# MIND, BODY, SPIRIT: MUSLIM WOMEN'S EXPERIENCES IN THERAPY

by

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*To the women who continue to sacrifice for the betterment of community, to the friends and family who saw my strength before I did, and to young scholar-activists—I see, hear, and am here to support you. Finally, to the academic elders in this paper and my grandparents – Azmat Elahi, Naseem Akhtar, Kishwar Butt, Muhammad Afzal Firdausi. I wish I knew more of your stories and am proud to finish this degree as your granddaughter.*

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# ABSTRACT

The field of counseling psychology has made considerable strides in identifying and acknowledging the role of psychologists in attending to system-based harms both in and outside of the therapeutic space. For counselors to effectively address system-based traumatic stress, they must first be educated and trained to recognize and acknowledge it (Bryant-Davis, 2007). As clinicians this recognition means acknowledging our own identities, our own history, and our own complicity in the systems we navigate which cause harm to marginalized communities, being compassionate towards others and ourselves, financially supporting organizations and activist groups, and understanding spirituality can be and IS a strength for many people.

This dissertation presents in the form of two distinct chapters conceptually related in nature. The first chapter integrates literature from various fields from an indigenous, womanist, and feminist lens to propose nine principles for counseling psychologists when working with Muslim women. The purpose of the second chapter is to examine Muslim women's experiences in therapy. The study will explore women's experiences from social determinants of health perspective—namely, how intrapersonal, interpersonal, institutional, community, and policy factors inform women's experiences at university counseling centers. Participant voices via qualitative analysis of the multiple systems women navigate will include beliefs about self and others, family and community relationship, and the university system.

# INTRODUCTION

Muslim scholars in anthropology, American studies and ethnic studies, law, theology, and psychology have written extensively on Muslim identity. Scholars in anthropologists (i.e., Su'ad Abdul Khabeer, Donna Auston, Shabana Mir and Muna Ali), ethnic and religious studies (i.e., Sylvia Chan Malik, Kayla Wheeler, Juliane Hammer, Kecia Ali, Amina Wadud, Asma Barlas), and law and psychology (i.e., Azizah al-Hibri, Asma Uddin, and Carrie York Al-Karam) are all North American scholars who study the American-Muslim experience and jurisprudence. However, this body of literature and knowledge remains untouched in counseling psychology when considering what it means to be Muslim within a therapeutic context.

The role of context and person-environment fit is particularly important to the field of counseling psychology as the field takes a developmental and preventative approach to wellness (Packard, 2008). Few scholars in counseling psychology have begun to address the role of systems in understanding axes of inequity within therapy. Individuals like Bonnie Moradi, Helen Neville, and Dawn Szymanski have addressed the ways in which sexism, racism, and heterosexism impact psychosocial functioning (Moradi & Subich, 2002; Szymanski et al., 2008; Thompson & Neville, 1999). Little has been done however, to assess the various systems of oppression that influence Muslim women and Muslim women's mental health. This is particularly important as there are multiple systems impacting this population and especially because Muslim women's identities are particularly complex, co-constructed, and include interlocking matrices of dominations (Collins, 2002). Clients and patients suffering intense psychological distress often seek care with the hope that mental health clinicians will help alleviate their emotional pain. However, given that the majority of mental health services are provided by White, European American therapists trained in Western psychotherapy, non-

dominant groups are less likely to use mental health services and may fear discrimination and misunderstanding within the system (Chang & Berk, 2009). Specifically, the cultural implications of Western training in psychotherapy, such as the emphasis on separateness and individualism, may be particularly unhelpful for Muslim women, who have different beliefs around the etiology of mental illness, the treatment of mental illness, and the role of environment and context in the onset of distress (Padela et al., 2012). Moreover, this group faces multiple systems of oppression, including but not limited to—anti-Muslim racism and gendered Islamophobia both within and outside of their communities of origin (Fine & Sirin, 2008; Mir, 2006; Padela et al, 2012; Shawahin, 2016).

Disrupting, dismantling, and changing the discourse around Western forms of knowledge and is a form of systems change from an indigenous methodological stance (Mutua & Swadener, 2004). Theoretical frameworks such as Red Pedagogy (Grande, 2004) and Tribal Critical Race Theory (Brayboy, 2005) argue the necessity of acknowledging colonialism in sustaining the erasure of indigenous people and the continued impact of settler colonialism in the United States. Indigenous methodologies also emphasize multiple ways of knowing, including but not limited to "research by and for indigenous peoples, using techniques and methods drawn from the tradition of those peoples" (Evans, Hole, Berg, Hutchinson, & Sookraj, 2009, p. 894). Pulling from these methodologies, the first chapter of this dissertation highlights the ways in which I (Alia Azmat) have come to understand needs in Muslim community by proposing nine principles to consider when working with this group. I draw specifically on the intellectual scholarship of Muslim women and women of color in the academy, and by doing so I center the voices of the marginalized rather than framing them as alternative experiences (Masta, 2018a).

Feminist and womanist methodology also address the ways in which knowledge is cultivated and challenged (Sheared, 1994). Feminist theory honors the client or participant as an expert in their own experience and strives to acknowledge inherent power differentials. From this orientation, feminists must work to be aware of their own values, biases, and worldviews (Enns, 2011). Womanist theory was created as an alternative model to feminism to address the integration of racism, sexism, and classism Black women experience. First coined by Alice Walker, womanism is a model in which race, class, gender, and sexual orientation are interactive, not isolated, in women's lives (Walker, 1983; Williams & Wiggins, 2010). The integration of Muslim identity as a culmination of race, class, sexual orientation, sectarian differences and additional intra-community power differentials are the ways in which I pull from these two methodologies in framing these nine principles. Finally, strength-based frameworks are a key component of feminist and womanist theories. Specifically, that there is power in women's voices and narratives (Walton & Oyewuwo-Gassikia, 2017).

In effort to rewrite narratives that portray Muslim women as oppressed, the first chapter of this dissertation uplifts the numerous ways in which Muslim women are active and agentic in the creation of their own liberation and wellness. I present nine principles to guide clinical work with Muslim women. Therapeutic work with Muslim clients, particularly Muslim women requires therapists, organizations, and communities to honor the complexity of Muslim women. I highlight the ways in which various systems, including the mental health system, silences, flattens, and participates in reductive binaries around Muslim women's stories and experiences. Specifically, I ask clinicians to: (1) identify the relationship Muslim women have to land; (2) recognize racial differences within the Muslim community; (3) honor relational and caretaking roles of women; (4) encourage "embodied faith" via social justice activism; (5) encourage

multiple networks of connection via “third spaces”; (6) challenge stories of conditional worth by integrating spiritual scripture; (7) utilize trauma-informed principles; (8) engage with Muslim feminist concepts such as "tafsir of praxis"; (9) emphasize the ecological model in harm and healing in women’s lives.

# CHAPTER 1

American-Muslims are one of the most racially diverse religious groups in the United States. No single racial group forms the majority of this group, with 41% of Muslim adults identifying as white (including people of Middle Eastern ancestry), 28% identifying as Asian, and 20% identifying as Black or African American (Pew Research Center, 2017). Moreover, 58% of Muslims in the United States are foreign born while 42% are native born. Foreign-born Muslims come from areas including South Asian (20%) and North Africa/Middle East (14%). Socio-economically, about 31% of Muslims in the United States have college or postgraduate degrees and about 24% of Muslims in the United States report household incomes of over $100,000 (Pew Research Center, 2017). On the other hand, about 40% of Muslim-Americans report incomes under $30,000. Within-group religious diversity also exists within this population, with 55% of American-Muslims identifying with Sunni Islam, 16% with the Shia tradition, and 14% identifying as "just Muslim" (Pew Research Center, 2017). Twenty percent of American-Muslims surveyed by Pew were converts to the religion.

While Muslims and non-Muslims alike assume Islam is a monolith, diversity within the Muslim community in regard to thought, belief, and practice is a reality of the community (Nadal, 2016; Rana et. al, 2021; Ayubi, 2019). This diversity provides a unique challenge to studying "the Muslim experience" as assumptions from both within and outside of the Muslim community around the homogeneity of this population can contribute to harm within faith-based spaces—particularly for Muslims at additional margins (i.e queer, non-Sunni, disabled, etc.). Therefore, highlighting the ways in which Muslims are different is just as important as reflecting on shared rituals and worldviews within the therapeutic relationship.

