
“Seeking Help is Difficult:” Considerations for Providing Mental Health Services to Muslim Women Clients « Demander de l’aide, c’est difficile » : Points à prendre en considération pour la prestation de services de santé mentale auprès de clientes musulmanes

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ABSTRACT

Mental health professionals who counsel Muslim women are well positioned to offer guidance on working with this underserved population. A basic interpretive qualitative research design was utilized to explore mental health professionals’ ($N = 5$) experience of providing counselling services to Muslim women. Analysis yielded four areas of consideration in the provision of counselling services to Muslim women: (a) difficulty of seeking help; (b) lack of awareness as a barrier; (c) need for community outreach, psychoeducation, and cross-cultural training; and (d) centrality of trust and careful application of modalities and orientations. Findings are described alongside implications for counselling practice, and directions for future research are identified.

RÉSUMÉ

Les professionnels de la santé qui œuvrent auprès de femmes musulmanes sont le plus en mesure d’offrir des conseils sur la façon de travailler auprès de cette population mal desservie. On a eu recours à un concept de base de la recherche qualitative interprétative pour explorer l’expérience des professionnels de la santé mentale ($N = 5$) dans la prestation de services de counseling auprès de femmes musulmanes. L’analyse a permis de dégager quatre grands aspects à tenir en compte pour la prestation de services de counseling auprès de femmes musulmanes : (a) la difficulté de demander de l’aide; (b) le manque de conscientisation qui fait obstacle; (c) le besoin de visibilité dans la communauté, de psychopédagogie et de formation transculturelle; (d) le caractère crucial de la confiance et l’application soigneuse de modalités et d’orientations. On y décrit les résultats ainsi que les implications pour la pratique du counseling, de même que des orientations pour la recherche à venir.

Muslims are the fastest growing population in Canada, expected to grow to about 2.7 million by 2030 (Qasqas & Jerry, 2014). They are a heterogeneous group comprising diverse cultural, ethnic, linguistic, professional, and economic backgrounds; they can be immigrants, second-generation immigrants, and non-immigrants, as well as converts and born Muslims (Mahmood, 2013; Riley, 2011). As Canada becomes increasingly multicultural, so does the need for culturally responsive counselling for vulnerable client populations (En-Nabut, 2007). While

there is some effort on the part of Muslim organizations to establish counselling services for Muslim clients, formal services or agencies tailored to address the needs of this client population are severely lacking (Haque, 2004). Muslim women may represent an underserved minority group requiring particular attention given the current sociocultural zeitgeist (En-Nabut, 2007).

BEING MUSLIM AND PRACTICING ISLAM

In addition to recognition of their cultural and ethnic background, knowledge of Islam is an important prerequisite for counsellors working with Muslim clients. This knowledge helps in understanding how Muslims conduct their lives and how religious beliefs influence their perceptions, attitudes, decisions, and behaviours (Turkes-Habibovic, 2011). Although Muslims are the most diverse religious group in regard to race and ethnicity, belief in Islam unifies their experience and worldview (Rippy & Newman, 2008). Islam is a form of worship or religion; the Arabic word means submission, specifically submission to Allah, the supreme and only God (Hodge, 2005). Although it is important not to confuse Islam with ethnicity or culture, it is also important to acknowledge the influence of cultural traditions on religious practices, such as slight differences in performing daily prayers, a celebration of Islamic holidays, attire, and relational aspects (Hamdan, 2007). Ansari (2002) described Islam as not only a religion but also an absolute and comprehensive way of life governing “the relationship between a human being and the Creator as well as the relationships among human beings themselves” (p. 325); it prescribes values and actions within the individual, family, and social realms (Kobeisy, 2004). Direction on all aspects of living can be found in the two main sources of knowledge: the Qur’an and the Hadith (Hamdan, 2007).

STATUS AND ROLE OF MUSLIM WOMEN

The past decade has seen an increased focus on Muslim women living in the West. Unfortunately, Muslim women have been stereotyped and often portrayed in the media as subjugated, veiled, and oppressed women who are uneducated, unintelligent, at the mercy of patriarchal men, limited to the household, and/or exotic belly-dancing harem girls (Haddad, Smith, & Moore, 2006). Although often seen as powerless in their roles, Muslim women are influential decision makers, are a source of guidance and consolation for their families, play an important part in making family and Muslim community decisions, and regularly visit mosques and attend community events (Turkes-Habibovic, 2011).

Understanding notions of gender equity in Islam is an important step to identifying possible bias or assumptions that mental health professionals may unconsciously hold about this population (Ahmed & Amer, 2012). Muslim societies are family- and community-oriented. Although men and women are equal, their innate differences give rise to different social roles or rules as evidenced by familial financial responsibility, inheritance laws, and clothing requirements (Ahmed &

Amer, 2012; Turkes-Habibovic, 2011). In Islam, a woman enjoys absolute equality with regard to civil and criminal laws. A woman's life, honour, and property are as sacred and sacrosanct as that of a man's (Haque & Kamil, 2012). Furthermore, the spousal relationship described throughout the Qur'an emphasizes the importance of mutual kindness and respect among spouses (Turkes-Habibovic, 2011); a distinction of roles between husband and wife does not imply an imbalance of power (Ali & Aboul-Fotouh, 2012).

