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## Cultural Humility and Mental Health Care in Canadian Muslim Communities L'humilité culturelle et les soins de santé mentale dans les communautés musulmanes canadiennes

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Athir N. Jisrawi

*Western University*

Carrie Arnold

*King's University College, Western University*

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### ABSTRACT

Canadian Muslims are a growing, oft-scrutinized group that faces critical challenges in a global environment of rising xenophobia and nationalism. *Cultural humility* is an emerging socially conscious mental health care framework that combines multicultural competencies with personal and institutional accountability in provision of care. Its goal is to strengthen communities by helping individuals in a therapeutic setting and to promote positive institutional change. This article explores the hallmark characteristics of cultural humility as they apply to mental health care for diverse Canadian Muslim communities in the context of identity and belonging, acculturative stresses, and cultural and religious values.

### RÉSUMÉ

Les musulmans canadiens constituent un groupe en pleine croissance et souvent scruté à la loupe, qui doit relever de sérieux défis dans le contexte mondial d'une poussée de xénophobie et de nationalisme. *L'humilité culturelle* est un nouveau cadre de soins de santé mentale socialement responsables qui conjugue les compétences multiculturelles et la responsabilité personnelle et institutionnelle dans la prestation des soins. Elle vise à renforcer les communautés en aidant les personnes se trouvant dans un contexte thérapeutique et à promouvoir un changement institutionnel positif. Le présent article permet d'explorer les grandes caractéristiques de l'humilité culturelle selon leur application aux soins de santé mentale destinés aux communautés musulmanes canadiennes, dans le contexte de l'identité et de l'appartenance, du stress de l'acculturation et des valeurs culturelles et religieuses.

Muslims are one of the largest and fastest-growing minority groups, with more than 1 million people, or approximately 3.2% of the population of Canada (Statistics Canada, 2015), a number that is projected to increase to 5.5% by the year 2050 (Pew Research Center, 2015). Muslims are currently one of the most vilified groups in the media (Kolmer & Shatz, 2015), and have been targets of significant racial profiling and discrimination since 9/11 (Amri & Bemak, 2012). According to recent polls, between 33% and 57% of Canadians hold negative views of Muslims or Islam (EnviroNics Institute, 2016; Sevunts, 2016). As many

as three out of four Canadians agree immigrants should be tested for “Canadian values,” and a recent poll showed that nearly one in four would support a ban on Muslim immigration to Canada (McInnis, 2017).

As well as subtle daily microaggressions that cause social and employment inconveniences (Nadal et al., 2012), police-reported hate crimes against Muslims in Canada have more than doubled in recent years (Paperny, 2016), and these statistics are likely understated because hate crimes are generally underreported. These crimes have even reached deadly levels (e.g., the Quebec mosque shooting that was perpetrated by a man seemingly influenced by nationalistic and anti-Muslim political rhetoric; Campbell, Hutchins, & Gillis, 2017). It is no surprise, then, that Canadian Muslims often express anxiety about being targets of hate, particularly when external factors such as accent, skin colour, and cultural or religious dress make them more visible (Akram-Pall & Moodley, 2016; Jamil, 2012). Media portrayals of Muslims, discrimination, and stereotypes are frequently cited as prime concerns (EnviroNics Institute, 2016).

Although Muslims are often caricatured as followers of a monolithic belief system lacking in complexity (Ciftci, Jones, & Corrigan, 2013) and reduced to a homogeneous group that supposedly espouses values incompatible with Western civilization (Inayat, 2007), Islam is a 1,400-year-old religion that has seen different forms since its inception. While the religious philosophies of Muslims around the world are connected by common themes, Islamic culture has developed distinctive characteristics that have spawned some differences in practice and beliefs in every region it has spread to (Al Wekhian, 2016). Today, Muslims are one of the most ethnically and culturally heterogeneous groups, with adherents hailing from all continents, belonging to most major racial groups, and speaking myriad languages (Allen, 2015; Mogahed & Pervez, 2016; Pew Research Center, 2015). Muslims have been part of North American society since before the establishment of the United States, as many immigrated early on or were brought on slave ships from Africa (Abu-Bader, Tirmazi, & Ross-Sheriff, 2011). Others became Muslims in North America and have no ethnic connection to the East.

Despite this diversity, many reported anti-Muslim hate crimes in North America are perpetrated against those who are readily identifiable as Muslims, including Middle Eastern-looking men and women wearing *hijab* (i.e., dress code including a headscarf and loose clothing). The fact that hate crimes are committed against Arab Christians (Mathias, 2016) and Sikh men (Holley, 2015; Mathias, 2016) thought to be Muslims, due to their appearance, demonstrates how fear of the unknown motivates such attacks and exposes anti-Muslim hate as a form of racism.

Given their overexposure to various challenges, Muslim engagement with psychological services is important, but they remain a misunderstood and understudied group in the mental health field (Qasqas & Jerry, 2014). Many authors (e.g., Breakey, 2001; Lemkuil, 2007; Ratts, Singh, Nassar-McMillan, Butler, & McCullough, 2015; Steffen & Merrill, 2011) have been shedding light on the modern role of mental health professionals, including psychologists, counsellors,

social workers, therapists, and medical health professionals (Ontario Association of Consultants, Counsellors, Psychometrists and Psychotherapists, 2016), in counselling diverse groups and countering antiminority sentiment. Much of the literature on multiculturalism in counselling has shifted from focusing on mere competence (Ratts et al., 2015) to embracing cultural humility (Fisher-Borne, Cain, & Martin, 2015; Hook, Davis, Owen, Worthington, & Utsey, 2013; Owen et al., 2016; Rosenblatt, 2016) as an alternative framework that is more responsive to the needs of diverse groups and that better equips practitioners to deal with the changing sociopolitical landscape of pluralistic societies.

