast (New York, New Jersey, Massachusetts, Rhode Island, and Washington, DC) and in California and Chicago (U.S. State Department, 2001). One of the largest Muslim communities (predominantly Arab American) is located in Dearborn, Michigan (U.S. State Department, 2001). Because of the high numbers of Arab Muslims and the media attention directed toward them, a common misperception is that all Arabs and Arab Americans are Muslims. However, this is not the case. In 1980, more than 90% of Arabs in the United States identified as Christian (Naff, 1983). More recent immigration trends suggest that the number of Arab Christian immigrants is decreasing, and recent Arab immigrants are Muslims (Erikson & Al-Timimi, 2001).

Moreover, African American Muslims represent a visible American Islamic group. Islam, for African Americans, has a long history predating slavery in North Africa. But slavery and the conversion of African Americans to Christianity essentially limited the practice of Islam until the mid-1920s. Usually considered to be only a part of the Nation of Islam (NOI), African American Muslims actually reflect a wide diversity of Islamic practices and beliefs (Lumumba, 2003). With the founding of the NOI by Wali Fard Muhammad (Gianakos, 1979) and its visibility based on prominent leaders such as Elijah Muhammad and El Haij Malik El Shabazz (Malcom X; Lumumba, 2003), the NOI became virtually synonymous with African Americans and Islam. However, not all

African American Muslims are a part of the NOI. Some may be members of the African American Orthodox Al-Islamic communities. Considering all Islamic groups, almost 40% of African Americans may be practicing Islam (El-Amin, 1993).

### *What Is Islam?*

Terminology is important when working with Muslim American clients. The word *Islam* comes from the Arabic root word *salaam* ("peace") and literally translates from Arabic to English as "surrender." *Islam* denotes the religion, and *Muslim* literally translates as "one who submits to the will of Allah" and denotes a follower of Islam. Islam is sometimes referred to as *Al-Islam*, with the *Al* denoting Allah (Lumumba, 2003), but in this article, the word *Islam* will be used. A term commonly mistaken to be synonymous with *Muslim* is *Mohammedan*, which has been mostly used by non-Muslims to describe the "followers of Mohammed" (to liken Islam to Christianity, as Christians are the followers of Christ). However, Muslims believe that Muhammed was a messenger of God and do not worship Muhammed. In fact, there is a strict prohibition in Islam from ascribing godlike powers to Muhammed, and Muslims may find it offensive to be described as Mohammedan (Hasan, 2002). For Muslims, *Allah* is the word for God of all humanity. Of interest, *Allah* is also used by many Arab Christians when referring to God.

### *Historical Background*

Muslims believe that the religion of Islam began in 7th-century Arabia, when the first words of the *Holy Qur'an* were revealed to Muhammed ibn Abdullah. At this time (610 A.D.), Muhammed was an Arab businessman in the city of Mecca, and every year at the same time, he would meditate in a cave in the Mountain of Hira. During this annual meditation, Muhammed would fast, pray, and give money to the less economically advantaged members of society. Most Islamic historians (Esposito, 1998; Haykal, 1976) agree that Muhammed was deeply troubled with the state of religious affairs in Arabian society, and in particular, the city of Mecca. Muhammed was concerned with the treatment of the elderly, poor, and women (disenfranchised members) in the Arabian society. He believed that the tribal responsibility of caring for all members of society was not properly responded to by its leaders (Armstrong, 2000). Retreating to the Cave of Hira, Muhammed meditated on ways to assist Arabian society to return to a system that promoted social justice and equity (Lippman, 1995). On the 17th of *Ramadan* (Muslim holy month) 610 A.D., while meditating in the cave of Hira, the angel Gabriel brought the first of 6,340 verses of the *Qur'an* to Muhammed. Over the next 22 years, it is believed that the angel Gabriel continued to bring the message of God to Muhammed, who in turn preached to the people of Arabia until his death in 632 A.D.