## Feminism, Womanism, Imperialism

The start of feminist therapy has been attributed to the Women's Movement in the mid-20th century. Consciousness-raising in the 1960s and 1970s surrounding civil rights, social change, and women's reproductive rights started discussions suggesting women's experiences may be different than men. Research around this time also highlighted the ways in which being a woman was fundamentally different than being a man and the implications for differing lived experiences (Gilligan, 1977). Feminist scholars call attention to power, gender socialization, social location and often emphasize the self-in-relation to others and work to be aware of their own values, biases, and worldviews (Gilligan). Historically, feminist theorists and researchers have had difficulty tending to diversity and complexity in this philosophy of change (Root & Brown, 2014). Often, conceptualizations of feminist therapy are still based on white women's lived experiences (Root & Brown). However, contemporary feminist therapy is closely aligned with multicultural theory and critical approaches aimed at dismantling all oppressive hegemonic systems including masculinity (Kahn et al., 2011). Nonetheless, spirituality and religion remain under-addressed in this literature (Goodrich & Luke, 2019).

Womanist philosophy began as an alternative to feminism in the 1970s. Womanism, first coined by Alice Walker, emerged as an Afrocentrist alternative to understanding of the needs of Black women. Specifically, it is a model which addresses racism, sexism, and classism in Black women's lived experiences. Moreover, womanist perspectives attend more critically to the role of spirituality in health-behaviors of women (Harvey et al., 2013). Womanist understandings of religion and spirituality also attend to the role of relationship to community as a means of facilitating positive well-being for women of color (Musgrave et al., 2002). Much of womanist theory has been influenced by a theology of liberation, specifically, by defining the health of a person and community as the absence of oppression (Musgrave). Moreover, womanist theory

recognizes the role of spirituality as a means to affirm the presence of God through struggles such as a slavery, sexual abuse, and separation of families (Musgrave et al., 2002). Finally, womanist theory recognizes the importance of caretaking and rebuilding of family and relationships in the home. Specifically, womanist theory embraces women's roles as protectors, providers, and nurturers of family (Barry & Grady, 2019).

What are the narratives Muslim women hear about themselves and how do history, power and privilege, and global policies inform psychotherapy research and practice in the United States related to Muslim women? Often, narratives of "being voiceless," "unveiling" and a being subservient group which needs "saving" are tropes replicated in the scholarship around this population. However, as anthropologist Lila Abu-Lughod (2002) shares:

> When you save someone, you imply that you are saving her from something. You are also saving her to something. What violences are entailed in this transformation, and what presumptions are being made about the superiority of that to which you are saving her? Projects of saving other women depend on and reinforce a sense of superiority by Westerners, a form of arrogance that deserves to be challenged. (p. 788 -789).

Abu-Lughod provides a counternarrative to colonialist or imperialist feminisms, or feminist ideologies that claim white men and women should "save" brown women from brown men (Salaymeh, 2020). Imperialist feminism strips women of color of their agency by otherizing Third World women by describing these women savage, exotic and as actresses of their own oppression. Specifically, Third World women are seen as women without agency, "trapped" by sexist understandings of religion and womanhood all the while Western women are seen as enlightened, civilized, and liberated and free from societies in which gender and race-based violence runs rampant. As Shenila Khoja-Moolji theorizes, a specific type of Muslim woman is

often used to represent the collectivity of Muslim woman and in turn the collectivity of Muslim men which replicates binaries of oppressed/free, empowered/disempowered, and modern/traditional representations of Muslim womanhood. Specifically, Khoja-Moolji highlights how the use of Malala Yousafazi in media codes Malala as an oppressed Muslim woman. She re-reads and asks her readers to re-read Malala as a representation of Muslim women on the process of *becoming* rather than categorizing Muslim women in reductivist and essentialized categories (Khoja-Moolji, 2015). Khoja-Moolji also compares media responses to two young Muslim women, Pakistani Malala Yousafzai and Palestinian Ahed Tamimi, to demonstrate how the West often engages in "selective humanitarianism" whereby only particular bodies and causes are deemed worthy of intervention (Khoja-Moolji, 2017). Rather than focus attention on structural causes of suffering such as poverty, violence, and hunger, often areas where the West must take account of the consequences of intervention, this narrative again reduces a certain type of non-Western women as subjects unable to lead, advocate, or define their own selves and creates a false binary in which the West has "progressed forward" from gender discrimination, sexism, and state-sanctioned violence within their own states and abroad. In doing so, these forms of feminisms also replicate Orientalist conceptualizations of power which suggest the East is inferior and dependent on Western "aid" and "intervention" (Said, 1978; Hall, 2017). This systemic exclusion of Muslim feminism and replication of Muslim bodies as "threats" result in young Muslim students embodying negative and harmful stereotypes about themselves (Ali, 2014).

## Why Now? Why Nine Principles?

In effort to rewrite or provide a counternarrative to portrayals of Muslim women as oppressed, silent, submissive, I have chosen to uplift the numerous ways in which Muslim

women are active and agentic in the creation of their own liberation and wellness. Therapeutic work with Muslim clients, particularly Muslim women requires therapists, organizations, and communities to honor the complexity of Muslim women. I highlight the ways in which various systems, including the mental health system, silences, flattens, and participates in reductive binaries around Muslim women's stories and experiences. Pulling on Sara Ahmed's politics of citation (2013) and work of the members of Cite Black Women Collective (2021) this paper is informed by womanist and feminist praxis in that the scholars I have chosen to highlight in each principle are Muslim women and women of color who are making contributions in their respective fields of study who I believe mental health practitioners need to listen, learn, and engage with. By uplifting their work, I intentionally challenge the systemic silencing of Muslim women and women of color in the academy and use language native to the Muslim tradition within each principle to assert women's spiritual voices in the academy. By synthesizing scholarship in this way, I intentionally center Muslim women's voices and perspective as a core tenant of strength-based frameworks to wellness. There is power in women's voices and narratives and these women are speaking in resistance to multiple systems of erasure and oppression (Walton & Oyewuwo-Gassikia, 2017). Moreover, the purpose of centering these scholars' voices is to encourage Muslim and non-Muslim mental health professionals to take a nuanced stance in their therapeutic work and to frame the scholarship of Muslim women and woman of color as primary rather than alternatives experiences in this discipline (Masta, 2018a). Moreover, by drawing specifically on the intellectual scholarship of Muslim women and women of color in the academy, I employ decolonized praxis by challenging which knowledge is prioritized (Kovach, 2009).

While I could have organized these principles by body, mind, spirit, I worried categorization and "boxing" of the principles would erase the relational nature of each principle. Kovach (2009) states relational ethics is a core part of indigenous methods—while these principles can be organized and reorganized in many ways, it is important to note these principles build on each other, are engaged with each other, and rely on each other to deepen the conversation about Muslim mental health. The principles are also relational in nature in that they are meant to help the reader begin exploring with themselves how they might make sense of these concepts both intrapersonally and within therapeutic and collegial relationships. Inevitability many Muslim scholars have not been included—nonetheless, this paper is a starting point to resist the erasure of Muslim voices in mental health curriculum and to center the role of individual and systemic change in creating equitable changes for Black, Indigenous, and other racially minoritized clients.

As psychologists, we must acknowledge how our own identities, our own history, our own complicity in the systems we navigate cause harm to marginalized communities (Hargons, 2017; Grzanka, 2019; Singh, 2020). Given our multiple roles as researchers, educators, advocates, and community members, the field of counseling psychology must engage critically in discussions around who is included, who is erased, where there are similarities between us and our clients, and the role inequity plays in structural narratives replicated within counseling psychology (Cole, 2009). To support this critical engagement around how counseling psychologists and other mental health professionals engage with Muslim women, I invite clinicians to engage with the following: (1) identify the relationship Muslim women have to land (2) recognize racial differences within the Muslim community (3) honor relational and caretaking roles of women (4) encourage "embodied faith" via social justice activism, (5)

encourage multiple networks of connection via “third spaces”, (6) challenge stories of conditional worth by integrating spiritual scripture (7) utilize trauma-informed principles (8) engage with Muslim feminist concepts such as "tafsir of praxis" and (9) emphasize the ecological model in harm and healing in women’s lives.