This article aims to analyze the application of cultural humility to work with Canadian Muslims by drawing upon concepts that may apply to multicultural communities in general. First, we discuss a hallmark characteristic of the cultural humility framework: practitioner self-accountability and its relation to empathy and acceptance. Then, we review some acculturative challenges faced by Muslims and explore the role of family, community, religion, and institutions in facilitating culturally humble counselling practice. Finally, we provide a perspective on the global political context of counselling Muslims.

While mental health research on Canadian Muslims is scarce (Qasqas & Jerry, 2014), their experiences are highlighted wherever possible in this article. Barring the availability of such information, comparable trends from other Western nations are discussed. The broad term *Canadian Muslims* is used throughout this article in reference to an ethnically, culturally, racially, and theologically diverse community, which includes newcomers, refugees, immigrants, and Canadian-born individuals. Although this diversity admittedly makes it difficult to make broad conclusions about this group's experiences, including samples of the experiences of Muslims of diverse backgrounds and circumstances helps to provide a more inclusive look at this community's challenges.

#### INDIVIDUAL ACCOUNTABILITY: THE FIRST CORE ELEMENT OF CULTURAL HUMILITY

Mental health professionals have traditionally used cultural-competence frameworks that emphasize knowledge, skills, and behavioural changes as sufficient for work with minorities (including immigrants, refugees, and members of religious groups with diverse ethnocultural identities; Fisher-Borne et al., 2015). This is due to a belief that possessing factual knowledge about minority groups will help reduce or prevent (a) practitioners from acting in a discriminatory manner; (b) stereotypes; and (c) overreliance on clients to teach them about their culture, which can be highly unethical (Arthur & Stewart, 2001; Qasqas & Jerry, 2014). This includes having knowledge about "the political, economic, historical, social, and psychological development specific to a particular cultural group" (Arthur & Stewart, 2001, p. 8). However, sole reliance on this approach can potentially lead practitioners to assume a superior understanding of culture, become too self-focused, and reinforce underlying issues affecting the therapeutic alliance, such as practitioner privilege (Rosenblatt, 2016).

Cultural humility is an emerging counselling framework that combines traditional multicultural competencies (Ratts et al., 2015) with an interpersonal dimension that encourages counsellors to adopt an “other-oriented” stance (Hook et al., 2013); in other words, it focuses less on what the practitioner knows and more on how the practitioner can learn to be comfortable with a client perceived as different (e.g., for holding religious or cultural views that differ from the practitioner’s). Advocates of culturally sensitive therapy agree that practitioners ought to move from an ethnocentric, “one-size-fits-all” perspective to a culturally humble approach in assessment, practice, training, and research (Fisher-Borne et al., 2015; Ratts et al., 2015).

Under this framework, basic competencies accompany the acceptance that there is ultimately a limit to understanding a culture one does not personally belong to (Hook et al., 2016). While avoiding complete reliance on the client for cultural education is necessary, putting aside one’s perceived expertise in the face of unfamiliar cultures is crucial to practicing with humility (Chang, Simon, & Dong, 2012; Rosenblatt, 2016). This presents a more realistic view of health professionals’ capabilities, ensures genuine commitment to justice for minority clients, and encourages practitioner self-evaluation and accountability. With a culturally humble approach, practitioners continuously reflect upon the circumstances that allowed them to become healthily integrated in their own societies, and compare how this process may be different for others who have different worldviews or challenges. The purpose of ongoing introspection is for practitioners to critically analyze their own biases, prejudices, assumptions, and preconceptions, and to identify how their upbringing and cultural conditioning produces a worldview that can be reflected in their work (Ratts et al., 2015), sometimes to the detriment of the client.

Similar to Collins and Arthur’s (2010) Culture-Infused Counselling framework (for a discussion of its application to counselling Muslims, see Qasqas & Jerry, 2014), cultural humility guides counsellors to reflect on how their own socialization and cultural backgrounds shape their practice and perception of what is normal, to identify real or perceived incongruities with the client’s worldview, and to strengthen the working alliance by empathizing with the client’s experiences (Ahmed, Wilson, Henriksen, & Jones, 2011; Arthur & Stewart, 2001; Ratts et al., 2015). Research has demonstrated that cultural humility can attenuate negative attitudes, and experimentally induced humility can even increase religious tolerance and create more harmonious relationships with religious out-group members (Van Tongeren et al., 2016). Use of this framework has also been shown to improve health outcomes and client-practitioner relationships in the medical field (Fisher-Borne et al., 2015).

Self-reflection for practitioners who work with Muslim clients can begin with a critical analysis of their own views about Islam and Muslims. Does the practitioner hold assumptions about Islam and Muslims that can hinder progress in a therapeutic relationship? How familiar is the practitioner with Islamic principles and traditions? What sources does the practitioner access for such information? How much exposure does the practitioner have to Muslim people on a daily basis?

How aware is the practitioner of the media's role in shaping perceptions of Islam and Muslims and how these perceptions impact the lives of Canadian Muslims and their participation in society? Such introspection can lead mental health workers to identify potential incongruities in worldviews between themselves and their Muslim clients and the manner in which this may affect the development of rapport in a therapeutic relationship. Two key humility concepts that can help bridge the gap between practitioner and Muslim client are empathy and acceptance, which we discuss in the next section.