### *The Holy Qur'an*

The *Qur'an* (or *Koran*) is the holy book for Muslims and has a literal translation into English as recitation. The *Qur'an* was originally in Arabic but has been translated into almost every major language in the world. The majority of the religious terminology in

Islam remains Arabic. The *Qur'an* is divided into 114 *surahs* or chapters organized from the longest to the shortest. Some of the verses of the *Qur'an* are believed to be answers to specific questions or crises (Armstrong, 2000), and thus, many Muslims also learn about particular historical and contextual issues of 7th-century Arabia to better understand the *Qur'an*. *Hadith* refers to the Prophet's sayings, and *sunnah* refers to his teachings. Muslims believe that verses also contain broader universal guidance for future generations of Muslims. Included in this broader guidance are the basic principles of the Islamic religion known as the five pillars of Islam (Esposito, 1998; Lippman, 1995).

### *Five Basic Pillars of Islam*

Although there is great variation in cultural practices (varying by national origin) and adherence to many of the principles of Islam, five basic principles are commonly accepted by all Muslims and serve as foundational principles (Esposito, 1998). The first pillar of Islam is the belief (*iman*) in one God and the belief that the prophet Muhammad was his last and final prophet. *La liha illallah Muhammedoor Rasoola* ("there is only one God and Muhammad is his messenger") is known as the *shahaada*. This is the only phrase that one needs to recite in order to convert to Islam and is considered the basis of the religion. Lang (1996) characterized this phrase not only as a declaration of faith but also as a socio-political statement that implies recognition that there is only one God for all humanity.

The second pillar of Islam is prayer (*salat*). Prayer is prescribed for five times a day. Prayers involve a series of Arabic recitations and prostrations, completed while facing east toward the *Kaaba* (Muslim holy shrine in Mecca), and are uniform across all Muslims. The timing of these prayers is as follows: before sunrise (*fajir* prayer), early afternoon (*zuhur* prayer), midafternoon (*aser* prayer), just after sunset (*maghrib* prayer), and before retiring for bed (*isha* prayer). All of these prayers can be individually or congregationally performed. The third pillar of Islam is called *Zakat*, the alms tax. *Zakat* originally meant self-purification and was not just a charitable act but was considered a "loan to God" (Schimmel, 1992, p. 35). The idea behind *Zakat* is that it is not only a form of worship, but that Muslims give money to rectify social inequalities (Esposito, 1998). The most common estimate of *Zakat* practiced among Muslims in the United States is that 2.5% of all savings and earnings are donated annually. This percentage is to be given to the less fortunate and is commonly paid at the end of the month of Ramadan. (Lippman, 1995). Islam also prescribes fasting (*sawm*), the fourth pillar of Islam, for its followers (those who are financially and physically able). This prescription is completed in the month of Ramadan and requires Muslims to refrain from drinking any liquids, eating, and engaging in sexual activity for the entire period of sunrise to sunset. During this month, Muslims are required to continue their daily activities (work, family obligations, etc.) but also to use this time for self-reflection and spiritual discipline; this is designed to increase empathy for the poor and hungry (Esposito, 1998). Ramadan is the 9th month of the lunar calendar and typically lasts 30 days. Because Muslims follow the lunar calendar, the timing of the month of Ramadan generally falls at different points on the Roman calendar.

Finally, the fifth pillar of Islam is the pilgrimage to Mecca (*Hajj*) to be performed once in a lifetime. Once the pilgrims have arrived in Mecca (the city is currently located in Saudi Arabia), they are required to perform a complex series of rituals to commemorate the lessons of the prophet Abraham (the same Abraham that both Christians and Jews endorse as the founder of these religions). The *Hajj* is obligatory only for those individuals who can afford it, and it happens once a year on the 10th day of *Zul-Hajjah*, which is the 10th month of the lunar calendar.

### *Other Obligatory Practices*

Several other foundational practices are also found in Islam. Because there are a diversity of spiritual practices (Lippman, 1995), this discussion will address only dietary practices, gender roles, dress, and family values.

*Dietary practices.* There is a prohibition on the consumption of pork and alcohol (Lumumba, 2003). The *Qur'an* does not give specific reasons for these restrictions. Although there are different explanations for the prohibition against alcohol and pork, most are speculations by Muslims and Muslim scholars.

*Gender roles, customary dress, and family values.* Gender relations and roles are among the most controversial and disputed issues within the Muslim community with an emphasis on the rights, treatment, and responsibilities of women (Haddad & Esposito, 1998). Because Islam is practiced in almost all parts of the world, ethnic, cultural, and national differences influence the treatment of Muslim women. Many texts offer a more comprehensive view and analysis of Muslim women's issues than this article can address (see Esposito & DeLong-Bas, 2002; Haddad & Esposito, 1998; Hasan, 2002; Wadud, 1999).