Although women are given a high status and rights in Islam, in different Muslim countries all over the world Muslim women cannot fully enjoy their rights because cultural and ethnic values and Islamic teachings are not differentiated. Also, custom-driven legislation is often portrayed as Islamic law (Ali, Liu, & Humedian, 2004; Krivenko, 2009). However, even with the suppression of Islam-given rights in many cultures, Muslim women are actively using religion to reinvent their roles (Turkes-Habibovic, 2011). They feel empowered by their religion and are able to successfully balance household and community roles with a strong sense of sisterhood and community cooperation (Wang, 2006). Islam has a substantial influence on many Muslim women's beliefs, lifestyle, and decision-making processes (Dwairy, 2006). It is important for mental health professionals to recognize the ways Muslim women feel empowered by Islam and use this knowledge to assist their clients (Ali, Mahmood, Moel, Hudson, & Leathers, 2008).

MUSLIM WOMEN AND MENTAL HEALTH

Current research on the mental health concerns and service needs of Muslim women in Canada is limited. Most research to date has focused on attitudes toward help-seeking, gender issues in utilizing services, religious and cultural issues, indigenous treatment and influence of Western psychological treatment methods on clients from Eastern perspectives, cultural competency, and other issues such as client/therapist match in the context of therapy. Western psychotherapy is at times ineffective for Muslim women because its individualistic, fragmented method is contrary to Muslims' holistic spiritual approach to life (Carter & Rashidi, 2003). Misunderstanding the influence of Muslim clients' Islamic faith, beliefs, and values may lead to the provision of mental health services that reflect Western values, lifestyle, and culture and leave clients feeling stigmatized and alienated.

Like other women, Muslim women in North America seek therapy for a variety of concerns including depression, anxiety, relationship concerns, and grief and loss issues. Aside from dealing with the everyday stressors of life, Muslim women often have the added responsibility of defending basic religious rights and values as normal and acceptable (Douki, Zineb, Nacef, & Halbreich, 2007). Issues gaining increased research attention are marriage and domestic violence, hijab (i.e., head scarf), acculturation issues, discrimination and Islamophobia, dating, body image, conversion to Islam, and cultural and generational differences (Mahmood, 2013).

When working with Muslim women, mental health professionals are encouraged to consider their clients' multiple identities, as these identities determine how

their religious identity is interpreted and practiced. Cultural, religious, and social class identities are impacted by the larger sociopolitical context of being a Muslim woman in the West today (Mahmood, 2013). Therefore, a Muslim woman client's faith might not be her primary identity.

The Muslim community is also composed of people from a wide variety of ethnic backgrounds and national origins (Hamdan, 2007). Lack of awareness of this diversity can lead to a great deal of confusion regarding distinguishing religious variables from other cultural variables and poses challenges for mental health professionals who seek to provide respectful and culturally appropriate and responsive services (Hamdan, 2007). According to Sue and Sue (2008), to have a useful understanding of a cultural group, it is important to do an adequate exploration of historical background, subcultural values, and unique conflicts. This is equally important for Muslims as a cultural group.

Weatherhead and Daiches (2010) found the lack of mental health professionals from minority backgrounds contributed to a minimal utilization of mental health services within this minority population. Muslim women mental health professionals may be well positioned to illuminate the intricacies of providing mental health services to Muslim women clients. Hence, the purpose of this study was to gain insight from female Muslim mental health professionals about (a) the concerns of Muslim women clients, and (b) ways of working psychotherapeutically with this population.

METHOD

Basic interpretive qualitative research (Merriam, 2002) was used to explore the issues identified above. Ethical approval was received from the affiliated university's behavioural sciences research ethics board.

Participant Recruitment and Description

Five female Muslim mental health professionals working in a mid-sized prairie city participated in this study. Participants were recruited using purposeful sampling. All of the participants were mental health professionals currently working with Muslim women clients.

Participants varied in their practice in the field of mental health and their professional degrees and credentials. They were employed as social workers, a psychiatrist, a youth counsellor, and a psychologist. All participants were immigrants from different parts of the world, and their experience providing counselling services to Muslim women ranged from 3 to 25 years. Two participants worked with Muslim women clients primarily presenting with several mental health issues. Others worked with clients who were recent migrants to Canada and/or were refugees with several settlement and adjustment concerns in addition to their mental health issues.

Participants used strength-based and person-centred approaches as their primary theoretical orientations and integrated other techniques and orientations

when necessary (cognitive behavioural and brief solution-oriented therapy). One participant emphasized the use of a feminist perspective as an anti-oppressive, sensitive, empathic, human rights-oriented framework, to ground her work with Muslim women clients.

Data Generation

Each participant completed two in-depth semistructured interviews with the first author, a Muslim woman graduate student in applied psychology. All interviews were audio-recorded, transcribed verbatim, and made available to each participant for review prior to analysis. The first interview introduced the study and provided an opportunity for participants to share their experiences of working with Muslim women clients. Questions were designed to elicit their understanding of the primary issues that Muslim women bring to counselling, the models of counselling that appear to be most effective, the barriers Muslim women appear to experience in accessing services, the role of culture, spirituality, and religion in the provision of mental health services, and their ideas about how to provide culturally competent services to this population. The second interview provided an opportunity for in-depth follow-up on participants' descriptions. All participants appreciated the opportunity to share their professional experiences.