#### TOLERANCE IS NOT A VIRTUE

While knowledge-based tolerance of others is a commendable component of cultural competence frameworks, critics (e.g., Fisher-Borne et al., 2015) insist that this may inadvertently convey a sense of superiority by portraying certain characteristics or behaviours as negative and inherent to an entire culture because they are unfamiliar to the practitioner. In counselling and therapy, empathy for clients and acceptance of their experiences, viewpoints, and cultures have typically been preferred to tolerance (Batson, Chang, Orr, & Rowland, 2002; Brown, 2007; Geller & Greenberg, 2002). To be treated otherwise in a care setting where a power imbalance exists between client and practitioner undermines the therapeutic commitment to justice and client self-empowerment and serves to keep the client in a position of dependence both inside and outside the therapeutic setting. This is not to say that acceptance necessitates adoption of views one does not personally believe in. However, a professional can disagree with a client while accepting the client's right to hold their own personal views (Ratts et al., 2015).

Acceptance can be achieved by practicing empathy in daily life. Brown (2007) described empathy as "the skill or ability to connect with an experience someone is relating" (p. 33). Empathy is the ability to adjust one's frame of reference to understand even a tiny part of another person's experience, as Lee's (2006) famous line suggested: "You never really understand a person until you consider things from his point of view ... [u]ntil you climb inside of his skin and walk around in it" (p. 33). As empathy is the basis for many interactions that occur in the therapeutic working alliance, and a skill that needs continuous honing, most theoretical frameworks necessitate the application of empathy in the personal lives and professional practice of mental health practitioners. Within frameworks such as cognitive behavioural therapy (Thwaites & Bennett-Levy, 2007), integrative therapy approaches (Constantine, 2001), and Rogerian person-centred therapy (Geller & Greenberg, 2002), empathy is foundational for counselling skills such as validation and presence (Ahmed et al., 2011; Geller & Greenberg, 2002) and for the success of the therapeutic alliance.

Self-reflecting practitioners use empathy and acceptance as tools to connect with clients. Practitioners can strive to empathize with Muslim clients' struggles and accept that Islamic practices are not necessarily obstacles that clients want to overcome or discard. This can strengthen the relationship between client and prac-

tioner, as illustrated by the example of hijab. The debate over hijab in the West is arguably one of the most contentious, and typically centres around perceptions of choice and oppression. The reality is that Muslim women's reasons for adhering to or forsaking this dress code are complex and largely dependent upon personal religious and cultural experiences (Allen, 2015). In some cases, Muslim women feel pressure to wear hijab and fear rejection from their families or communities if they do not wear it (Ellis et al., 2010), and in other cases, it is freely chosen. This is precisely what Litchmore and Safdar (2016) found in their investigation of Canadian Muslim women's views on hijab. Both those who do and those who do not cover expressed having a choice in the matter, and indicated that they engaged in thoughtful research before deciding. Some even stopped themselves from wearing it for fear of being discriminated against (Litchmore & Safdar, 2016). In a survey of 81 Canadian women who wear *niqab* [face veil], not a single woman reported being forced to wear it, only about 15% said they were influenced by a spouse or friend, and several actually faced opposition from family members and spouses for deciding to wear it (Clarke, 2013).

It is clear that wearing hijab in Canada is complex and occurs at the intersection of cultural, religious, social, and political influences. However, the perception of Muslim women as passively subjugated and oppressed victims is still prevalent (Zine, 2001), even in some counselling literature (as reported in Qasqas & Jerry, 2014). Holding such stereotypes can hinder progress in a therapeutic relationship by fostering mistrust between client and practitioner. To avoid the potential alienation of Muslim women clients, whether they cover or not, culturally humble practitioners ought to engage in a critical analysis of their own thoughts about culturally acceptable dress, enter the therapeutic alliance with few (if any) preconceived notions about their clients, recognize that Muslim women do have agency, and approach the topic of dress when and if it becomes relevant in therapy. Understanding the client's personal context and motivations can help create the rapport needed to proactively tackle the challenges she faces.

#### EXISTING AMONG WORLDS: NEITHER HERE NOR THERE

Self-reflection can also help practitioners understand the confusion of identity that Muslim clients may present due to belonging to multiple cultures. Culture represents a group's shared way of living, encompassing both intangible concepts such as values and beliefs, and tangible patterns of behaviour, communication styles, food, and clothing (Pollock & Van Reken, 2009; Weaver, 2008). Identity can be thought of as the answer one would give to the questions "Who am I?" and "Who are we?" (Pollock & Van Reken, 2009; Vignoles, Schwartz, & Luyckx, 2011). Canadian Muslims, who often interact with what are essentially multiple cultural environments (i.e., religion and sometimes more than one nationality and/or ethnicity), may struggle to reconcile sometimes-conflicting views about values and beliefs that stem from each of these cultures (Amri & Bemak, 2012). This may delay or hinder the development of personal identity and group affiliation.

The challenge for Western Muslims lies in determining which parts of their Islamic identity to maintain and which to abandon, when some are overtly scrutinized by Western culture (Asvat & Malcarne, 2008).

Determining the degree of influence one culture will have on another, also known as acculturation, is therefore a crucial aspect of Muslim identity formation in the West. Four possible acculturation paths have been described in the literature: assimilation, integration, separation, and marginalization (Berry, 2005). Completely leaving one's heritage culture and adopting the new culture results in assimilation, while maintaining heritage culture and avoiding involvement in the new culture leads to separation. Marginalization occurs when an individual loses their heritage culture and is also unable to become involved in the new culture, and integration results from merging both cultures to form a bicultural identity (Al Wekhian, 2016; Berry, 2005; Steffen & Merrill, 2011).