For both men and women, Islam does prescribe modest dress, but the *Qur'anic* prescriptions have been interpreted many different ways. Some Islamic cultures believe that women are to cover completely (*burqa*), whereas others believe that the meaning of modesty is open to interpretation and take these verses more liberally (Haddad & Lumis, 1987). Muslim American women often choose, or by cultural or familial expectations decide, to wear the *hijab* (traditional head covering; Cole & Ahmadi, 2003; Inayat, 2002).

Muslims also place a high emphasis on heterosexual marriage (Almeida, 1996; Haddad & Lumis, 1987). Generally, unmarried men and women are discouraged from forming close ties, and intimacy between unrelated members of the opposite sex prior to marriage is discouraged. Muslims are expected to marry other Muslims and will often marry within their ethnic groups because of shared sociopolitical histories and cultural similarities that extend beyond religious commonality. Divorce may be sought, but it is highly discouraged.

The practice of polygamy in some Muslim societies and Muslim American communities is a religiously sanctioned practice. In a response to war when widows and orphans were left without families, the *Qur'an* sanctioned polygamy in a verse that supposedly allowed women and children to be integrated into pre-existing families (Hassouneh-Phillips, 2001). According to the *Qur'an*, polygamy is afforded exclusively to men, who may marry up to four wives only if they are able to treat them equally (i.e., economically, emotionally, and socially). The majority of Muslims

have used this religious injunction as a recommendation for monogamy, arguing that it is theoretically impossible to treat all four women equally (Hassouneh-Phillips, 2001). We discuss the clinical issues and problems that women face as a result of this practice in subsequent sections.

### Clinical Issues and Therapeutic Implications

#### *Refugee Status*

Generally, the concept of mental health and seeking therapy varies for Muslim Americans depending on ethnicity, acculturation, and culture (Hedayat-Diba, 2000; Kelly, Aridi, & Bakhtiar, 1996). Trauma, such as posttraumatic stress, may be a relevant clinical concern for recent Muslim immigrants from Bosnia, Iraq, Afghanistan, and Palestine who have experienced wars and political strife (Weine & Laub, 1995). Some have described the severe postwar trauma of Iraqi refugees as "beyond PTSD [post-traumatic stress disorder]" (Nasser-MacMillian & Hakim-Larson, 2003, p. 156), which has contributed to attention-deficit/hyperactivity disorder, depression, and substance abuse (Nasser-MacMillian & Hakim-Larson, 2003). Additionally, sometimes the trauma may be passed down generationally from parents to children (Sack, Clarke, & Seeley, 1996). Nasser-MacMillian and Hakim-Larson (2003) suggested group counseling may not be effective with refugee groups because of feelings of fear, paranoia, guilt, and shame.

#### *Post-9/11 Anxiety*

Immediately following the 9/11 terrorist attacks, many Muslim Americans reported anti-Muslim incidents, such as acts of violence, threats, and hate messages or harassment (CAIR, 2002). Consequently, Muslim Americans may be feeling anxiety and concerns over their own safety and may also question their allegiance to the Islamic faith. In a qualitative study of British Muslims conducted after 9/11, Inayat (2002) found that participants reported feelings of loss and confusion about their own faith, a need to be different from the perpetrators of the terrorist attacks, the fear that children would not remain Muslim, and reflection on other injustices committed in the name of Islam. These feelings may also be prevalent among Muslim Americans and may lead them to seek therapy. Non-Muslim therapists may serve as a safe and nonjudgmental resource for Muslim Americans to express their doubts about religious beliefs or to cope with experiences of post-9/11 discrimination.

#### *Family Issues*

Many Muslim societies tend to be collectivistic, and individualism and individuation from families is discouraged (Almeida, 1996). The *Qu'ran* repeatedly encourages showing respect to parents, and Muslims (regardless of age) will often defer to parents before making important decisions. Muslims are also discouraged from disclosing personal or familial difficulties outside the family. Because family structures are usually hierarchical and interdependent, members of the family must consider benefits to the family and larger community before making most decisions.

