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Stress & Trauma Toolkit

for Treating Muslims in a Changing Political and Social Environment

Around the world, both terrorism and the war against terrorism threaten Muslims with death and displacement, destroying neighborhoods and distressing individuals. The heightened anti-Muslim rhetoric of the current political and social environment, coupled with recent terrorist attacks, has created the phenomenon of irrational fear of Islam and its adherents.

Muslims residing in the United States are not immune to these threats. Roughly 1% of the American population identifies as Muslim, and 13% of the American Muslim population is under the age of 15. According to the Council on American-Islamic Relations (CAIR), the number of anti-Muslim hate crimes in the United States rose 91% in the first half of 2017 compared with the same period in 2016. A Pew Research Center analysis of new hate crimes statistics from the FBI found the number of assaults against Muslims in the United States rose significantly between 2015 and 2016, easily surpassing the level of hate crimes against Muslims after the 9/11 terrorist attacks.

Another Pew Research Center survey conducted in early 2017 found that three-quarters of American Muslim adults say there is "a lot" of discrimination against Muslims in the U.S., a view shared by nearly 7 in 10 adults in the general public. In addition, half of American Muslim adults say that in recent years it has become more difficult to be a Muslim in the U.S., with 10% of this group attributing this to discrimination, racism, and prejudice.

Oftentimes, Islamophobia adds to already existing layers of trauma particularly for Muslims who have immigrated to the U.S. seeking safety from conflict-heavy regions of the world. For example, below is a clinical vignette from the American Journal of Psychiatry about Executive Order 13769, titled "Protecting the Nation from Foreign Terrorist Entry Into the United States." This executive order—often dubbed the "Muslim Ban"—was signed into effect by the White House on January 27, 2017.

Clinical Vignette

Ms. A., 40 years old

Ms. A. is a married 40-year-old Muslim Sudanese doctoral student at a university in the United States who was doing dissertation-related field work in Sudan when she learned from her study subjects that a ban limiting the travel of Sudanese nationals to the United States was to be signed into effect the following day.

Ms. A immediately contacted her university and was advised to get on the next plane back to the United States. She missed one of her connecting flights and landed at JFK International Airport in New York 20 minutes after the Executive Order was signed. As a result, she was held in a separate holding area, questioned extensively about her political views and religious affiliation, and asked to disclose her social media handles. She was then patted down in an invasive manner

(including in sensitive areas such as her chest and groin), handcuffed, and transferred to a holding area where she was detained for several more hours with other Sudanese, Iraqi, and Iranian citizens with valid visas.

After legal intervention, she was eventually released and advised by U.S. Customs and Border Protection officials not to return to Sudan because even holders of U.S. Permanent Residency Cards ("green cards") from the seven countries affected by the travel ban were not guaranteed reentry into the United States. This meant that Ms. A would need to forfeit the fieldwork necessary to complete her dissertation and that she could not visit her family. She found herself forced to choose between her academic career and her family.

The incident retriggered PTSD symptoms resulting from trauma earlier in her life that had been dormant for some time. A full mental status examination revealed that she was suffering from severe insomnia, dissociative reactions, flashbacks, nightmares, hypervigilance, poor energy, and lack of productivity. She denied suicidal ideation.

Ms. A met full criteria for PTSD, and she was referred to both psychiatric treatment and therapy. Treatment thus far has been only partially successful, reflective of her post–travel ban situation. Although a revision to the travel ban later permitted green card holders to travel without restriction, Ms. A's situation remains complicated. Her husband's immigration status remains tenuous, and uncertainty about when they will be reunited has put a strain on their relationship. Furthermore, Ms. A had applied for visas for her elderly parents prior to the ban in order to help her father obtain medical treatment in the United States. She reports unrelenting stress after realizing that she may need to wait at least 4 more years for a potential administration change before she can attempt to reapply for a visa for her father, who may not live to see the change.*

** This clinical vignette originally appeared in Awaad, R. (2017). A Muslim Graduate Student from Sudan Trapped by the Travel Ban. American Journal of Psychiatry, 174(10), pp. 925–926.*