Young Canadian-born Muslims are generally more integrated into Canadian society than their immigrant parents, but they are also "the most religiously observant generation in the Muslim community" (EnviroNics Institute, 2016, p. 5), maintaining their religious identity by, amongst other things, frequently attending mosques and wearing hijab. Older Muslim immigrants in the United States tend to separate from mainstream American culture (Abu-Bader et al., 2011), as do Arab American Muslims, for whom there is evidence that strong religiosity can orient them toward their heritage culture (Al Wekhian, 2016; Goforth, Oka, Leong, & Denis, 2014). The fear of losing core aspects of religion due to external pressures may be a driving force toward this separation. There is also evidence that acculturation differs by gender. Ellis et al. (2010) found that Somali Muslim refugee girls in the United States are more closely connected to their heritage culture than their male counterparts, who are more likely to assimilate, as they are typically given more flexibility to explore their new culture.

While it can be a positive experience, acculturation can be stressful when individuals struggle to overcome value dissonances, form collective and individual identities, and healthily integrate into society (Berry, 2005). Stresses include "mental, emotional, cognitive, social, and somatic difficulties" (Akram-Pall & Moodley, 2016, p. S138). Acculturative stresses are experienced by Western Muslims around the world, including in Australia (Khawaja, 2007), the United States (Al Wekhian, 2016), and Canada (Akram-Pall & Moodley, 2016). Akram-Pall and Moodley (2016) found two reasons for the manifestation of acculturative stresses in South Asian Muslim immigrants in Toronto: *perceived* and *real* losses and fears. Some of the fears that study participants reported experiencing after immigration were related to raising children in an unfamiliar culture, unemployment, and language barriers. Some of the losses included family connections, social status, gender roles, and religious self-identity (Wong & Yohani, 2016).

Prolonged fixation on fears and losses can lead to identity crises, serious mental health issues (Akram-Pall & Moodley, 2016; Berry, 2005), and feelings of isolation, inauthenticity, inferiority, or lack of belonging (Pollock & Van Reken, 2009; Taylor & Nanney, 2011). Such feelings are exacerbated by the internalization of

negative beliefs and feelings about oneself and one's group. This can lead to self-stigma or the avoidance of seeking help (Corrigan, Larson, & Rüschi, 2009) and, if individuals feel that their situation is hopeless due to their belonging to a group targeted by discrimination, this could also lead to social withdrawal. Arab Muslim Americans, for example, view discrimination as the main factor that hinders their acculturation (Al Wekhian, 2016).

Interestingly, a strong connection to heritage culture and religion seems to attenuate the effects of depression and discrimination on young bicultural Muslims (Ellis et al., 2010), whereas the same connection tends to predict depression in older Muslim immigrants (Abu-Bader et al., 2011). Clearly, the acculturation paths of North American Muslims are complex and affected by various factors including gender, age, race, and socioeconomic status. Exposure to diverse demographics in both training and nonprofessional settings is crucial for practitioners to understand Muslim acculturative struggles in the personal context of each client.

Integration, which results in the best outcomes across cultures, is the acculturative path most in line with the goals of cultural humility. Not only does it lead to better adjustment (Shebib, 2014; Steffen & Merrill, 2011) and resiliency for Canadian Muslims who identify strongly with their heritage culture and religion (Asvat & Malcarne, 2008; Ellis et al., 2010), but also the acknowledgement by practitioners that culture is not an obstacle to be overcome promotes a stronger working alliance that respects clients' wishes and elevates the needs that clients consider important (Ahmed et al., 2011; Arthur & Stewart, 2001; Ratts et al., 2015). Several aspects of Muslim culture can be used to encourage healthy acculturation, including the promotion of family units, community connections, and spiritual fulfillment. We explore these topics further next.

#### IT TAKES A VILLAGE: ACCULTURATIVE STRESSES, FAMILY, AND COMMUNITY

One of the most important aspects of Muslim identity is the family. Islamic tradition and Muslim societies are family- and community-oriented (Amri & Bemak, 2012). For example, even the most autonomous Muslim adults respect the advice of older family members, and committing to caring for elderly parents is seen as a virtue. In general, collectivistic family structures view the individual first and foremost as a member of a group, thus instilling in each person a sense of obligation toward others from a young age (Chang et al., 2012). While Muslim family structures do vary from one family to another, understanding their impact on acculturation and mental health care access is essential to a culturally humble approach (Ratts et al., 2015).

Muslim family dynamics are strongly connected to acculturative experiences. Families are likely to experience power shifts after immigration, for example, if children who learn English and acculturate faster than their parents start taking on adult roles, or if gender roles cease to be strictly defined (Akram-Pall & Moodley, 2016; Al Wekhian, 2016; Amri & Bemak, 2012). Many are accustomed to strong extended family support back home, with everyone sharing



responsibilities and providing help during hard times (Amri & Bemak, 2012). Based on reports by study participants that being away from their large extended families made life harder and made them feel lonely, Akram-Pall and Moodley (2016) found that for South Asian Muslim immigrants in Toronto, “family support and cohesiveness increases resiliency and ability to deal with hardships” (p. S151). Loss of such support can be devastating, especially if suitable alternative systems cannot be found, and even more so if family reunions are unlikely. Providing an environment that mimics the traditional Muslim family and community connection may curb depression (Asvat & Malcarne, 2008) and reduce isolation (Khawaja, 2007).