Moreover, Muslim American clients will vary in the degree to which they adhere to religious principles and practice religious prescriptions. Recent immigrants may be considered more religious than their American-born children (Haddad & Lumis, 1987). Conflicts between parents and children about Islam are likely to be common (Lang, 1996). Psychologists working with Muslim families may need to assess the degree of religiosity of both the parents and the children.

Another common issue arising in therapy for Muslim American clients is arranged marriage, which is common among Arab and South Asian immigrants. A great deal of conflict between parents and children may arise because of acculturation and differing views of marriage (Hermansen, 1991). For instance, the practice of arranged marriage for South Asians is based on the concept of practical love versus romantic love. The parents often try to find suitable mates for their children and screen suitable candidates on the basis of certain demographic characteristics (education, career, family background, religious ideals). Parents also facilitate introductions. At times this practice can cause conflict between parents and children, or other issues may arise in relation to this practice. The director of one of the largest college counseling centers in the United States commented about arranged marriages:

Arranged marriages are a common issue for students from cultures where arranged marriage is a tradition and psychologists can increase their credibility among students from those cultures either by having South Asian staff or interns or by targeting outreach to those communities by staff with demonstrated expertise in the cultural mores. When they increase credibility in the population, they will encounter more students with arranged marriage issues. Helpful assistance should be delivered without judgment about the appropriateness of the custom. Students who come to counseling are often in acculturation conflict already. They need assistance in sorting out the various internalized messages, their current cultural realities, consequences and priorities of various options. (L. Douce, personal communication, November 3, 2003)

#### *Alcoholism*

Another important clinical issue receiving little attention in the psychological research or literature is the prevalence and treatment of alcoholism in Muslim societies. Although the religion forbids the consumption of alcohol, it cannot be assumed that all Muslim Americans adhere to this principle. For example, it is quite possible that some Muslim American students who attend large universities where binge drinking is common are as susceptible as their non-Muslim counterparts to alcoholism. Similarly, recent refugees may turn to alcohol to cope with PTSD and adjustment issues (Nasser-MacMillian & Hakim-Larson, 2003). In therapy, Muslim American clients who seek treatment for alcohol-related problems may also feel more comfortable discussing their issues with a non-Muslim therapist because they may be able to discuss alcohol-related problems without feeling guilty or judged.

#### *Depression and Suicide*

In a study of religious factors and coping with depression, Lowenthal, Ginnirella, Evdoka, and Murphy (2001) found that relative to other religious groups, Muslims believed more in the ability of Islam and social support to help them cope with depres-

sion than in mental health treatment. Hence, psychologists may be able to use religious practices and community social support to help devout Muslim clients overcome depression. For example, therapists may be able to suggest that Muslim clients use Islamic tenets to deal with depression, such as using the five daily prayers for meditative purposes or turning to the *Qu'ranic* passages for spiritual lessons. However, caution should be used with these suggestions, especially when feelings of depression seem to be linked to clients' struggles with their religious identity.

Assessing suicidal ideation might be difficult with Muslim clients, especially with those who are less acculturated to Western culture (Hedayat-Diba, 2000). Islam strictly forbids suicide, and for many Muslims, suicide is a criminal act. Therefore, it may be necessary to assess for suicidal ideation by asking about passive expression of suicidal ideation. For example, the therapist could ask, "Do you wish that God would let you die?" rather than asking if they have thoughts of killing themselves (Hedayat-Diba, 2000).

While the majority of practicing Muslims recognize suicide as a criminal act (Hedayat-Diba, 2000), there are many political groups that conduct and support suicide bombings as a way to make political statements. These groups often use the *Qu'ran* and Islam as a way of justifying these acts, just as the Ku Klux Klan has used Christianity to justify violence and hate crimes against various minority groups, in particular African Americans. There are a number of Muslim Americans and Muslim American groups who condemn suicide bombings and the killing of innocent civilians in the name of Islam, regardless of the cause (CAIR, 2003).

### *Women's Issues*

As mentioned previously, there are many women's issues that are important, but only a few can be addressed in this article. For example, Muslim women in America may not feel free to express their religious identity (i.e., how they dress; Hermansen, 1991). Some Muslim American women may decide to fully express their religious identity by wearing the *hijab* or *burqa*, whereas others may rationalize that such dress is not required in the American context and may choose to wear Western clothing (Hermansen, 1991). Other Muslim women may have decided to stop wearing the *hijab* because of negative reactions from others (Cole & Ahmadi, 2003). Religious expression may be a clinical issue for some women, and the therapist may be asked to assist the Muslim woman in making this decision. A discussion of the pros and cons of wearing the *hijab* may be helpful, as well as an exploration of the religious implications of discontinuing this practice.