### Principle 1: identify the relationship Muslim women have to land

Indonesia, India, Pakistan, Bangladesh, and Nigeria are countries with the largest Muslim populations (Pew Research Center, 2019). While Muslims have shared beliefs around five pillars of Islam (Ali, 2009), it is important to note that even within these five countries, Islam is not the dominant or majority religion in India or Nigeria. As such, Muslim women across the global navigate not only what faith and religion means to them personally but may also impacted by being a minority or majority religion in their country of residence. Muslim women in the United States as well as other countries of origin maybe navigating unique stressors related to being a religious or caste-minority subject. For example, current literature around Muslim women’s mental health and the impact of migrating from war suggest trauma, depression, loss of community, loss of land, and loss of identity are factors which shape women’s relationship to land (Ashraf & Nassar, 2018; Abu-Ras & Abu-Bader, 2009; Hassouneh & Kulwicki, 2007; Murthy & Lakshminarayana, 2006). Women’s experiences with the concept of homeland maybe particularly complex if they are members of a diaspora identity, children of enslaved Africans, international students, immigrants, refugees, or asylum-seekers. For example, in a study about Muslim graduate international students in the United States, Tummala-Narra and Claudius (2013) found Muslim students must learn to navigate diverse views of the new cultural environment, social isolation, overt and aversive discrimination, while also trying to educate others about Islam. Protective factors for these students were access to religious and ethnic

communities in the United States and country of origin. Concerns about adjusting to a new environment, concerns about being perceived as a perpetual other, and difficulty practicing religion, and culture while managing overt and aversive discrimination are also concerns of Native, Asian, Latinx, and Black students (Masta, 2018b; Ng, Lee, & Pak, 2007). Women's experiences of grief and loss after being forcefully displaced or immigrating to a new country, state, or location are important therapeutic considerations. Specifically, women who may not have a strong connection to their histories, such as a child of enslaved Africans or immigrants unable to trace their lineage, may benefit from therapeutic support in which the indigenous method of remembering is utilized to rebuild an ethnic identity (Smith, 1999).

Within the United States, over 42% of Muslim are born in the United States and identify as second or third generation American. Therefore, disrupting systemic notions that American's "look" or "behave" a certain way are clinical implications for training communities. For Muslim-American clinicians, students, and leaders, engaging in critical dialogue around what "American" identity means is important in shaping anti-racist and anti-imperialist identity. Understanding settler-identity in the United States and engaging in critical dialogue around decolonization is one-way clinicians can begin to engage in these conversations with themselves (Tuck & Yang, 2012; Azmat & Masta, in press).

Clinicians interested in understanding the role of land in women's lives should consider asking questions such as "what land do you call home" or "what is your relationship to the notion of homeland" as a means to unpack the complexity of client's relationship to various countries of origin (Dennis, Ibrahim, & Lopez, 2018). Clinicians are equally responsible in taking a non-defensive stance around the sociopolitical and historical dimensions of settler-colonialism in the United States (Tuck & Yang, 2012).

**Principle 2: recognize racial differences within the Muslim community**

Differences in race, gender, class, and understanding of Islam shape the ways Islam is taught, experienced, and embodied. Specifically, the racialized needs and experiences of Black Muslim women are categorically different from South Asian and Arab Muslims women, which are different than the experience, of Native and convert Latinx Muslim women. As such, learning the history of Islam in the United States and the role Black Americans Muslims have had in creating American Islam is critical in working with and understanding this group.

Black American Muslims have consistently challenged previous notions of identity and authenticity in the United States. As Amina McCloud (2010), a Black feminist scholar, argues the literature on the Black Muslim experience in the United States focuses on examining the community either as (a) failed Christianity or (b) Black Nationalism. In this way, being #BlackandMuslim—a hashtag started in February 2014 by the Muslim Anti-Racism Collaborative to center the identity, history, politics, and culture of Black Muslims— is often erased in dominant conversations about the Black experience within the United States and the Black Muslim experience in the Muslim community.

Jamillah Karim explores this systemic silencing further in a dialogue between three Muslim women -- an Eritrean (immigrant) woman, a Pakistani (immigrant) woman, and an African American woman. She uses her privilege and access as an African American Muslim researcher to enter into the "margins" of this community (Karim, 2006). Karim's analysis highlights how South Asian and immigrant Africans Muslims benefit from anti-black racism racial color-blindness. She does this by highlighting how immigrant Muslim's harbor racial prejudice and participate in antiblack racism by distancing themselves from Black people and downplaying the present-day impact of systemic racism. Karim also uses the story of the African American woman, Melanie, to share how for Black Muslim women are seen as African

American before being seen as Muslim American. Karim also uses Melanie's story to highlight the ways in which Black women are not victims, but rather independent powerful subjects in the creation of their communities—a core tenant of black feminist thought (Collins, 1990).

As such, clinicians must be able to identify the history of Islam in America and the racialized and gendered tensions experienced by Muslims even before 9/11/2001. Resources such as #islamophobiaisracism and the #BlackIslamSyllabus inspired by the #FergusonSyllabus and the #StandingRockSyllabus would be useful places for clinicians interested in this population to begin developing their own critical consciousness around race and faith.

### Principle 3: honor relational strengths and caretaking abilities of women

Working with Muslim women using womanist approaches requires that the relational and caretaking roles such as market work, personal care work, and personal relationships are honored regardless of the social context of the client and her friends and family (Richardson, 2012). This value and appreciation for honoring women's socio-economic and political environment and the healing nature of relationships are also concepts rooted in black feminist thought and indigenous studies (Ali, 2009; Masta, 2018a; Norwood, 2013; Walker, 1983; Williams & Wiggins, 2010). Specifically, Carolette Norwood (2013) suggest African women have historically used "their position of mothers as a basis of moral authority from which to argue for their inclusion in politics. They have used it as resources with which to demand changes in political culture, demanding that the values of nurturing, sacrifices, and justice be included in political practices" (p. 299).

Acknowledging relationships, caretaking, sacrifice in the name of community and community building reflect the centrality of motherhood and maternal care in womanist theory (Norwood, 2013). Acknowledging the ways relational work is valuable, important, and critical in

women's identity development and understanding of themselves allows women to be seen for this labor as many Muslim women want to serve as cultural bearer and caretakers (Ali, Mahmood, Moel, Hudson, & Leathers, 2008). However, self-sacrifice also contributes to poor mental-being and additional stereotypes around what it means to be a "strong black woman" (King, 2019). Pulling again from womanist thought, taking a "both/and" orientation rather than "both/or" approach around the role and implications of self-sacrifice is a recommendation for clinicians working within this principle (Sheared, 1994). Specifically, honoring the ways self-sacrifice and caretaking maybe contributing to depression and poor mental health while *also* valuing the role caretaking plays in women's lives is one way to address the dialectical nature of this value (Ali, 2009; Azmat & Ciftci, 2019; Jack, 1991).

Taking a cultural feminist approach in this regard would help Muslim women feel validated for their caretaking roles and may reinforce they do not need to give up their relational skills to be successful (Ali, 2009). Furthermore, relationship building via storytelling is often used a way to maintain community and familial ties with in this group. Honoring the role of storytelling, the role of food in bringing people together, and the maintenance of cultural traditions are ways to "relationally resist," re-write, and reshape internalized shame-based narratives of Muslim womanhood (Saleh, 2017). Clinicians interested in utilizing this principle should first attempt to understand the adaptive role and value of caretaking, family, and the importance of motherhood in a client's life. Addressing the ways this value is aligned with womanist understandings of womanhood while also exploring the ways caretaking may be detrimental to client's health are concepts that must be simultaneously held when working with this group.