Young Muslims may experience dissonance between the views of their heritage culture and faith, and dominant cultural views on family dynamics, while also facing typical adolescent challenges (Zine, 2001). Parents fear that their Canadian-raised children might become alienated from them and abandon their religious and cultural traditions entirely. Paradoxically, parents also fear that their children may question their identities as Canadians due to discrimination and prejudice (Amri & Bemak, 2012). These fears and stresses can be major causes of family conflicts, depression, anxiety, decreased social interaction, isolation, feelings of hopelessness, and somatic manifestations of mental health problems (Arthur & Stewart, 2001; Asvat & Malcarne, 2008).

Gender relations are an important Muslim family dynamic. Muslim family and social life often involve gender-based rules that are strictly adhered to. While coming to Canada may lead to significant changes in perceptions, for many Muslim immigrants, the culturally defined gender roles they are accustomed to (e.g., the husband as the primary provider and the wife as the primary childrearer) continue to be part of their lives (Akram-Pall & Moodley, 2016). However, views of acceptable behaviour (e.g., whether a woman is allowed to receive an education and pursue a career) can differ significantly depending on the Muslim family’s background. A family from Afghanistan is likely to have different perceptions of gender roles than a family from Morocco. Even within the same country, gender expectations may differ between regions. This discrepancy may be attributed to the fact that for many Muslims, gender roles are defined by both Islamic and ethnic or national cultural norms, which are not always alike (see also Abbott, Springer, & Hollist, 2012).

Gender perceptions can sometimes restrict help-seeking behaviour. For example, Muslim males may feel ashamed to seek help, due to dominant cultural expectations for men to be “strong” (Saleem, 2015). Muslim women must also overcome similar barriers to access care (for a thorough discussion of therapy with Muslim women, see Cook-Masaud & Wiggins, 2011, and Saleem, 2015). Additionally, because of practicing Muslim families’ tendency to encourage gender segregation in social situations (Dhami & Sheikh, 2000), Muslim clients may seek out a practitioner of the same gender to feel more at ease discussing personal issues. If such an option is not readily available, some may avoid seeking therapy altogether.

Culturally humble mental health practitioners seek to accommodate aspects of culture that are most important to the client, and this may mean including family in care. Practitioners may consider implementing family counselling frameworks such as the multiple partnership model, which is a collaboration between a family counsellor and a settlement counsellor who acts as a cultural consultant, facilitating discourse by respecting clients' preference for family involvement in care, deepening cultural understanding, and breaking down possible language barriers (Grant, Henley, & Kean, 2001). Clients may also be assisted in finding adequate community-based resources (e.g., religious institutions) that can at least partially fulfill the role of extended family, creating new social networks with people who both share their heritage culture and understand the new culture (Khawaja, 2007).

#### RELIGION AND SPIRITUALITY:

##### A BRIDGE TO ACCULTURATION OR A BUFFER FROM SOCIETY?

Although trends away from religious affiliation have been observed in some economically developed European countries (Pew Research Center, 2015), this may not be universal. Economic development has not been a factor for secularization in Muslim-majority nations (Pew Research Center, 2015), where most people still hold onto their religious beliefs and practices, and where Islam often plays a prominent public role. In Canada, only about one quarter of the population (23.9%) profess no religious affiliation, while more than two thirds (67.3%) identify with Christianity, and about 7.2% identify with Islam, Hinduism, Sikhism, or Buddhism (Statistics Canada, 2015). Even in societies where participation in organized religion has declined, people are not necessarily turning away from spirituality entirely; some are taking individualized approaches to its practice. If interest in spirituality is high, then there may be demand for its inclusion in psychological treatment. Patients with diagnosed mental health issues do tend to want therapists to provide the option of integrating spirituality into treatment plans (Ali, 2016; D'Souza, 2002; Lemkuil, 2007). Faith can be a companion to or central component of therapy, helping clients translate religious beliefs and habits such as prayer into clinical assessments and interventions that may aid in healing (Leighton, 2016).

Despite this, few health professionals report using spirituality or religion in practice (D'Souza, 2002; Leighton, 2016), and many say they have not received formal training in this area (D'Souza, 2002). This is unfortunate, given the well-documented positive association between spirituality and wellness (Barton & Miller, 2015; Leighton, 2016; Nelson, 2009; Rowold, 2011), but unsurprising, given the deliberate disconnect between spirituality and empiricism that has characterized modern psychology since Freud. This disconnection has been debated by Western scholars since Aristotle and Plato (Leighton, 2016).

Additionally, spirituality is deeply rooted within the heritage of many ethnic groups, so excluding it from therapy may be culturally insensitive and may disregard a potentially vital healing tool (Hall & Breland-Noble, 2011; Lemkuil, 2007;

Ratts et al., 2015). Hall and Breland-Noble (2011) suggested that the reason for the “failure to acknowledge issues such as spirituality in the psychology literature” is that “psychology, like its relatives, psychiatry and medicine, is an outgrowth of a Western Eurocentric approach to understanding human well-being” (p. 152). This conflicts with the cultural humility framework, which seeks not to impose the practitioner’s worldview upon the client.

There is evidence that religious involvement can act both as a buffer from, and as a bridge to, acculturation (Cadge & Ecklund, 2006). Many immigrants use spirituality as a guide, especially in navigating the difficulties of integrating into a new and often relatively strange society (Steffen & Merrill, 2011). Religious institutions offer immigrants a bridge to social services, employment opportunities, housing, and contact with other immigrants with shared life experiences. Mosques and religious community centres can also act as buffers against loss of heritage and religious self-identity (Akram-Pall & Moodley, 2016; Akresh, 2011).