Factors that Put U.S. Muslims at Risk for Mental Health Problems

Discrimination, bullying, and profiling: Muslims often report feeling attacked, isolated, and alienated in the US. This affects not only Muslims, but anyone who "appears" or "sounds" Muslim. Muslim women, especially those who wear the Islamic outer Islamic covering, hijab, have become victims of harassment, intimidation, and physical violence. Muslim youth are treated as potential threats and bullied by peers and those in authority, including teachers and professors. Muslim children are more likely to be bullied in school than children of other faiths. A survey by the Institute for Social Policy and Understanding (ISPU) reveals that 42%of Muslims with children in K–12 schools report bullying of their children because of their faith. Kunst et al., reports that the daily, repetitive harassment Muslims face is the biggest factor contributing to long-term mental health issues in Muslim populations. The younger the age of exposure to harassment, the greater the likelihood of developing depression, anxiety, and post-traumatic distress. The sense of persecution felt by Muslims, particularly youth, can impact self-esteem and identity.

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Islamophobia and hostility: Islamophobia attacks core aspects of Muslim identity--race, religion, and ethnicity—creating toxic and persistent stress that has detrimental and cumulative effects on the physical and mental health of individuals in the community as well as the community as a whole. Faith-based discrimination can deprive Muslims of the health-promoting aspects of social connection and communal solidarity, instead of creating a sense of fear, uncertainty, and insecurity that makes it difficult for American Muslims to develop a healthy communal life.

Challenges accessing health care: While socially, culturally, and economically diverse, the American Muslim community by and large shares a religious worldview that influences its members' health-related behaviors and their interactions with the health care system. Despite this, few studies have explored whether American Muslims experience health disparities, or how their beliefs may both hinder and promote health. Researchers with an interest in this topic face immense challenges, including a lack of funding, potential language barriers, and difficulties identifying study samples. Since Muslims are portrayed so negatively in the current political and social environment, many Muslim Americans may not want to discuss mental health issues.

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Suggested Assessment and Treatment Recommendations

Please see Suggested Assessment and Treatment Recommendations for Marginalized Populations

Employ culturally sensitive therapeutic interventions. Research suggests that culturally sensitive therapeutic interventions could make it easier for Muslim families to discuss mental health problems and accept care. A report in the Journal of Muslim Mental Health advises that clinicians recognize the microaggressions and unconscious bias Muslim patients experience that contribute to their vulnerability, including those that may occur in treatment or therapy. A 2017 report published in the American Journal of Psychiatry, outlined some of the issues that patients from marginalized communities such as American Muslims may face, including discrimination based on ethnicity, cultural background, or faith, and the fear of deportation.

Consider building specialized, culturally and religiously congruent clinics. The Khalil Center, the largest national mental health provider for Muslim faith communities, offers a recommended model for spiritually integrated therapy. TThe Handbook on the Cultural Formulation Interview contains supplementary modules including ones on Immigrants and Refugees and Spirituality, Religion, and Moral Traditions that can be useful in this process.

Recognize Muslim patients' vulnerabilities and the stressors and trauma they may experience.

Seek out cultural and religious sensitivity training for health professionals as needed to provide culturally appropriate care to Muslim patients. Build awareness of your own implicit biases to help prevent stereotyping patients and further hindering the treatment process.

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Engage with the local Muslim community to provide education and information about mental health conditions and services, including inpatient hospital admission policies, insurance coverage, and patient rights. Institutions and hospitals that serve Muslim populations are ideal partners for engagement opportunities with local Muslim communities.

Work with community and faith leaders to help reduce stigma, increase understanding, and develop services that are more accessible to Muslims. An example of this would be to ensure hospital units have available praying spaces, chaplain services, and halal food.

Consider creating collaborative care models and ways to make Muslims feel welcome at area clinics.

Address potential language barriers by providing forms and medical info in Arabic, Urdu and Farsi and using official interpreters or language lines when needed.

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Resources

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