Analysis

A step-by-step process of thematic analysis (Braun & Clarke, 2006) was used to uncover the themes relevant to Muslim women mental health service providers' understandings of Muslim women clients' needs and how to work therapeutically with this population. Thematic analysis has been described as "a method for identifying, analyzing, and reporting patterns (themes) within data" (Braun & Clarke, 2006, p. 79); it can be theory-driven or data-driven, deductive or inductive (Braun & Clarke, 2006). Inductive thematic analysis was used for this study, meaning that the data were analyzed without "trying to fit it into a pre-existing coding frame, or the researcher's analytic preconceptions" (Braun & Clarke, 2006, p. 83). The text was read for semantic meanings, which were coded at face value instead of being read for underlying meanings and influences.

THEMATIC FINDINGS

Analysis yielded four areas of consideration in the provision of counselling services to this population: (a) seeking help is difficult for Muslim women; (b) lack of awareness is a barrier; (c) there is a need for community outreach, psychoeducation, and cross-cultural training; and (d) there must be a centrality of trust and careful application of modalities and orientations. Although the following themes and subthemes overlap, they are presented as separate themes that represent the most salient aspects arising across interviews. Findings are presented and anchored with participants' words, followed directly with connections to the literature and implications for counselling practice.

Seeking Help Is Difficult

Although seeking and accessing professional help for a variety of mental health concerns is challenging for most clients, cultural restrictions, loss of language, and challenged resources present unique difficulties for Muslim women clients.

Cultural restrictions. Participants noted that Muslim women face several cultural restrictions when it comes to identifying their need and seeking help for mental health issues. Primary among these are traditional family and gender roles, a stigma about mental health, and fear of the consequences of seeking counselling services. A Muslim client's family is usually the central aspect of her psychosocial well-being, and family unity is highly valued. For many Muslim women clients, family dynamics and fear of their husband's opinion of them and losing their children and reputation in the community are barriers to seeking help.

Many Muslim women clients prefer not to disclose personal or familial information to strangers. Given the importance of family, revealing personal information may automatically be associated with revealing family information. Sexual issues, suicide, and substance abuse are examples of issues that Muslim women clients may be particularly hesitant to discuss with a counsellor. Many clients may also hide information about experiences with domestic violence for fear of their safety and further tarnishing the reputation of Muslims in the community.

For many Muslim women, challenging their traditional roles and expectations brings about shame on their families, social isolation, lack of support, and even ostracism from the community. Some Muslim women may never seek counselling services because they are not aware of them and such services are not culturally condoned. One participant spoke about how some families of Muslim women seeking counselling services: "fear that such women are going to become 'liberated'; they worry that she will become a 'dangerous feminist' and will 'lose control.'" She further shared, "male patriarch (father, brother, husband) losing control over their women is another issue. Women themselves fear becoming liberated."

Another participant explained how many mental health professionals fail to understand the role, status, and family structure of their Muslim women clients. Many of them appear insensitive to the negative and often racist stereotypes toward Muslim women within society, which further reinforces these attitudes. A participant described her understanding of Muslim women as living at the intersection of race, gender, and society and how this is often not understood by mental health professionals:

[T]he subordination of women within the family and home and then outside the intersection of race, gender, and society, seeing Muslim women as the most oppressed, the most subordinate, obedient, not intelligent enough, and so that's the mixture of racism and sexism. They are less than other women, and then other women are lesser than most men, and then that's a really, really painful mixture of circumstances which are created by that intersection of race and gender. Inside the home, they are dominated and controlled by family, and outside the home they just experience racism not only as racialized population,

but they also experience sexism, and these intersect with each other and puts three to four times more burden on Muslim women.

Regarding marital concerns, one participant shared: “It is not easy for Muslim women to express their feelings, especially in regards to marital problems. It is not culturally acceptable to talk to strangers about intimate relationships.” The shame and stigma associated with divorce within the Muslim community, guilt about becoming a financial burden on the family, feelings of failure if their marriage ends, and a lack of immediate and follow-up support and resources within the Muslim community for women who choose to divorce their spouses amplify their burden and often leave them isolated.

One participant worked with a client whose parents were “controlling and overinvolved” in her client’s life to the extent of making important life decisions for her. Often, depending on the background of the client, it is culturally appropriate for relationships between parents and children to overlap—relationships and family are more important than the individual. Sometimes this can be seen as problematic by the counsellor; however, such individual-family relations can be quite normal and a significant source of emotional and economic support for Muslim women, particularly in times of need.

Another participant talked about the challenges of working with clients from the same cultural background as her own. Circumstances where the client and counsellor share similar cultural and/or religious backgrounds can sometimes lead a client and her family to believe that they can put undue pressure on the counsellor. In this instance, the counsellor can be unintentionally exploited and cause serious harm to the client should pressure from the family impair their professional judgement.