Some have suggested that religious centres are an isolating force pushing immigrants to use congregations as buffers from society (Cadge & Ecklund, 2006). While this may be true, it is important to note that many factors drive immigrants to attend religious services in the early years of immigration, including unemployment, language barriers, and a desire to hold onto one’s religious identity. Muslims coming from conflict areas, especially those at high risk of social isolation, depression, and other negative health outcomes, benefit greatly from maintaining strong ties to their religious practices (Mogahed & Pervez, 2016; Mosaic Institute, 2014). In fact, Canadians from conflict areas of the world, irrespective of religious background, experience stronger ties with their faith and amplify the parts of their faith they view as being in line with Canadian values (Mosaic Institute, 2014). In Canada, Muslims identify equally strongly with their identities as Canadians and as Muslims (Environics Institute, 2016), and in the United States, Muslims who report having stronger religious identities also report having stronger American identities (Mogahed & Pervez, 2016).

Even years after immigration, spirituality often continues to play a role in immigrant life, and religious participation actually increases (Akresh, 2011). Ellis et al. (2010) found that adolescent Somali Muslim refugees in the United States who had stronger ties to their religion felt empowered and were more resilient in the face of discrimination. In general, Muslim American involvement in mosques and other religious institutions tends to prevent social isolation and promote civic engagement (Mogahed & Pervez, 2016). These trends suggest that encouraging Muslim clients to participate in religious activities, should they wish to do so, can lead to positive therapeutic outcomes. Finding empowerment through religion is more productive for Muslim clients than deliberately ignoring or casting it aside, which can cause friction and goal mismatches in the therapeutic alliance.

Though spirituality can ease acculturation, religious affiliation can be a cause for underutilization of mental health services. Stigma is a powerful barrier, and the desire to avoid being labelled may compel people to resist seeking and committing to professional care (Amri & Bemak, 2012; Ciftci et al., 2013). In the Muslim

community, there is a general belief that health and illness are the result of destiny, and while changes in health are ultimately controlled by God, seeking medical care in addition to prayer is an obligation. This positive outlook is associated with an optimistic expectation of healing (Ciftci et al., 2013), but unfortunately it is typically only applied to physical illness. Muslims overwhelmingly believe mental health issues are private, “shameful” matters that should not be disclosed outside familial circles, and exhibit mistrust of service providers out of fear of discrimination and cultural misunderstandings (Amri & Bemak, 2012; Cook-Masaud & Wiggins, 2011; Inayat, 2007). One way to combat this self-stigmatization is to work through systems that Muslims already trust: *imams* [spiritual leaders] and families. Imams often have considerable influence on Muslim family and community attitudes (Ali, 2016), so investing in their formal education and training in mental health counselling is useful, as this will inspire holistic practices that combine religious teachings with professional counselling approaches (Amri & Bemak, 2012; Cook-Masaud & Wiggins, 2011; Saleem, 2015). To provide authenticity to mental health care and foster trust between mental health practitioners and possibly skeptical Muslim clients, sessions may be cofacilitated in familiar settings (e.g., at a local mosque or youth centre) in the presence of religious leader, practitioner, and family members (Amri & Bemak, 2012).

Using discretion to handle cases that may involve cultural taboos or religiously prohibited matters is also of the utmost importance. For instance, if a Muslim client is struggling with alcohol use, which is prohibited in Islam, this must be treated with the knowledge that it is a matter that can potentially alienate clients from their communities. If treatments are administered in a manner that protects privacy and ensures confidentiality within often close-knit Muslim communities, more Muslims who are suffering silently may be motivated to seek help without fear of being shunned (Amri & Bemak, 2012). Finally, through workshops and information sessions that seek to reduce stigma and dispel myths about psychological services, professionals and religious leaders can educate Muslim communities about the reality of mental health and the benefits of seeking professional assistance when necessary (Saleem, 2015).

#### INSTITUTIONAL ACCOUNTABILITY:

##### THE SECOND CORE ELEMENT OF CULTURAL HUMILITY

Ultimately, the goal of cultural humility is to inspire self-reflecting mental health practitioners who strive to create institutional change to benefit the communities they work with. Practitioner engagement in self-reflection and empathy, as described by the first core element, can trigger empathy for the stigmatized community as a whole, and compel action to alleviate institutional barriers (Batson et al., 2002). Institutions that provide mental health services, graduate training, and/or set policy, including the Canadian Counselling and Psychotherapy Association, the Canadian Psychological Association, universities and colleges, community social services, and private counselling practices, can take steps to ensure

cultural humility is exercised at all organizational levels. The duties of culturally humble mental health practitioners inevitably extend beyond the therapy room to address existing inequalities and power imbalances that can hinder minority clients' self-actualization, exacerbate acculturative stresses and identity crises, and prevent access to care (Fisher-Borne et al., 2015; Hall & Pilisuk, 2006; Owen et al., 2016; Rosenblatt, 2016). Culturally humble institutions equip practitioners with the necessary tools to tackle these issues.