**Principle 4: encourage "embodied faith" via social justice activism**

Sylvia Chan-Malik, a scholar of American studies, Critical Race and Ethnic Studies, Women's and Gender Studies, and Religious Studies highlights the strength and resistance of Black Muslim women and women of color in American Islam in her book "*Being Muslim: A Cultural History of Women of Color and American Islam."* Using interviews, archival data, and cultural artifacts, she argues for a concept called "*affective insurgency*" – namely that "day-to-day lives are circumscribed by racial, gendered, and religious logics that place them beyond the pale of citizenship, humanity" (Chan-Malik, 2018). She argues that that Muslim womanhood is constructed by every day and Muslim women use their bodies to enact resistance to narratives dehumanization based on race, gender, and religious scripts.

Another space of embodied faith is the streets of cities—where Muslim women are active and engaged in social change. Donna Auston (2017) illuminates the ways in which one Black Muslim woman in particular believed it was her spiritual duty to protest the murders of unarmed black bodies at the hands of white supremacists and police. Auston writes:

> In July of 2013, the day after George Zimmerman was acquitted for his act of profiling and the vigilante murder of unarmed Black teenager Trayvon Martin, I protested in the streets of that city in company with a Muslim woman I met at the march who expressed to me that it was her sacred duty to be out marching on this day, as hot as it was, and even though she was depleted from fasting (it was Ramadan). For her, the spiritual imperatives to draw closer to Allah during this sacred month on the Islamic calendar were not just realized in fasting and prayer but also in meritorious acts such as standing up against injustice and protecting innocent lives—actions that became more urgent in line with the holiness of the season (p. 17).

Muslim women are involved in activism on campus, in their communities, and through virtual spaces. Encouraging Muslim women to explore organizations and causes that embody their values as women of color and women of faith may be helpful clinician considerations.

Moreover, encouraging an "embodied faith" which recognizes and supports the role of social justice activism in the role of Muslim women's lives may mean clinicians also embody roles as advocates. Specifically, this may look like helping women find organizations they feel connected to, or supporting interpersonal concerns that may arise within social activist groups. Depending on a woman's connection to faith and religiosity, it is possible activist work may not be directly connected to faith-based spaces. Clinicians working with Muslim clients should consider the role activist work has for Muslim women--that the role of social change and engagement is a means to build power, agency, and leadership is a way women find connection through shared values and identity (Chambers & Phelps, 1994). Clinicians interested in demonstrating their commitment to honoring the wholeness of Muslim women should honor the ways activism plays a role in women's understanding of themselves in relation to others and their communities. Clinicians interested in supporting embodied elements of faith and activism should consider the ways they can use their institutional power to create spaces for marginalized groups to come together to share and heal after global and local tragedies. Institutional support may also look like clinicians at university counseling centers allocating financial resources to support student activism and decision-making (Azmat & Mohajir, 2018).

### Principle 5: encourage multiple networks of connection via "third spaces"

Mosques in the Muslim world serve as places of prayer, community building, and places of civic engagement. However, mosque spaces have also been critiqued for marginalizing women, young adults, LGBTQ+ Muslims, and converts (Institute for Social Policy and

Understanding, 2016). Moreover, rates of mosque vandalisms and security threats around mosque spaces suggest mosques may no longer be a safe haven for Muslims who attend the mosque regularly (Ahmed et al., 2017). Similar to other communities of faith, anecdotal research demonstrates that Muslims report being "UnMosqued," or feeling distant and a lack of engagement with local mosques (Eid, 2013). Specifically, a compliant in the documentary UnMosqued is that Muslim women must pray behind a barrier or a separate room and can therefore not directly see the imam. While 47% of Muslims aged 18-29 attend a mosque at least every week and 46% Muslims aged 30-39 attend a mosque at least every week, supplementing and creating alternative spaces for Muslim worship, connection, and community building has been vital for Muslim women who may not attend or want to enter mosque spaces given this gender inequity (Institute for Social Policy and Understanding, 2016).

Specifically, Muslim women have been critical in creating "third spaces" in the United States to fill in for sacred spaces the mosque is no longer able to provide. In her book "*Suburban Islam*" Justine Howe (2018) explores how third spaces have begun to reshape American Muslim communities by providing an environment to challenge exclusion from mainstream America while also creating an American Islam different from local mosques. Howe suggests a particular third space, the Mohammed Alexander Russell Webb foundation, creates an alternative vision of North American Islam by creating a space for ritual and devotional practice, leisure activities, and communal reading of sacred texts. Howe also addresses the ways in which this "third space," although attempting to be inclusive, still produces its own exclusions particularly around race, gender, and understandings of citizenship. Another "third space" for connecting and finding community is online. Specifically, Kayla Wheeler argues Muslim women are engaging in complex conversations around their faith and identity via virtual spaces, such as YouTube

(Wheeler, 2014). Wheeler asserts women are able to rewrite mainstream discourses around Muslim womanhood through vlogging. Finally, Jennifer Zobair also writes about the internet as an equalizer in the United States, as Muslim feminists use online platforms such as "AltMuslimah" and "Muslimah Media Watch," hashtags such as #MuslimMaleAllies and #FireAbuEsa, and blogs such as Hind Makki's "Side Entrance" to respond to the double silencing at the hands of patriarchy and "white savor" feminism (Zobair, 2015). All three of these women's analyses of physical and virtual third spaces suggest that not only are Muslim women resisting systems and spaces which do not align with their vision of Islam, they are also creating their own avenues of representation in opposition to historically created binaries around their personhood. Clinicians interested in connecting Muslim women to third spaces may be particularly interested in exploring networks of connection centered around reproductive justice and sexual health (e.g. The Village Aunty, HEART, Advocates for Youth) and identity-affirming mental health wellness (e.g Sapelo Square, Muslim Wellness Foundation, Muslim-ARC, NBA Muslims, Arab American Family Services). Moreover, asking clients about the spaces they feel the most seen (regardless of if it is physical or virtual) maybe an entryway into understanding community dynamics a Muslim client is navigating based on their unique positionality and identity.

### Principle 6: challenge stories of conditional worth by integrating spiritual scripture

Rogerian or person-centered therapy is often the center of training in counseling psychology (Kelly & Byrne, 1977). Rogerian therapy focuses on unconditional positive regard, empathy, and genuineness between the client and clinician. However, Khatidja Chantler (2005) argues Rogerian therapy overlooks social conditions of an individual's experience such as race and gender, particularly when working with women of color. She argues that silencing

differences in the therapy room particularly--the expression of emotions and racialized and gendered conditions of worth, limits and depoliticizes person-centered therapy. Specifically, she states:

> Racialised and gendered conditions of worth account for those conditions of worth generated through social contexts and include the behaviours and emotions proscribed through existing power relations and structural arrangements. Examples of these might include: men must not show vulnerability, women should be care-givers, Asian women should be passive, African-Caribbean women are strong, it is not acceptable to be gay. Tempting as it maybe to dismiss these as stereotypes and therefore as redundant, such statements, nevertheless, communicate powerful messages to us about how certain groups are expected to behave, and do indeed influence how services are conceptualised (p. 250).

Chantler highlights the ways systems and narratives inform not only how clinicians "see" clients but also how clinicians inform and conceptualize their clients. Cheryl El-Amin and Aneesah Nadir (2014) supplement this idea by highlight how clinical practice extends beyond intervention to include *how* and *where* we gather information to inform treatment plans (El-Amin & Nadir, 2014). One such way to challenge racialized and gendered conceptualizations of worth is to consider the ways faith and scripture as forms of healing and support for some Muslim communities. Specifically, numerous books and chapters have been written on working with Muslim clients while emphasizing the role of faith in understandings of healing (e.g. Al-Karam, 2018; Ahmed & Amer, 2012). When working with Muslim women, clinicians should honor the multiple interpretations, spiritual traditions, and rituals Muslims engage in as well as the role of religion and religious communities in contributing to complex traumatic experiences. While it is

highly encouraged for clinicians working with Muslim populations to read these texts and educate themselves on the ways scripture has been appropriated to serve the needs of the powerful, another way to integrate scripture into the clinical relationship may be to ask clients about verses, lessons, and stories from Quran, Hadith, and tradition which are salient for the client's understanding of the world and distress.