Traditional gender roles in Islamic societies may have a significant impact on the lives of some clients (Graham, Bradshaw, & Trew, 2008; Haque & Kamil, 2012; Turkes-Habibovic, 2011). Several restrictions may be imposed on activities of Muslim women by parents, husbands, and extended family because of different cultural interpretations about the role of women in Islam (Ahmed & Aboul-Fotouh, 2012; Daneshpour, 2012). Muslim women who challenge these traditional roles and expectations often end up disappointing their parents and families, consequently leading them to frustration, stress, and depression.

Loss of language. All participants emphasized that language barriers play a significant role in Muslim women’s access to and experience of mental health services. Many clients and counsellors do not share the same language, which poses a significant challenge to therapeutic communication and rapport. Such challenges can lead to major misunderstandings between client and counsellor. For example, one participant shared:

I saw a Muslim woman ... she was depressed with psychotic symptoms, and she was admitted to the [hospital] ... I was able to talk to her, communicate with her in the language she spoke. In the morning she would refuse her medication and the people would call security, and they’d give her injections instead ... It

turns out that she would not take medication because it's a cultural thing that you don't take medication on an empty stomach. But she couldn't speak the language so she could not explain herself.

All participants mentioned the discomfort and lack of trust on the part of their Muslim women clients in working with an interpreter or translator from their community. The reasons given by the participants were lack of awareness and social stigma in the community regarding mental health issues and lack of privacy, which are cited in the literature (Abugideiri & Alwani, 2003; Nadir & El-Amin, 2012; Smart & Smart, 1995). Because stigma and shame is a great concern for many Muslim families, it is important to be sensitive to clients' concerns about other community members knowing that they are receiving mental health services (Nadir & El-Amin, 2012).

Using relatives or family members as interpreters has been discouraged due to the potential for negative impact on family dynamics (Ahmed & Aboul-Fotouh, 2012; Cox, 2009; Smart & Smart, 1995). When utilizing the services of an interpreter or translator, mental health professionals are encouraged to make sure that the interpreter is bicultural/bilingual, knowledgeable, and able to interpret cultural and social cues between the counsellor and client (Abugideiri & Alwani, 2003; Lynch & Hanson, 1999; Smart & Smart, 1995).

Lack of trained interpreters was another concern voiced by participants. One participant noted:

Interpreters are not trained here ... anybody can walk in and interpret. Interpretation ... by racialized women can cause severe problems, especially in the health sector, because in the past there had been cases where women would be seen by medical doctors and their cultural brokers would interpret and they would twist what women would be saying and conceal the violence against women.

Participants talked about the agony of loss of social connections that many Muslim women clients face upon immigrating to Canada. One participant described the challenge:

One of the losses we (Muslim women) go through, by moving to Canada, is loss of voice, language, and not finding people to listen to us and understand. It's not only people outside but people within the community. And then it magnifies the social isolation. A lot of Muslim women who are now coming to Canada are not educated as much. They are coming here, and they do menial jobs. Those jobs never give them any opportunity to learn the language or take courses or move ahead.

Lack of language skills has consistently been identified as a significant barrier to client-counsellor communication and access to counselling services (Ali & Aboul-Fotouh, 2012; Casimiro, Hancock, & Northcore, 2007; Rahiem & Hamid, 2012). Language has also been identified as a potentially integral factor that a clinician must be aware of when assessing a Muslim client (Mahmood & Ahmed, 2012).

For clients whose native language is not English, the counsellor should speak slowly and clearly, limit the use of professional jargon, and assess clients' understanding periodically throughout the provision of services (Nadir & El-Amin, 2012). It is important to note that language barriers not only hinder communication within the therapeutic relationship, but they also magnify the isolation of the client from the community (Casimiro et al., 2007).

Challenged resources. In addition to the multiple roles Muslim women play within the family and community, economic strain, unemployment, lack of transportation, physical impairment, limited social supports, unaffordable child-care, and lack of services in the client's language make accessing mental health services difficult. Participants commented that there should be easy access to transportation for clients with mental health services being provided in their native language. One participant emphasized, "The whole issue of access. That's the biggest problem for Muslim women. Access to resources, access to a safe space." Furthermore, many Muslim women "do not have three dollars to spare for the bus to go somewhere, let alone to go somewhere to seek help." One participant noted that many Muslim women clients are quickly catching up with the First Nations in Canada in terms of poverty.

Although poverty is mentioned in the literature as a potential trigger for mental illness, it has not been directly linked to influencing utilization of services for Muslim women (Utz, 2012). Muslim women looking for employment find no relief from household responsibilities that are often coupled with the challenge of finding affordable childcare and trying to navigate between old and new cultural expectations and norms (Ahmed & Aboul-Fotouh, 2012).

Lack of Awareness Is a Barrier

All participants commented on the need for increased awareness amongst Muslims about mental health issues and services. They also provided insight on how bias, stereotypes, and general lack of cultural awareness of mental health professionals can adversely affect the helping relationship.