Concrete institutional change will ultimately benefit practitioners, clients, and communities (Fisher-Borne et al., 2015). Diversity ought to be encouraged at management levels to represent multiple viewpoints and influence the formation and implementation of training programs. Including cultural humility as a counselling framework in graduate and professional training programs and providing continuing education (Ahmed et al., 2011) to give practitioners confidence in handling diverse clients (Constantine, 2001) should be a priority. While traditional theoretical orientations can increase multicultural competence in counsellors (Constantine, 2001), eclectic frameworks seem to be most successful at improving counsellors' confidence in working with diverse clients (Constantine, 2001; Inayat, 2007). Supervisors can lead by example, infusing cultural humility into every aspect of training, and setting aside time for trainees to reflect upon the challenges they face when working with culturally, ethnically, or racially different clients (Hook et al., 2016). Supervisors may encourage their trainees to choose practicum settings that would guarantee exposure to diverse clients, and to participate in activities that would ensure positive contact with people who are different from them outside the therapeutic setting (Gerson & Neilson, 2014; Hook et al., 2016).

Islamic organizations, including mosques and youth centres, ought to provide spaces for health practitioners to engage in interfaith and community activities that would create familiarity with Muslim religious and cultural practices (Constantine, 2001) and educate Muslim communities about mental health. For care to be humble and culturally responsive, Muslim organizations should determine what services they lack and what degree of culturally and religiously relevant teachings ought to accompany mental health care to develop support systems and crisis interventions according to their communities' needs (Amri & Bemak, 2012). Muslim communities can encourage their youth to seek education in the mental health fields, and professional training programs may encourage the intake of diverse students who can better serve their own communities (Grant et al., 2001). Initiatives such as NISA (a Muslim women's helpline) and Naseeha (a Muslim youth helpline), which are created for the Muslim community by the Muslim community in North America, are vital resources. Preliminary successes of these helplines indicate that young Muslims benefit from having access to counsellors who come from similar religious or cultural backgrounds. In 2016 alone, NISA and Naseeha received more than 4,500 and 16,000 calls, respectively, on topics ranging from mental health and family issues to Islamophobia and discrimination (Lui, 2017).

Religious, social, and mental health organizations ought to communicate openly to keep health practitioners informed about community-specific mental health challenges. Listings of community resources and support networks should be accessible for practitioners and imams to refer community members to (Ali, 2016). Mental health practitioners have an opportunity to collaborate with the Muslim Medical Association of Canada, which held its first annual Canadian Muslim Mental Health Conference at the University of Toronto in November 2016 (Muslim Medical Association of Canada, 2016), bringing together a range of professionals, students, spiritual leaders, and members of all faiths to discuss current challenges facing the Muslim community and to share research and best practices in the field. Such conferences that combine community experience and professional expertise are crucial to share knowledge, adapt practices that address specific community needs, and reassure Muslims of the compatibility of evidence-based mental health practices with Islamic principles (Ahmed et al., 2011; Ali, 2016).

To improve access to care, institutions may address first-language access and employment barriers. Training multilingual professionals and making interpretation services available will ensure clients lacking English fluency have access to quality mental health services (Arthur & Stewart, 2001). Underemployment, unemployment, and low-income rates are some of the main contributors to acculturative stresses. The socioeconomic drop some Muslim immigrants experience from a high social status in their home country to a lower status in Canada can be devastating (Akram-Pall & Moodley, 2016). Even though Canada's primary immigration program attracts highly educated skilled workers (Harris, 2016), foreign credentials or experience are rarely accepted for employment or education purposes (Ontario Human Rights Commission [OHRC], 2013). Degree equivalencies may be difficult to attain, forcing some to work in low-wage jobs outside their field of study or spend years in school, struggling to learn English, and trying to build "Canadian experience" to be eligible for work (OHRC, 2013). It may take years to reach the same socioeconomic status they had attained in their country of origin, and some remain locked out of certain job market segments forever (Akram-Pall & Moodley, 2016; OHRC, 2013). Health practitioners can advocate to limit the "Canadian experience" requirement for employment, which the Ontario Human Rights Commission has declared "discriminatory" (OHRC, 2013, p. 3).

Neglecting the existence of such pitfalls in the immigration process may cause practitioners to view their clients through pervasive stereotypes; for example, that immigrants "live off welfare" or that they should be content with subpar living conditions and/or discrimination because where they came from was worse (Paré, 2014). Instead of always addressing clients' internal issues as the only barriers, identification of real external barriers can be a source of validation that empowers individuals to reject negative stereotypes about themselves and to exercise their abilities to address these issues and advocate for their own rights (Owen et al., 2016; Rosenblatt, 2016). Awareness of the sacrifices made in coming to Canada (e.g., leaving behind major social support networks), understanding that many socioeconomic barriers still exist for minorities and immigrants (e.g., discrimina-

tion in the workplace, preexisting trauma, rejection of foreign credentials), and advocacy for equitable socioeconomic policies for all Canadians are necessary and can be addressed by practitioners committed to the second core element of cultural humility.

COMPLEX GLOBAL EMERGENCIES:  
IMPLICATIONS FOR CULTURALLY HUMBLE PRACTICE

The geopolitics of conflict in the historical Muslim world is complex and beyond the scope of this article, but it is important to acknowledge its relationship to counselling in Canada. By the end of 2016, a historical high of 65.6 million people worldwide were forcibly displaced from their homes, 2.8 million of whom have filed asylum claims, mostly to Germany, the United States, Italy, and Turkey (United Nations, 2017). The top four refugee-producing nations in 2016 were Syria, Afghanistan, South Sudan, and Somalia, three of which are majority Muslim (United Nations, 2017). More than 46,000 refugees were resettled in Canada in 2016: about 40,000 Syrians (Government of Canada, 2016), and the rest from elsewhere in the world (Organisation for Economic Cooperation and Development [OECD], 2017).