### Principle 7: utilize trauma-informed principles

Trauma-informed care acknowledges the pervasive nature of trauma and calls for environments of healing within the therapeutic relationship and organizational culture. Respecting and appropriately responding to the effects of trauma at *all* levels is a key component of this approach (Bloom, 2010). Scholarship demonstrates that even when Muslim clients enter the therapy space, microaggressions prevent safety and trust from developing between Muslim clients and clinicians (Nadal et al., 2012). Assumptions that Islam is the problem for women with comments such as "if only you didn't wear *hijaab*" or "why don't you just leave the religious tradition?" are narratives replicated in the therapeutic space (Huang, 2018). These narratives also highlight how global perceptions of communities' impact therapeutic rapport and progress (Haque et al., 2019; HEART & MAWPF, 2017). Clinicians caring for individuals who have experienced race, gender, and religion-based discrimination, should be trained in principles of trauma-informed care and have knowledge around the specific microaggressions this population may hear as well as and how to interrupt them within and outside of the therapeutic space (Sue et. al, 2019).

Within the therapeutic relationship, principles of trauma-informed care should also attend to intra-community traumatic experiences of heterosexism, Shiaphobia, and sexual violence at the hands of family, friends, or clergy (Yousuf, 2016). Utilizing trauma-informed principles of

safety, choice, collaboration, trustworthiness, and empowerment may first look like an understanding that clinicians will likely make mistakes within the diversity of the community. This may also mean clinicians asks themselves questions about the ways they see the client, the assumptions they are making about the client, and the ways in which global narratives maybe influencing a binary version of the client (El-Amin & Nadir, 2014). The second principle of trauma-informed care, choice, suggests clients are provided clear messages about their rights, responsibilities, and limits to confidentiality. This may also mean honoring a woman's choice not to see a male clinician or a clinician of faith or ask for a reassignment. This may also mean honoring the client's choices to dress by resisting giving feedback to clients that *hijaab* and *niqaab* will not help them assimilate or adjust to their environment (Rangoonwala, Espinoza, & Sy, 2011). Collaboration, the third principle of trauma-informed care may mean encouraging the client to engage in multiple forms of healing in addition to therapy. This may also mean collaborating and consulting with community organizations, mosques, or third spaces to provide holistic care. Trustworthiness, the fourth principle of trauma-informed care means clinicians and organizations are able to acknowledge the historic medical mistrust in communities of color and an active commitment to hiring staff which represent the communities they work with (Chang & Berk, 2009). Finally, empowerment, the fifth principle of trauma-informed care means providing clients with skills and tools they can build on their own. Cultural humility and clinician's responsibility to name when elements of "white saviorism" are apparent in the therapeutic relationship are also particularly important given the tensions between Muslim women and white feminism (Zobair, 2015).

**Principle 8: engage with Muslim feminist concepts such as "tafsir of praxis"**

The notion of *tafsir as praxis* was first coined by Sa'diyya Shaikh, a scholar of critical Muslim studies and religious studies in Cape Town, South Africa. She writes about the ways South Asian women who are survivors of interpersonal violence assert their religious agency by developing their own sense of religious identity that challenges Islamic gender hierarchy (Shaikh, 2007). Again, the role of women's bodies being a place of trauma, agency and embodiment of power is highlighted through a renegotiation of scripture and practice. The role of lived experience in creating and negotiating knowledge is also illuminated by Shahnaz Haqqani's (2018) dissertation. Her ethnographic analysis of Sunni Muslim Americans demonstrated the following: first, while dominant Muslim scholars are resistant to negotiating issues around gender, laywomen in the community find gendered issues in Islam—such as female-led prayer or women's marriage to non-Muslims—as negotiable because of their lived experience. Second, participants were open to changing doctrine but also recognized change may only occur when all-male scholars agree to a new consensus. Finally, Haqqani's analysis suggests that Muslims engage with scholars in complex ways. They do not rely on Muslim scholars for "correct" interpretations but critically evaluate interpretations to make sense of them themselves. The notion that women can and have been re- negotiating faith opens possibilities for other Muslim women to interrogate and engage with scripture and their faith. Clinicians who are able to share the scholarship of feminist Muslim women such as Amina Wadud, Asma Barlas, Nimat Hafez Barazangi, Azizah al-Hibri, Kecia Ali, Su'ad Abdul Khabeer, and Juliane Hammer may be able to provide new avenues of thinking about and practicing faith for their clients and healing from trauma related to faith identity.

Utilizing this principle also means acknowledging the role of the body in holding multiple forms of trauma after histories of colonial violence, slavery, and exploitation (Norwood,

2013; van der Kolk, 2014). Recognizing the ways women's bodies have been harmed and offering an alternative understanding of the body as a form of *embodied tafsir* maybe empowering. Contemporary scholars have also written about the ways Black Muslim fashion and beauty are manifestations of a new Muslim cool and how fashion can be used as a form of embodied theology (Wheeler, 2017; Khabeer, 2016). Therefore, allowing for multiple perspectives around faith, fashion, and feminism within and outside of the therapeutic space are crucial for Muslim women.

**Principle 9: emphasize the ecological model in harm and healing in women's lives**

Ahmed, Amer, and Killawi (2017) suggest the ecosystems model is well aligned with how Islam views an individual. Specifically, they state, "Islam views the individual as embedded within a larger ecosystem in which different parts of the system interact with and impact one another" (p. 50). The authors demonstrate how social workers can integrate micro, meso, exo, and macro level interventions into their practice with Muslim clients. Specifically, they address unique features such as friends and family in the microsystem, organizational settings such as schools, higher education, the workplace, and the mosque in the meso and exo systems, and finally exposure to war and displacement and an unwelcoming environment in the United States as macro level influences. A number of other authors have used the ecosystems approach to understand Muslim women's adjustment to college, the efficacy of Acceptance and Commitment therapy, and implications in family therapy (Daneshpour, 1998; Rangoonwala et. al, 2011; Tanhan, 2019). An ecosystems perspective allows for a simultaneity of experience—specifically that some systems can be both healing and harmful in the multiple communities' Muslim women live, work, play, and pray in. Clinicians interested in applying these principles can consider collaborating with clients on interventions which address and name the systems Muslim women

navigate in which there is values conflict or a lack of agency. Given the chrono and macro systems are ecological systems in which women may feel they have the least amount of power, building awareness around the ecological systems which women have choice, agency, and autonomy maybe a useful way to integrate and understand multiple aspects of women's wellness. In my own work with college students, the ecological systems framework has given language and insight to students around how they have been socialized, who informs their beliefs and values, and the implications of their relationships in each ecological system in creating and contributing to shifts in culture.

## Conclusion

In this chapter, I center the voices, strengths, and scholarly activism of Muslim women and women of color in the academy by constructing nine principles to consider when working with Muslim women and I have attempted to honor the complex stories and systems Muslim women navigate on a daily basis. These considerations are a framework by which counseling psychologists can begin to challenge imperialist feminist assumptions about Muslim women needing to be saved and support strength-based frameworks in working with marginalized communities.

It is imperative counseling psychologists, both in the academy and working in clinical roles, disseminate scholarship and writing by Muslim women, and listen to Muslim women clients as they share concerns around adjustment, racism, sexism, challenges within their faith identity, experiences of trauma, and conditional worth. It is just as imperative for counseling psychologists to invest in the leadership of Muslim women and connect with community organizations to supplement the knowledge synthesized here about Muslim communities.

For counseling psychologists to endorse and implement these principles, clinicians and organizations must be educated on the history of Islam in the United States of America, the ways spirituality and faith can be both a form of trauma and strength for Muslim women, and the ways Muslim women are active and agentic in challenging narratives of oppression. As these principles suggest, working with Muslim women clinically requires service providers to acknowledge the role of the mind, body, and spirit for this group and requires clinicians to challenge themselves to engage in critical self-reflection and action.

# CHAPTER 2

Predominant narratives in counseling psychology and medical research suggest marginalized communities underutilize services because of lack of trust in the medical system, stigma, cultural values, and access (Ciftci et al., 2013). However, even within the therapeutic relationship and system, norms around what can and cannot be addressed directly, such as racial and cultural trauma, must be taken into account by clinicians (Anderston, Lunnen, & Ogles, 2010). As multicultural psychologist Derald Wing Sue (1992) asserts, counseling does not occur outside of or "in isolation from larger events in our society" (p. 479). As such, the worldview of both the client and counselor is linked to historical and current experiences of racism and oppression in the United States (Sue, 1992).