Fear of the unknown and the stigma of mental illness. Participants explained that many Muslim women clients have no idea what the counselling process entails—"they can't imagine that they can share their feelings with somebody." Furthermore, there is a lack of education and acceptance of mental health problems within the broader Muslim community (Ali & Aboul-Fotouh, 2012). Often family members have no awareness of severe mental illness in their relatives, or they may be so concerned about the stigma that they are quick to deny the presence of a family member's mental health concerns (Ali & Aboul-Fotouh, 2012). Many Muslim women clients believe "counselling is not for normal people. I know many educated people believe that, too. It's not easy if you tell someone, 'I have a counselling appointment today,' they may say that are you 'crazy.'"

Lack of awareness about mental health problems and services occurs at the individual as well as community levels. One participant commented that "acceptance and realizing that mental health issues do exist" is important. However,

she continued, “culturally, people tend to seek help for medical reasons that are obvious, which can be explained, and which you can see, but not for the invisible things that can affect your whole behaviour.” Many Muslim women clients believe that their troubles are a test from God and therefore will pass with patience and prayers. It can be challenging to explain to them that Islam emphasizes seeking help for mental health issues equally as much as seeking help for physical ailments. Furthermore, many Muslim women and their families neglect their emotional issues. One participant commented, “Muslim women clients often comment on worrying about what people will think of and say about them; the fact that they are seeking help means that they are ‘weak,’ and their reputation in the community is at stake.”

Lack of awareness of mental illness is not unique to the Muslim community. One participant commented that there is systemic social stigmatization of mental health issues, and assumptions that anybody who goes for counselling is doing so because they are not mentally well. Many Muslim women clients struggling with depression attend counselling once or twice, believing that things should be okay after just a couple of sessions. Again, their family roles and responsibilities often keep them from seeking help.

Lack of awareness on the part of mental health professionals. Participants provided insight on how bias or a lack of cultural awareness on the part of mental health professionals can also adversely affect the client-counsellor relationship for Muslim women clients. Participants emphasized the importance of mental health professionals gaining accurate knowledge about their Muslim clients’ faith and culture in order to tailor services. Mental health services that are low on cultural competency are associated with poorer outcomes such as potential misdiagnosis and consequent incompetent treatment. One participant shared a story about a client who had never had to deal with financial issues, so when her husband passed away, she was faced with a myriad of problems, including being misdiagnosed with a mental illness. In many Muslim cultures, males are financially responsible for their family whereas females are not, so Muslim women may never have to deal with financial issues. If the mental health professional working with this client was aware of her situation or would have done a thorough assessment, the misdiagnosis may not have occurred.

In addition to a client’s culture and faith, the status of the client (e.g., a convert, refugee and/or immigrant, socioeconomic background) are important considerations for assessment and intervention. If a Muslim woman client has escaped a country where there is war and persecution, she might be experiencing severe war trauma or posttraumatic stress and may find it difficult to trust anyone. In such cases, mental health professionals who are sensitive to the backgrounds of their clients and aware of their own cultural biases can work toward providing more culturally appropriate and sensitive services.

Because there is no monolithic Muslim culture, participants talked about the challenges faced by mental health professionals in knowing the cultural background of all their clients. Awareness and acknowledgment of simple things that

are important to the client can immensely facilitate the client-counsellor relationship. One participant talked about how she sees mental health professionals limiting their helping relationships to their offices. So she tries to be reasonably accessible beyond the office to her Muslim women clients, and advocates for them on a regular basis. Often Muslim women clients are immigrants struggling to make ends meet economically; in the rush of day-to-day life, they forget to advocate for their own needs. Working with this population requires skilled advocacy.

One participant talked about the lack of cultural awareness on the part of many counsellors at her workplace. Recently, a Muslim woman client was misguided into leaving her husband by a counsellor who had little knowledge about the client's cultural background and social norms. Later, when the client realized what she had done, she was devastated by the choices she had made. A husband and wife have different roles in Islam, and it is important for the counsellor to understand the dynamics of these roles and relationships.

Another participant shared her distress about counsellors ignoring fundamental individual differences and working with clients with a "one size fits all" approach. They also highlighted the ethical dilemmas counsellors might face if caught unaware of their clients' cultural expectations. Participants talked about situations where managing the boundaries in their relationships with clients becomes challenging. One participant warned, "they may put you in a different role like a friend, sister, mother ... They want to call you evenings, weekends. They feel that we are like a family and they want to invite you to their home." Instead of refusing clients' requests outright or accommodating them out of fear of offending them, participants noted the value of honest, open, and clear dialogue. Mental health professionals should be aware of situations where their values, duties, and obligations as counsellors will clash with that of their clients' expectations due to cultural or religious differences.

Need for Community Outreach, Psychoeducation, and Cross-Cultural Training

All participants reinforced the need for community outreach activities, psychoeducation, and cross-cultural training for mental health professionals working with Muslim women clients.

Community outreach and psychoeducation. Participants emphasized the need for community outreach mental health education and services for Muslim women as well as partnerships between mental health organizations and the Muslim community. Participants agreed that providing group psychoeducation to create awareness and to build trust and relationships with this population is important. Because of the significant stigma associated with mental illness in the Muslim community, it is important to create safe spaces to talk about and clarify misconceptions. One participant recommended that regional health authorities collaborate with families, local religious and community leaders, and policy makers to focus on the needs of this population. She recommended "publication of booklets and posters in different languages that contain information on mental health problems, as well

as information about where to go for help and support.” Another participant advised involving members of the Muslim community in planning and organizing such activities: “We can include educated Muslim women on boards of different organization, in leadership positions, so they can share information, issues, or counselling techniques” that can help Muslim women.