The extent to which asylum seekers should be welcomed has framed an ongoing political debate in the West characterized by fear and stigmatization of minorities (Komaromi & Singh, 2016) and the use of identity and faith to cause divisions. During the 2016 U.S. election season, Muslims were referred to by prominent politicians only in the context of disturbing stereotypes, or as a fifth column for which a solution must be found (Mangla, 2016). In the build-up toward the United Kingdom's "Brexit" referendum (the vote to exit the European Union), tensions were ignited by the antiminority, xenophobic, and racist rhetoric of major political parties and mainstream media outlets; reports of hate crimes spiked post-referendum, targeting "anyone perceived to be 'foreign'" (Komaromi & Singh, 2016, p. 5). Recently in Italy, far-right activists have been intercepting rescue boats in the Mediterranean, fearing that asylum seekers fleeing war in North Africa are Muslims invading Europe (Townsend, 2017).

Canadian politics is not immune to such fearmongering about Muslims. During the most recent federal election and Conservative Party leadership race, politicians exploited the public's fear of Islam (McMaster, 2017), portraying newcomers as radicalized Muslims who have no respect for "Canadian values" such as plurality and gender equality and as such need to be shunned. While more than half of Canadians believe that multiculturalism is a leading symbol of Canadian identity (Environics Institute, 2015) and the majority of Canadians are generally supportive of welcoming immigrants and refugees into Canada (McMaster, 2017; OECD, 2014), public opinion polls reveal that Canadians are uncomfortable with Muslim immigrants in particular and view them as a potential security risk, even though researchers say "there is no evidence to suggest these immigrants are any more likely to radicalize—or even commit petty crime—than Canadian citizens already here"

(McMaster, 2017). Some possible factors contributing to the prevalence of negative feelings toward Muslims include stereotypes perpetuated by media coverage of the now 16-year-long “global fight against terrorism,” lack of factual knowledge about Islam and Muslims, and current ethnonationalist trends in Western politics.

Canadian mental health practitioners may certainly encounter Muslim clients struggling with these realities (Kazi, 2014). Conflicts in clients’ countries of origin, and the involvement of Western countries in those conflicts, might affect identity formation and acculturation of Canadian Muslims who struggle with concern for family and friends back home; anger over propaganda and inaccurate media portrayals of themselves, their home countries, and their beliefs; anxiety over anti-Muslim bias in their daily lives; and, for those who are newcomers, difficulty coming to terms with trauma caused by personal experiences with war and conflict. Many of the resiliency factors discussed throughout this article, including having social supports (e.g., connections to others in similar ethnic and religious communities), moral support from family, a sense of pride and purpose due to self-sufficiency in education and employment, and religion as a moral compass and protective factor for mental health, can be used by culturally humble practitioners to support coping and integration (Wong & Yohani, 2016). These factors are especially useful for those who have experienced violence, instability, and/or insecurity.

The experiences of refugees and immigrants with conflict are not forgotten after resettlement in Canada. If left unaddressed, the trauma that individuals and families carry can impede acculturation and social cohesion (Laucius, 2016) and be passed down to subsequent generations (Mosaic Institute, 2014). If newcomers can address their trauma, positive outcomes can be expected. A recent study of conflicts imported to Canada revealed that “Canadians often remain invested in ‘their’ conflict, but living in Canada dramatically transforms their perceptions of the conflict, as well as their view of possible outcomes. These transformations reflect Canadian modes of dealing with diversity and fostering social cohesion” (Mosaic Institute, 2014, p. 11). According to this study, the “single most powerful factor at work in achieving the repudiation of violence and reframing of the conflict and its solutions is social, economic, and political inclusion” (Mosaic Institute, 2014, p. 11). This underscores the importance of the second core element of the cultural humility framework, which can help address domestic policies that may hinder economic and political inclusion and compound fears of social exclusion. This may include helping to reduce employment barriers as discussed previously and supporting public efforts to counter the scapegoating and vilification of Muslims (Canadian Press, 2016; CBC News, 2016; Clough, 2016).

#### SUMMARY

Cultural humility is an emerging mental health care framework that combines personal and institutional accountability to train mental health practitioners who are self-critical and aware of the cultural contexts of diverse clients. This article



presented cultural humility as an ethical approach in mental health services for Canadian Muslim clients who face unique struggles in a society that is constantly questioning their belonging. Cultural humility can increase awareness of Canadian Muslim needs and help address institutional barriers that prevent adequate provision of care and exacerbate clients' wider social problems. In the future, a more conceptual framework for the theory of cultural humility is needed so that it can be applied more specifically to work with specific groups. Gaps in the research regarding Canadian Muslim acculturation, adjustment, and identity struggles should be addressed in the context of current political conflicts and nationalistic attitudes. Special attention should be given to gender-specific issues and the experiences of various Muslim immigrant generations. Whether cultural humility will be able to manage the complexities of mental health work with Muslim communities remains to be seen, but there is certainly an opportunity in exploring its potential.

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### *About the Authors*

Athir N. Jisrawi is a recent graduate of the medical sciences undergraduate program at Western University and is currently studying international relations at the University of London International Programmes.

Carrie Arnold is an adjunct faculty in the thanatology program at King's University College, Western University. Her research interests are in bereaved undergraduate students, particularly regarding health and wellness promotion on campus.

Address correspondence to Athir Jisrawi. E-mail: [azarir@uwo.ca](mailto:azarir@uwo.ca)