William Liu states counseling psychology must examine the ways history, culture, and systems of power and privilege leverage themselves to institutionally support white supremacy (Liu, 2017). Liu asks vocational and counseling psychologists to consider the ways the legitimization of western psychotherapy over other forms of healing impact the ways in which marginalized communities are able to access and attain culturally congruent mental health services. Therefore, the role of psychologists in providing space to process the impact of political distress, the role of power and identity *within* the therapeutic relationship, and the ways systems such as patriarchy, racism, and imperialism impact a client's well-being must be addressed by clinicians (Chantler, 2005; Inayat, 2007). Without doing so, psychotherapists may be replicating internalized, interpersonal, and institutional barriers to healing and may be unintentionally serving as barriers to clients' genuine and authentic expression of themselves (Martin-Baro, 1994; Rogers, 1957). Implicit and explicit narratives marginalized communities hear about

themselves may influence not only how they see themselves but also how clinicians see their clients.

What are the narratives Muslim women hear and how do history, power and privilege, and global policies relate to Muslim women's experiences? Often, narratives of "being voiceless," "unveiling" and a being subservient group which needs "saving" are tropes replicated in the scholarship around this population. However, as anthropologist Lila Abu-Lughod (2002) states:

> When you save someone, you imply that you are saving her from something. You are also saving her to something. What violences are entailed in this transformation, and what presumptions are being made about the superiority of that to which you are saving her? Projects of saving other women depend on and reinforce a sense of superiority by Westerners, a form of arrogance that deserves to be challenged (p. 788 -789).

The mental health field should consider— who writes, who speaks, and who is seen as a Muslim woman? How do Muslim women's relationship to their faith influence well-being? Finally, what is the impact of internalizing harmful narratives about Muslim women?

## The Role of Religion in Mental Health Help-Seeking and Wellness

Religiosity has been linked to a sense of meaning in life (Abu-Hilal, Al-Bahrani, Al-Zedjali, 2017), patience, and a sense of protection (Emam & Al-Bahrani, 2016) amongst Muslims. In these ways, religion act as a facilitator of mental well-being. In a study of 120 undergraduates, Herzig and colleagues (2013) found religiosity was related to active coping among American Muslim college students. Specifically, that mental health service utilization was mediated by religiosity. They suggest that religiosity may act as a buffer to mental health stigma and may increase the likelihood of adopting active coping strategies such as seeking

additional mental health supports. Religion may also inform help-seeking as well as community-oriented wellness interventions for some Muslims (Padela sermon)

However, as previously mentioned systematic research on health behaviors of Muslims is challenging because of the racial and ethnic diversity of Muslims. Racial demographics of Muslims in the United States suggest 41% of American-Muslims are White—a category which includes those who describe themselves as Arab, Persian, Middle Eastern 20% Black, 28% Asian, 8% Hispanic, and 19% other or mixed race (Pew Research Center, 2017). Ethnic categories and country of origin for American-Muslims range from Punjabi, Kashmiri, and Nepalese in the South Asian continent to Palestinian, Eretria, Sudanese, and Somali culture and subcultures in the African subcontinent and Middle Eastern subcontinent. Given this racial and ethnic diversity, it is hard to create unidimensional best practices around mental health help-seeking for Muslims. Moreover, like many marginalized groups, American Muslims may fear that mental health professionals will fail to understand their experiences and the vulnerability that accompanies disclosing emotional difficulties (Nassar-McMillan & Hakim-Larson, 2003). Religious narratives such as "if you are religious enough, God will protect you from evil" or "seek help only from Allah" contribute to stigmatizing beliefs and behaviors related to mental health help-seeking, fatalism, and clergy as first responders (Ciftci et. al, 2012). These culturally specific narratives and beliefs are related to the underutilization of services for this group (Padela et al., 2012) and have led to calls for incorporating Islamic understands of health and wellness into psychotherapy.

Burgeoning research on Islamically integrated psychotherapy and Islamic psychological frameworks continue this trend by seeking to address how Islamic tenants and values can advance the field of psychology. In Haque and colleagues (2016) review on trends in Islamic

traditions and modern psychology, authors found that the current literature on Islam and mental health focused on (a) unifying western models such as CBT with Islamic beliefs and practices (b) historical accounts of Islamic Psychology such as highlighting the work of Malik Badri and Abu Bakr al-Razi (c) developing theoretical models and frameworks utilizing Islamic frameworks such as Keshavarzi and Haque (2013) framework for guiding psychological interventions utilizing Islamic concepts of the *nafs, qalb, aql,* and *ruh* (d) developing interventions and techniques within Islamic psychology and finally (e) developing assessment tools and scales normed for use with Muslims. Since Keshavarzi and Haque's publication, Carrie York Al-Karam has edited a book on Islamically integrated therapy and offers compassionate critique of the field. Specifically, she asks readers and scholars the field of Islamically integrated psychotherapy to think conceptually about how Islamically integrated therapy is defined. She writes:

> Is Islamic psychology just Sufism (*tasawwuf;* e.g. Skinner, 1989; Haeri, 1989)? If so, which kind? Is Islamic Psychology simply 'Psychology from an Islamic Perspective' (e.g. Badri, 1979; Utz, 2011)? Is it psychology with a little bit of Islam (which Islam? Sunni? Shia? Whose interpretation?)? Or, is it Islam with a little bit of psychology (which psychology? Clinical, organization, social, neuro? And with which Islam?) (Al-Karam, 2018, pg. 98).

Al-Karam also asks where contemporary Muslim psychologists who come up with their own modalities such as the HEART Method (Lodi, 2018) and systemic integrations of scripture into therapy (Malik, 2018) fit into definitions of Islamic psychology. She offers a conceptual framework and methodology to define Islamic psychology via the Multilevel Interdisciplinary Paradigm (MIP) – a flexible and dynamic model which allows psychology subdisciplines and related disciplines to engage at a particular level with Islamic sects, sources, and schools of

thought (Al-Karam 2018). She also engages with the concept of *taweed* or the unity of God as a template for MIP. Specifically, she asserts that Islamic psychology, like some Muslim understandings of God—can be understood though the relationship between its parts. In offering this conceptual framework, Al-Karam skillfully begins a dialogue in Islamic psychology discourse around how various parts of Islamic psychology are informed by power, privilege, access, and knowledge production within this field of study.

A gendered analysis of the broad literature defined as Islamic psychology highlights notable gaps in Islamic knowledge production from an anti-patriarchal lens. For example, in an article in which Rothman and Coyle (2018) interview 18 participants to gain insight on principles related to the conceptualization of a person within an Islamic paradigm, 17 out of the 18 participants were men. The notable absence of women and non-binary interviewees replicates patriarchal knowledge production and continues to erase Islamic feminist exegesis. For example, amina wadud explores concepts of the *nafs*, human purpose, *tawhid*, and *taqwa* according to the Quran in their work (wadud, 2021). However, their readings of scripture include highlighting the ways in which oppression, or *zulm*, is arrogant and ungodly, thus opening pathways of dialogue around how addressing internalized, interpersonal, and institutional oppression—including justifying women's unequal status in the name of Islam must be addressed (wadud, 2021). Continued development of Islamically integrated psychotherapy frameworks, interventions, and models must therefore attend to questions of "whose Islam; and how is that Islam constructed" (wadud, 2021, pg. 8). For example, what is the responsibility of Muslim and non-Muslim therapists to have access to knowledge around the variety of perspectives on abortion, domestic violence, end of life care, and organ donation in the Muslim tradition? (Hammer, 2019; Ayubi, 2019; Padela and Mohiuddin, 2015; Mireshghi, 2016; Al-Hibri, 1993). How might the concept of

*nafs al lawwama* be connected to experiences of self-criticalness, fear of negative self-evaluation, and social anxiety for Muslim individuals and communities? (Keshavarzi & Khan, 2018). How might the concept of *nafs al ammarahibil* be related to institutional avoidance and resistance to address sexual and racialized harm in mosque communities particularly at the hands of clergy? How might the concept of *fitra* be reimagined to resist culturally sanctioned conditions of worth and community belonging around sexuality? What role does satanic arrogance or the "Iblisi worldview" (Al-Hibri, 2005, pg. 183) vis a vis -isms such as sexism, racism, and ableism prevent connection and inclusion of a variety of lived Muslim experiences (wadud, 2021)? How might knowledge of scripture inform Islamic relational ethics of accountability, humility, and compassion? What role do Muslim mental health professionals play in shrinking injustice (Mohr, 2018; Mohr, 2019, Ali-Faisal, 2020)? These complex questions and the complexity of lived realities for Muslims around the world suggests religion can be both a barrier and facilitator to mental health help-seeking and require continued critical engagement in the field of Islamic psychology.