Marriage is sometimes a contentious issue among Muslim women. Because marriage is highly valued in Muslim societies, unmarried or divorced women may feel alienated from married Muslims. Although the practice of polygamy is illegal in the United States, it is still practiced among some Muslim American men. Hassouneh-Phillips (2001) argued that polygamy practiced among Muslim Americans is often intertwined with abuse and stated that it is important for health professionals to understand the complexity of this phenomenon in order to assist Muslim women in polygamous families to deal with the phenomenon. In a qualitative investigation, Hassouneh-Phillips found that women who were in polygamous families reported abuse and unequal treatment of the wives. They also reported that cowives were both witnesses

and perpetrators of abuse. However, most of the women in this study also expressed a desire to stay in the marriage and keep their families together, often citing the importance of marriage in Islam. In another qualitative investigation, Hassouneh-Phillips (2003) found that Muslim women recovering from partner violence and abuse used spirituality as a coping mechanism to deal with ongoing violence. Religious coping mechanisms included listening to *Qu'ranic* recitation, prayer, and meditation.

### *Social Class Issues*

As with any other religious or ethnic group, social class differences can impact the attitudes, values, practices, and beliefs of Muslims. Because virtually no research or literature addresses the issue of social class for Muslim Americans, it is unclear exactly how social class is operating to impact the lives of Muslim Americans. We can assume that well-educated Muslim clients with financial resources may respond to therapy differently or even better than those without resources. However, research in this area is sorely needed to support this idea and gain a clearer picture of Muslim Americans' responses to psychological treatment across different social class groups.

## Recommended Therapeutic Approaches

### *Establishing Rapport*

Regardless of immigration status, most Muslim Americans are ethnic minorities. Therefore, Muslim American clients may share concerns similar to those of non-Muslim ethnic clients about the therapy process and their trust of psychologists. One way to build trust with Muslim clients is to be aware of negative stereotypes about Islam and Muslims (Shaheen, 1997, 2001) and to provide a place for Muslim American clients to discuss their experiences of discrimination. Addressing clients' attitudes about seeking therapy (Abudabbeh & Aseel, 1999) and perceptions of stigma related to mental health treatment may also be helpful (Al-Issa, 2000; Haque-Khan, 1997). Because self-disclosure and a focus on the self are discouraged, Muslim clients (especially those less acculturated to Western culture) may be unaccustomed to drawing attention to themselves in therapy. Clients may initially hesitate to disclose issues of conflict about their religious beliefs and acculturation until trust is built in the relationship. Thus, Muslim American clients may appreciate an opportunity to discuss their cultural mistrust and suspiciousness of psychologists and may ask about the therapists' intentions and motivations.

### *An Empowerment Model*

McWhirter (1997) outlined a model for empowerment in therapy that may be useful with Muslim American clients. She suggested that facilitating empowerment requires the therapist to integrate five elements in his or her work with clients: collaboration, context, critical consciousness, competence, and community. Collaboration refers to the idea that therapist and client play an active role in the therapeutic relationship, which includes a collaborative definition of the problem and collaborative interventions and strategies for change. Context refers to acknowledgement of the role that context plays in the client's situation or problem. In

other words, the therapist takes into account larger social forces, such as racism, sexism, discrimination, and classism, that contribute to the client's problem. According to this model, critical consciousness is characterized by two processes: critical self-reflection and power analysis. Critical self-reflection "involves increasing awareness of one's privilege, power, strengths, biases, and so forth. . . . Power analysis refers to examining how power, including the power of privilege is used in a given context" (McWhirter, 1997, p. 5). The fourth element is competence, which refers to the therapist's acknowledgement and understanding of a client's resources that can contribute to the therapeutic process. And finally, community is defined in terms of ethnicity, family, friends, places of residence, and common organizational affiliation from which the client can acquire support and resources and can also make contributions to the community. The therapist is encouraged to help the client recognize his or her competence and also to use the resources of his or her community to deal with the presenting therapeutic issue. The following case vignette demonstrates therapy with a Muslim client from an empowerment framework.