Participants suggested that the masjid, or the mosque, has a full committee with a president, secretary, and director of cultural and women’s affairs. All of them should be well informed of mental health services available in the community. All participants encouraged collaboration between mental health professionals and Imams. Imams can play an important role in spreading a positive message about mental health and the role of community, thereby reducing stigma and discrimination about mental illness and increasing utilization of mental health services. On a note of caution, one participant mentioned that there are Imams that are “very conservative, and they’d just go by the scriptures,” but a “good” Imam will want to work for the betterment of the community. Although Imams are not typically trained in working with mental health issues, “if they’re knowledgeable they can give advice or help regarding how to deal with problems within the religious laws and cultural norms.” However, as one participant clarified, if Imams are not trained professionally and do not have experience with mental health-related concerns, they will be unable to help Muslim women in challenging situations. Furthermore, “if there is counselling and if there is training, and if they can explore how the current interpretation of Islam is affecting women, and how men are really using or misusing [the interpretations], then maybe there’s a stepping stone” to greater personal and community mental health.

All participants were in favour of a liaison between mental health professionals and the Imams as a way of encouraging the use of mental health services and a way to support Imams in this area of their work. Imams are often the first resource that Muslim families in crisis turn to after seeking support from family (Abu-Ras & Abu-Bader, 2008), and several studies have reported that many Muslims have sought help for a mental health issue from their Imam (Abu-Ras, Gheith, & Cournois, 2008; Khan, 2006). Additionally, Imams can also aid community psychoeducation as they have a wide audience during Friday prayer, a time equivalent to Christians’ Sunday morning mass, during which they can provide information in the khutba (sermon) that attempts to destigmatize mental illness and promote wellness (Ansary & Salloum, 2012).

One participant cautioned that if Imams are not trained professionally, “they can reinforce the same old oppressive ways of living for Muslim women.” Often Imams do not have the professional training required to identify and appropriately treat mental illness (Ali, Milstein, & Marzuk, 2005; Abu-Ras & Abu-Bader, 2008). Nonetheless, Abu-Ras and Abu-Bader (2008) suggested that many Imams are supportive of clinical therapy and the use of psychotropic medication, and are interested in learning more about Western treatment methods. Hence, Imams can be key partners in community outreach efforts and are best positioned to provide education on mental health issues, from how to identify individuals and

families in crisis to available and appropriate mental health resources (Ansary & Salloum, 2012).

Cross-cultural training. Participants emphasized the need for training and professional development for mental health professionals interested in working with Muslim women clients. They expressed significant concern about the lack of religious and cultural awareness among mental health professionals working with this population. Specifically, many organizations lack professionally trained and skilled counsellors. One participant commented, "Some of the counsellors don't have any background in counselling ... they come with different degrees and they work there because of the language, maybe they were teachers before, but they are not really counsellors, they're not social workers."

Indeed, evidence suggests that mental health professionals are generally uneducated in the religious and cultural practices of Muslim clients (Carlson, Kirkpatrick, Hecker, & Killmer, 2002; Furman, Benson, Grimwood, & Canda, 2004). Mental health professionals should strive to understand the worldviews and intracultural differences of Muslims in order to practice in an anti-discriminatory and culturally responsive manner (Qasqas & Jerry, 2014). In fact, they have an ethical obligation to ensure that their practice includes cultural awareness and competence (Qasqas & Jerry, 2014). Of concern, mental health services that are low on cultural competence are associated with poorer outcomes such as misdiagnosis (Delphin & Rowe, 2008; Rosenberg, 2000) and reduced levels of client engagement and retention (Ansary & Salloum, 2012; Delphin & Rowe, 2008).

Often mental health professionals face ethical dilemmas in trying to find a balance between respecting a Muslim woman's circumstances and beliefs, and upholding their professional and ethical obligations to intervene, particularly in cases such as abuse and domestic violence. In such circumstances, it would be helpful to familiarize oneself with some practical tools that could facilitate guiding Muslim women clients through difficult and compromising situations. In situations such as these, mental health professionals often misunderstand the link between a client's culture and well-being, erroneously assuming that culture is the root issue of their presenting problems (Qasqas & Jerry, 2014). Focusing on empowering the client is a feasible goal that can promote positive well-being and help clients to overcome the impacts of violence and abuse (Qasqas & Jerry, 2014). Furthermore, peer consultation concerning counselling practice, particularly regarding doubts or uncertainties that may arise during professional work, is always encouraged (Canadian Psychological Association, 2017).

Finally, participants suggested the need to be aware of the effects of the "colonial gaze," and how this may increase the stigma and isolation that Muslim women clients face as they seek help and experience the helping process. Furthermore, one participant suggested the importance of being aware of the social attitude toward Islam and the kind of isolation and denigration it puts on Muslim women. Many Muslim women are "compromising, sometimes, their own mental health, and don't talk about what's going on within their community and within their family because they're scared that their religion and their faith would be further demonized."