## Islam, Gender, and Mental Health

Gender plays a unique role in Muslim women's mental health. For some religion acts as a facilitator to mental health, while for others, religion may be a barrier. For example, Gulamhussein and Eaton (2015) found there is evidence to suggest religiosity and observing *hijaab* predict depressive symptomology in American-Muslim women. Being visibly Muslim and wearing hijab has also been demonstrated to increase anxiety around risks of discrimination and hate crimes (Mussap, 2009; Ciftci, Shawahin, Reid-Marks, & Ellison 2013). However, for other women wearing the *hijaab* may be helpful in bolstering faith (Al Wazni, 2015). In another study, Khan (2006) surveyed mosque-attending Muslims in the United States about their

attitudes toward counseling. She found that males were about twice as likely as females to have negative attitudes toward counseling, and that females were somewhat more likely to indicate the need for counseling. While Muslim men may still need counseling, Muslim women's help-seeking attitudes were strongly correlated with actual utilization of psychological services.

Identity negotiation is also related to mental health and well-being for this group. In an ethnography of American-Muslim women on campus, Shabana Mir (2014) found American-Muslim women navigate expectations and assumptions about womanhood and religious practice from both Muslims and non-Muslim individuals. Mir identifies three themes that Muslim women on campus must negotiate—the way they dress, date, and engage with drinking culture on college campuses. Given limited spaces exist for Muslim women to be authentically themselves on college campuses, the time, energy, and emotional costs of belonging and not belonging on college campuses are implications for higher education administrators and counseling center staff to consider. Throughout her writing Mir highlights the institutional nature of the discrimination and feelings of exclusion Muslim women face in higher education spaces in the United States. Her findings suggest American-Muslim women on campus interrogate definitions of what is "normal" and what is a "good" Muslim woman by constructing "third spaces" in which both American and Muslim identities are practiced mutually (Mir, 2014). By constructing a third space, Muslim women challenge global and systemic narratives that do not align with their own sense of self and wellness.

In another mixed-method study by Selcuk Sirin and Michelle Fine (2010) found gender moderated the relationship between Muslim and American identity—with Muslim-American women reporting more integrated identities than men. Sirin and Fine concluded that while American-Muslim men and women share experiences of discrimination, acculturation, and

identification, their negotiation processes are quite different. This supports the notion that perhaps Muslim women are using religion as a form of resilience in a way that Muslim men are not. Rather than compartmentalize salient identities, Muslim women are more likely to engage with their sense of self and their values as emerging adults on college campuses and negotiate for themselves how they hope to be seen by others on campus. Taken collectively with Mir's work, this suggests navigating what it means to be both American and Muslim may be qualitatively different for women than men in this community.

## Muslim Women in the University Counseling Center System

A plethora of research has addressed how Muslim women navigate and adjust to the university system and has demonstrated Muslim women' perceptions of campus climate. However, very little research has examined what is currently being done to support the mental health needs of Muslim students on campus (Mir, 2006; Rangoonwala, Espinoza, & Sy, 2011; Seggie & Sanford, 2010; Sirin & Fine, 2010). Several scholars have made calls to systems of higher education to reconsider campus diversity by examining and accommodating to the needs of Muslim students on campus (Ali & Bagheri, 2009; Cole & Ahmadi, 2010). Yet, a majority of the research on university students and college students still relies on convenience samples and does not attend to the unique racial, gendered, and within-group differences for Muslim students on campus.

Some university counseling centers have begun to address the needs of Muslim women on campus. Specifically, Ribeiro and Saleem (2010) assessed the interest and effectiveness of a support group for Muslim women on a college campus by hosting six group counseling sessions. With the assistance of faith leaders, sessions were established to help women navigate developmental, religious, and acculturative challenges. Themes that emerged from group

meetings included managing discrimination, negotiating relationships, career issues, body image and practicing Islam. However, this is the only literature on counseling Muslim women in the higher education system.

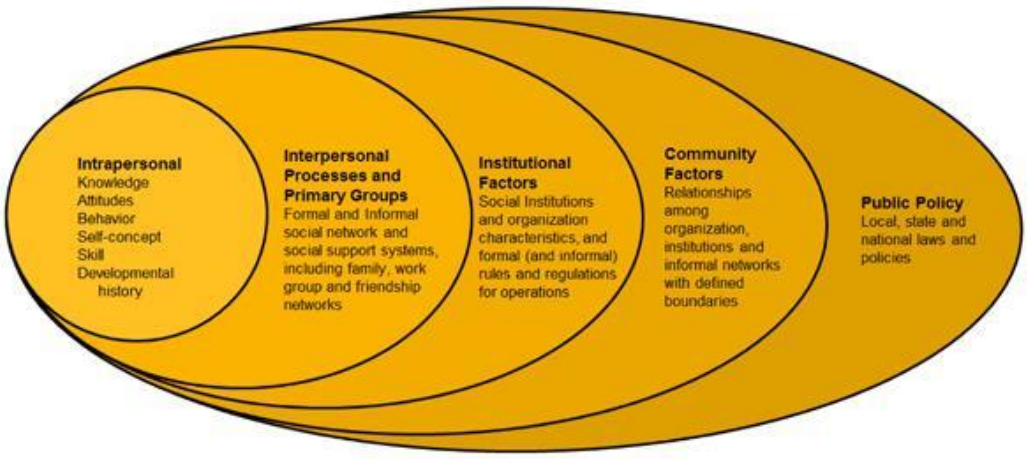
Additional research with other students of faith found group interventions are not enough to meet student needs in university counseling centers. Specifically, research that examined experiences and attitudes of religious students at a university counseling center found that majority of clients preferred not to discuss religious concerns within group counseling spaces (Post, Cornish, Wade, & Tucker, 2013). While foundational findings suggest group therapy within the university counseling centers appear to be restorative for Muslim women, this was the only empirical research found on Muslim women's experiences in therapy. No empirical literature exists about Muslim women's experience with individual therapy within the university counseling center system. Therefore, this project is likely the first of its kind to highlight Muslim women's experiences when seeking individual mental health care at university counseling centers.

## Theoretical Framework

Theories in public health, developmental psychology, and social psychology, guide this project. Specifically, the public health framework of social determinants of health (SoDH), or the conditions in the environment in which people live, work, play, and pray in, inform questions of how physical, social, and economic environments impact health (Healthy People, 2020). Social determinants of health also consist of policies, programs, and institutions, as well as community factors such as interactions with family, friends, and co-workers as well as cultural attitudes, norms, and expectations in workplaces, schools, health-care settings, and places of worship. Social determinants of health and the role the environment plays in an individual's well-being is

related to an ecological system approach similar to Bronfenfreener's ecological theory (1994) and Kurt Lewin's person-environmental analysis (Kaiser & Schulze, 2018). One of the problems with these models however is they lack specificity to guide conceptualization of specific problem or to identify a particular intervention (McLeroy, Bibeau, Steckler, & Glanz, 1988). Rather than focusing on the micro, meso, exo, macro, and chronosystems, the ecological approach from a SoDH perspective suggest (1) intrapersonal, (2) interpersonal, (3) institutional factors, (4) community factors, and (4) public policy factors should be examined when attempting to improve health (Healthy Campus, 2020). Given this project emphasizes the interpersonal and institutional factors around Muslim women's experiences in therapy at university counseling centers, this framework is more aligned to the types of questions I would like my participants to reflect on in regard to their health and wellness. For example, a recent example of a public policy factor which may impact women is Executive Order 13769 ("Protecting the Nation from Foreign Terrorist Entry into the United States") informally known as the "Muslim Ban." This Executive Order was signed by President Donald Trump and suspended entry to the United States for individuals from the following countries: Iran, Iraq, Libya, Somalia, Sudan, Syria, and Yemen, for at least 90 days, regardless of whether they hold valid non-diplomatic visas. The order also suspended the resettlement of Syrian refugees to the United States indefinitely. International students from these countries may be negatively impacted regarding their ability to re-enter the United States to finish school and U.S citizens including first, second, and third generation students from these countries may not be able to visit friends and family, attend weddings and funerals, or move easily between two lands they call home because of this policy concern. Social media campaigns during this time including hashtags such as #MuslimBan, #GrandParentsNotTerrorists, and #NoBanNoWall are ways in which impacted communities