### Case Vignette

Mona is a 21-year-old Muslim American senior in college. She was referred to the counseling center by the student health center after she sought their services repeatedly for diffuse symptoms. Mona reported experiencing headaches, body aches, fatigue, and insomnia for the past few months. After several medical tests revealed no known medical causes for her difficulties, Mona was encouraged to meet with a psychologist. Mona reluctantly made an appointment at her college counseling center so as not to defy the recommendations of the physician.

When Mona came in for the initial intake session, a male therapist was the only one available, and so Mona reluctantly agreed to see him for intake. The non-Muslim male counselor, vaguely aware of the Muslim tradition, was anxious. His first mistake, as he found out later, was to greet her in the waiting area by offering his hand to shake. She only stood and smiled at him and walked with him to his office. In her first session, Mona revealed to the counselor that she had kept her appointment a secret and was concerned that others would recognize her in the waiting room. Mona began by expressing her concern that she would be seen as sick. Mona tearfully disclosed that her parents would be very disappointed and concerned if they knew she was deemed to be in need of psychological services.

Mona's family immigrated to the United States from Kuwait during the Persian Gulf War. She was nearly 10 years old at the time. Her parents are Palestinian refugees, and their move to the United States was their third attempt at relocation. Mona reported that her parents had experienced multiple losses and traumas prior to immigrating to the United States. She has lived longer in the United States than in any other place. Mona speaks English fluently, yet is soft-spoken. She avoided eye contact with the male counselor and was uncomfortable with self-disclosure. In gathering information about Mona, the counselor also abbreviated his usual intake protocol by not asking Mona about sexual experiences and alcohol and drug use. He felt that these questions would be too intimate and shocking and would dissuade Mona from therapy.

She initially responded with short answers in response to questioning and interspersed her responses with questions about whether the therapist believed she was crazy or sick.

Before the therapist gathered more information, he outlined what therapy was about, his role, and his expectations. The structure, he believed, would help to alleviate the anxiety related to the ambiguity of being in therapy. In an attempt to form a collaborative relationship, he offered Mona time to think about her goals and to ask for clarification about therapy. Mona stated that she needed help improving her grades and getting over her sadness. She described having difficulty concentrating, tearfulness, and feeling on edge all the time. Mona said she recently quit her work-study position and fears burdening her family with the cost of her books next semester. She said she has been considering accepting a marriage proposal rather than pursuing her long-term goal of medical school. The therapist asked if she would have an arranged marriage. Mona merely stated, "*Inshallah* [God-willing], whatever God has planned for me will happen."

*Therapy issues with Mona.* As the therapist attempted to gain more information and developed a therapy plan with Mona, he would sometimes create therapeutic impasses. He realized that at times his attempts to gain information and make interpretations of Mona's problem stemmed from his stereotypes of Muslim Americans. He also experienced frustration at Mona's lack of self-disclosure. The therapist used supervision to discuss his own biases about Palestinian Muslims and their customs, and he processed his stimulus value in therapy and the power dynamic created when he insisted Mona self-disclose about marriage or family issues. He consulted with colleagues familiar with Palestinian Muslims and regained his confidence by focusing on developing a strong working alliance with Mona. He also began to recognize and focus on Mona's strengths, which included her faith. In the past, her faith provided a coping mechanism to deal with stress (e.g., fleeing Kuwait and relocating to the United States). Mona interpreted these actions as the therapist's interest and increased cultural awareness.

Mona felt more comfortable with self-disclosure after the therapist demonstrated his cultural awareness. She disclosed that she had been feeling increased hostility from classmates and had been facing prejudice at work related to her religion, ethnicity, and wearing a headscarf (that others referred to as a veil). Mona stated that some appeared "sympathetic" to her and wished to rescue her from her "religion that is oppressive to women." She said she felt guilty about her anger, because she knows they meant well. Mona often minimized her concerns, yet it was clear she had been experiencing racism, prejudice, and feelings of guilt for being "associated with the foreign enemy." Mona felt confused by this negativism toward her given that the United States is her home. Mona talked about the paradox that others assume that she is unable to work outside the home as a Muslim woman, and yet she feels discouraged to work because of others' lack of understanding and acceptance of her religious identity.