Centrality of Trust and Careful Application of Modalities and Orientations

Participants had many years of experience working with Muslim women clients, and several were immigrants themselves. They all emphasized the importance of trust and rapport-building with clients and regarded the quality of the therapeutic relationship as central.

Participants reported that although knowledge about clients' beliefs and practices can help in building trust and relationships, listening attentively without judgement to what Muslim women clients have to say is foundational to the therapeutic process. As noted, Muslim women clients might find it difficult to share confidential information with a stranger, mistrust the counselling process for fear of being stereotyped, and not feel proficient at identifying or expressing emotions. Consequently, imparting respect and genuine care is crucial. Genuinely listening to Muslim women clients, recognizing the mistrust that they may harbour toward Western understandings of mental health and services, valuing religious coping, and carefully considering the impact of various counselling modalities and theoretical models are important when working with this particular client population.

Some Muslim women clients may worry that if their counsellor is not from the same religious and cultural background, they will not be able to understand their problems. It takes time to get to know Muslim women clients before they risk talking openly about their issues. Mental health professionals can facilitate building trust and relationships with their Muslim women clients by attending the same social activities, or connecting with them at their religious or cultural centres. Listening carefully to clients not only helps build relationships but also gives the counsellor an understanding of their clients' context and ethnic background. Such listening also helps to identify clients' strengths and develop collaborative relationships. Despite the increasing cultural diversity within Canada, many counsellors do not respond to clients in a culturally sensitive way that respects their strengths and differences. Culturally insensitive service may leave clients feeling oppressed and disempowered (Graham et al., 2008).

In addition to the fear of shaming one's family by openly seeking mental health services, another obstacle Muslim women may face is a deep-seated mistrust of mental health professionals and Western treatment options (Abu-Ras & Abu-Bader, 2008; Abu-Ras et al., 2008; Hodge, 2005; Starkey et al., 2008). Nadir and El-Amin (2012) cited "blaming of the religion" as a primary reason many Muslim women do not seek the assistance of mainstream service providers. Abugideiri and Alwani (2003) indicated that "suspicion and distrust may be a result of Muslim women's fear that Western workers are biased toward divorce; guilt about seeking help outside the family or community; and uncertainty about the choices she will be asked to make" (p. 48). Therefore, mental health professionals should be sensitive to a Muslim woman client's reluctance toward interventions, perhaps allowing more time for the client/family and mental health professional to become acquainted (Nadir & El-Amin, 2012).

In times of distress, Muslim women may use religious coping (Abu Raiya & Pargament, 2010; Abu Raiya, Pargament, & Mahoney, 2011; Abu Raiya, Pargament, Stein, & Mahoney, 2007; Loewenthal, Cinnirella, Evdoka, & Murphy, 2001). Indeed, participants commented on the use and importance of recognizing the role of religious coping as a resource for Muslim women clients. According to one participant, Muslim women, or anyone who practices religion, may

rely on a “higher power,” and on worship, like praying, and fasting, and doing other things that can help them, so I think it’s good if the counsellor, if they are not Muslim, that they are aware of the ways Muslim people practice.

Participants commented that some of their clients used prayer to calm down and compose themselves throughout distressing situations while trying other interventions as appropriate (e.g., breathing exercises, meditation, mindfulness practices). Counsellors are advised to familiarize themselves with Islamic values and teachings about religious coping, as these, in addition to professional interventions, may be more effective in promoting resiliency among religiously oriented clients (Bhui, King, Dein, & O’Connor, 2008; Hamdan, 2007; Hodge, 2005).

Group counselling versus individual counselling with Muslim women clients is a relatively new idea that has yet to receive attention in the literature. Participants commented on how group counselling sessions are less formal and intimidating for many Muslim women. Group activities and information sessions facilitate trust and positive relationships with group facilitators and other group members, thereby reducing social isolation. Furthermore, through hearing stories of other group members, Muslim women may gain confidence and eventually feel comfortable in seeking more individualized help for their problems.

One of the participants emphasized the importance of a feminist perspective when working with Muslim women clients. Feminist theorists, practitioners, and researchers emphasize how a person’s gender, socioeconomic background, and cultural/racial group affiliation affect one’s psychological development and relational empowerment (Daniels, 2007). Mental health professionals working with Muslim women clients from a feminist perspective can examine the psychological distress of their clients as a function of the many systems operating in their lives, not simply as intrapsychic material (Chaudhry, 2012). They can work toward increasing their clients’ understanding of the responsibility to learn new ways to more effectively address unique stressors, injustices, and oppressive treatment within different environmental contexts (Daniels, 2007).

CONCLUSION

Although there is scant research to guide mental health professionals on the provision of culturally responsive services to Muslim women (En-Nabut, 2007; Lambert, 2008; Qasqas & Jerry, 2014), the time is ripe to explore such issues in the Canadian context. Many of the findings reported herein echo the literature, but importantly add a rarely heard and celebrated perspective, namely that of

Muslim women mental health professionals who have lived as Muslims, women, and helping professionals. However, there were limitations to this study. The sample size was small and limited to female Muslim mental health professionals living in a mid-sized prairie city. The small sample size yielded detailed information from participants who met specific criteria, and results were not intended to be generalizable.

Findings could be different if participants were recruited from other provinces in Canada, assuming an increased number of female Muslim mental health professionals practice in larger urban centres. Future research could extend these findings by exploring the perspectives of more Muslim women mental health professionals from different regions of Canada, as well as through conducting comparative interviews with non-Muslim service providers of both sexes. Although challenging, privileging Muslim women clients' voices in research on presenting concerns and access to, and experiences and satisfaction with, mental health services and professionals would yield important findings that could further inform service delivery and program development.

Family and the ethnic community are important to many Muslim women clients, and both have been described as fundamental Islamic values (Hodge, 2005). Mental health professionals should recognize that status in the community may be very important and that Muslim women may work hard to maintain their social position, even if it requires sacrifice. The community is also often the first line of support for many Muslim women, and it is a norm to resolve problems within the family or community rather than seeking outside help (Al-Issa, 1990; Al-Krenawi & Graham, 2000; Graham et al., 2008; Rahiem & Hamid, 2012). However, many do not turn to one another for support in times of crisis for fear of judgement due to disclosing familial problems, particularly of one's own or a relative's mental illness (Ansary & Salloum, 2012). Sanctions against talking about personal problems within the community combined with the stigma of mental illness and help-seeking create a formidable barrier to seeking mental health services for Muslim women (Ansary & Salloum, 2012).

For Muslim women who do manage to access such services, they are often confronted with mental health professionals who, although well intentioned, do not have sufficient knowledge about being Muslim and practicing Islam, let alone the complexities of such as experienced by their clients. According to Riley (2011), Muslims cannot be referred to as a coherent or stable category, Islam can be a very personal religion, and one can be a Muslim without belonging to a community or attending services in a mosque. In fact, some Muslims choose not to display their religion publicly due to fear of discrimination and harassment (Chaudhry, 2012).

There is a significant need for community outreach and psychoeducation on what constitutes mental illness and health and what services are available in different communities. Religious places such as mosques and Islamic cultural centres are beginning to recognize the need to address the stigma about mental illness and help-seeking by spreading awareness of mental health issues and services (Daneshpour, 2012). Within Muslim communities, Imams enjoy significant trust by com-

munity members and can play a significant role in educating the community as well as increasing service utilization (Kobeisy, 2004). Furthermore, mental health professionals have an ethical responsibility to increase their knowledge and cross-cultural competency through consultation with faith communities and Imams, and through organized professional development opportunities. Developing relationships with Muslim community members can be achieved by attending various cultural and religious programs at cultural centres. Volunteering with refugees and organizations working for diversity and inclusion are viable ways to increase cultural responsiveness, as are attending community conversations around racism, poverty, and systemic oppression, and working through an anti-oppressive lens.

Importantly, mental health professionals need to offer Muslim women clients a chance to speak for themselves, listen to them without judgement or bias, try not to change their belief system(s), and gather as much information as possible about their roles, status, and family structure. They should also be aware of the political climate and the negative and often racist stereotypes toward Muslim women so as not to reinforce these attitudes when working with this population. Islam is an important aspect of daily life for many Muslim women (Abu Raiya & Pargament, 2010).

Excluding religion from therapeutic conversations may have negative outcomes, including depriving clients of valuable and accessible resources that have significant implications for their overall well-being (Turkes-Habibovic, 2011). Mental health professionals are also encouraged to practice cultural humility (Hook, Davis, Owen, Worthington, & Utsey, 2013) in their work with Muslim women clients by reflecting on their experience with and biases about this population, increasing self-awareness of their strengths and limitations in providing culturally responsive services, and seeking regular supervision and consultation with peers (racialized and white) (Canadian Psychological Association, 2017).

Finally, given the influx of refugees from war-torn areas and the sociocultural change in Canada, mental health professionals are well advised to recognize the often significant sociocultural, language, and resource barriers that Muslim women often face in accessing culturally responsive services. Mental health professionals need to be cognizant of the impact of war and terrorism on Muslim women's mental health and the gender-based violence and sexual exploitation of refugee women, particularly in Bosnia, Iraq, Afghanistan, and Syria (Niaz, 2014). These victims of violence (wars, suicide bombings, terrorist attacks, and genocide) need urgent physical treatment, social and mental health support, and rehabilitation services to avert permanent disabilities (Niaz, 2014).

Trauma work can be complicated with this population, as it may have occurred at a single point in time, repetitively, or across multiple generations, such as with refugees and their experience of continuous war. Additionally, factors such as the client's role in the conflict and the presence of secondary trauma, such as being witness to the torture, rape, and humiliation of family members and friends, can be a major stressor. Mental health professionals should assess different facets of the client's identity such as gender, tribal, regional, ethnic, religious, and occupational

(Ahmed & Aboul-Fotouh, 2012). They should also probe clients gently, clarify the relevance of questions, and provide them with examples of how unrelated factors can impact clinical presentation and interventions. Some aspects of a Muslim woman's history of trauma may be too difficult to talk about at an early stage of therapy. Creating a safe therapeutic space and respecting the client's readiness to address difficult experiences is critical.

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