Mona disclosed that she feels uncomfortable and ambivalent about not informing her parents about her concerns, because she does not want to add to their burdens. Mona said she feels guilty that she sought outside help before her family, and she described her parents as being very concerned about her and discouraging her from leaving the home often for fear that she may be physically

threatened. Mona appeared to be experiencing symptoms of trauma and expressed sadness that her expressions of a positive religious identity or performing her religious practices, such as prayer and fasting, are viewed as fanatical or anti-Western. She expressed that she is tired of having to defend herself and her family and proving her loyalty to the United States. Mona told the therapist that she does not expect anyone to understand, and she feels alone in her struggles.

As Mona disclosed more about the conflicts in her life, the therapist worked with Mona to determine her priorities for therapy. Mona stated that, over the course of therapy, she had become more aware that the root of her sadness lay with her perception of a hostile environment. It was difficult for Mona to go to school knowing that she would have to encounter the same jeers day after day. She stated that much of this anxiety and sadness occurred shortly after the September 11th terrorist attacks. Mona found herself questioning her religious identity and convictions, not because she did not believe in Islam, but because she wanted to make herself as invisible as possible. Mona understood that this internalized racism or Islamophobia caused her to pause in doing her daily prayers and to consider removing her headscarf. At this point, the therapist was able to offer her room to discuss the possibility of choosing to remove her headscarf. This led to a conversation about the pros and cons of this practice and gave Mona the opportunity to process the religious ramifications of discontinuing the practice. After much discussion, Mona was able to conclude that she would like to continue to wear the *hijab*. The therapist by this point had become somewhat familiar with the Muslim groups on campus and recommended that Mona attend a nontherapy group for Muslim women. Mona reported that this group was helpful in reaffirming her faith and finding ways to deal with the discrimination she was facing. Mona also decided to become active on campus, helping to educate non-Muslims about the beliefs of Muslims.

Within therapy, Mona was given permission to ask questions of the therapist, a non-Muslim, about his perceptions and feelings about Muslims. At one point, Mona told the therapist how she was very distrustful of him at first because he tried to shake her hand. She talked about how, for some Muslim women, contact with nonrelative males was prohibited, but when he demonstrated some knowledge of Muslims in America, she felt more hopeful about the therapy process. One important part of therapy for Mona was psychoeducational material the counselor provided about the prevalence of Muslims in America, recent events of discrimination, and public activism against these hate acts. She also felt this information facilitated her own empowerment to become active in educating non-Muslims within the campus community about Islam. At termination Mona reported that therapy assisted her in normalizing her anxieties, sadness, and fears and made her aware of other communities struggling with the same difficulties.

*Case discussion.* In the case of Mona, cultural values and aspects of being a Muslim American woman were addressed. This case reflection highlights several pertinent issues for therapists. At the beginning of the relationship, the male therapist had to examine his own biases and power in the relationship (critical consciousness). By learning more about Mona's context and ethnic background, the therapist was able to identify her strengths and use these to forge a more collaborative relationship with Mona. As the

therapist became more familiar with Mona's religious beliefs and incorporated these in therapy, Mona felt more comfortable revealing her experiences of racism. After time, she was able to connect her racist experiences and her difficulties with her hostile environment. Finally, the therapist was able to help Mona draw on her community as a source of strength and eventually to feel empowered to provide education to those outside of her community. While there were various issues Mona brought to therapy, this case reflected ways that therapists can integrate information about Muslim Americans into an empowerment therapy framework.

## Conclusions

Muslim Americans represent one of the fastest growing religious groups in the United States. Yet, they also remain one of the most misunderstood communities. One outcome of these potential misunderstandings, or lack of information, is the perpetuation of biases in therapy. However, by educating themselves about Islam, cultural values, biases, and the worldview of their clients, clinicians can better provide culturally sensitive treatment.

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### New Editor Appointed for *History of Psychology*

The American Psychological Association announces the appointment of James H. Capshew, PhD, as editor of *History of Psychology* for a 4-year term (2006–2009).

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Manuscript submission patterns make the precise date of completion of the 2005 volume uncertain. The current editor, Michael M. Sokal, PhD, will receive and consider manuscripts through December 31, 2004. Should the 2005 volume be completed before that date, manuscripts will be redirected to the new editor for consideration in the 2006 volume.