were able to support one and other as well as community emotional support spaces where members of impacted communities can come together to vent, grieve, and express feelings of uncertainty and fear around this policy. Additional community factors in this case may refer to a student's ability to hire and have access to lawyers. Institutional factors around this example may include formal and informal support communities for students via the counseling center, mosque and Muslim Student Association spaces, and institutional support for campus activism (Albright & Hurd, 2021). This may also include a lack of institutional support such as university administrators lacking empathy and guidance on how to navigate this policy given student responsibilities and obligations on campus. Finally, interpersonal factors around this concern may be microaggressions as well as supportive social experiences students may have both on and off campus related to their perceived proximity to countries listed in Executive Order 13769. Intrapersonally, this may impact students by internalizing a sense of otherness, by challenging their sense of belonging on campus, and resulting in reduced self-efficacy and increased anxiety (Albright & Hurd, 2020).




Adapted from McLeroy, K. R., Steckler, A. and Bibeau, D. (Eds.) (1988). The social ecology of health promotion interventions. *Health Education Quarterly*, 15(4):351-377. Retrieved May 1, 2012, from http://tamhsc.academia.edu/KennethMcLeroy/Papers/81901/An_Ecological_Perspective_on_Health_Promotion_Programs.

By defining health as "not merely the absence of disease, but as a state of physical, mental, and social well-being" (WHO, 2019) this approach acknowledges the role of the environmental on positive and negative experiences of wellness and the role of power in changing these systems. Giving participants space to share their stories and voices around systems which have harmed and helped their health is necessary in creating patient-centered interventions and outcomes and increasing mental health promotion and advocacy (Castillo et al., 2019). Using this model for health allows the researcher to engage with participants unique voices, experiences in community and on campus, and allows the researchers and participants to identify specific institutional and policy changes as well as intrapersonal and interpersonal processes which may be necessary to support the wellness of this population. Finally, to conduct research that is change oriented and seeks to advance social justice causes, authors must identify power imbalances in the systems in which they engage with (Creswell & Plano-Clark, 2017). Therefore, by asking participants explicitly where and in what circles they believe they have power is an intentionally research design choice I am making to ensure participants engage in reflections around empowerment throughout this research process.

Attending to the role of intrapersonal, interpersonal, institutional, community, and public policy factors on Muslim women's health will guide the preparation, collection, and analysis done in this project. Using this framework, I will answer the following research question: *What are the experiences of Muslim women who have sought therapy at college counseling centers?*

## Methods

### Qualitative Design and Rationale: Narrative Inquiry

Postmodern perspectives regarding therapy have embraced narrative orientations to therapy by recognizing the importance of validating and accepting "local" knowledge and offering legitimacy to an individual's experience even if it is outside modernist truths (Payne, 2006). The use of narrative in counseling psychology is often limited to narrative therapy. However, storytelling as a form of healing is an empirically supported method to reduce distress in several populations (Chinoeso et. al, 2020; De Haene et. al, 2010; Lawrence & Paige, 2016). Specifically, scholars and researchers in emotion-focused therapy for complex trauma have elucidated the benefits of storytelling in the therapeutic relationship (Angus & Greenburg, 2011). Qualities of narrative therapy include collaborative conversations, reflexive awareness, externalization, and a re-writing of dominant pathologizing narratives (Nylund & Nylund, 2003; White, 1982). Moreover, questions and conversations around identity, politics, story-telling rights, and accepting multiple "truths" are encouraged in the therapy room (Madigan, 2011). The use of narrative has also been used minimally in health service psychology as a form of analysis (Wong & Breheny, 2018). When used as a form of analysis, researchers look for structural features of narrative, such as stage, setting, characters, and tensions in the story. Wong and Breheny also identify three levels of narrative including a) personal stories, often about everyday occurrences what Masta (2018) calls "small stories", b) interpersonal story-telling, what Masta (2018) calls the "process of story-hearing and story-telling", and c) social and structural narratives, such as dominant discourses about a person or group. As such, "stories are constructed, told, heard, and evaluated within particular historical, institutional, and interactional contexts, which include the background assumptions of storytellers, and story-hearers as well as the prevailing norms of storytelling" (Loseke, 2007, p. 663).

Scholars of narrative practice use the meaning derived from an individual's story to begin an "exploration of the social, cultural and institutional narratives within which individual's experiences are constituted, shaped, expressed and enacted... narrative inquirers study an individual's experience in the world and, through the study, seek ways of enriching and transforming that experience for themselves and others" (Clandinin & Rosiek, 2006, p. 42). One of the primary reasons for using a narrative methodology is because narratives on identity are "produced at cultural, institutional, organizational, and individual levels of social life" (Loseke, 2007, p. 662), and because narrative inquiry "makes audible the voices and stories marginalized or silenced in more conventional modes of inquiry" (Bowman, 2006, p. 14).

Engaging in the social practice of "sharing stories" is important in marginalized communities because stories often illustrate distinct cultural beliefs and practices and serve as important sources of data for understanding one's experiences (Brayboy, 2005; Kovach, 2010). Understanding the experiences of Muslim women lends itself well to a narrative approach for several reasons. First, dominant narratives about Muslim women, like many other women and marginalized groups, are often binary. The "good" Muslim woman often looks, behaves, speaks, and practices in certain ways because of socially and religiously sanctioned historical retellings of what it means to be a Muslim woman in the United States (Chan-Malik, 2018). Racial and religious binaries such as who is often seen as a "good" Muslim often erase complex and nuances stories, experiences, and contexts in which Muslim women live. Challenging these narratives by focusing on Muslim women's voices and stories may provide a more complex understanding of the depth and wisdom of this group. Second, stories are a form of healing and stories are a form of power. Story telling in the therapeutic relationship, particularly for clients with complex trauma, allows for catharsis, validation, and eventually an ability to retell or

rewrite painful stories. In this way, story-telling is not only a healing and hearing, but also a form of identity construction and re-negotiation. Given I have been trained clinically to hear stories and support clients in the re-writing of their narratives, and many Muslim women may have complex trauma related to various social determinants of health, I believe this form of qualitative research is particularly apt. Finally, the public health framework I am using in this study offers Muslim women an opportunity to share directly with a researcher and clinician on what they believe needs to change in their environment, and what they would like to see more of on college campuses to support their wellness. My positionality allows me to share their stories about their concerns with the academic community, who I invite to be story-hearers to learn from Muslim women before developing interventions for this group.

### *Recruitment and Sampling Strategy*

Currently there is limited literature on sampling strategies and mean sample sizes for narrative inquiry work. One review study wrote scholars in education have used sample sizes ranging from 1 to 24 while scholars in health science have used sample sizes ranging from 1 to 52 (Guetterman, 2015). Previous narrative inquiry studies exploring identity in higher education and health care settings have ranged from sample sizes of three (Cole, McGowan, Zerquera, 2017), and four (Haydon & Riet, 2014) to a maximum of six participants (Masta, 2018). Narrative inquiry is a "collaboration between researcher and participants, over time, in a place or series of places, and in social interaction with milieus" (Clandinin & Connelly, 2000, p. 20). Therefore, given qualitative research focuses more on depth rather than breath and narrative inquiry requires trust, collaboration, and safety--a sample size of six allowed me to dialogue with participants over time and explore multiple spaces, places, and social interactions which have impacted women's experiences on campus. A sample size of six was selected because it will

allow for a variety of stories in depth and breadth to be shared while also managing time constraints which necessitate that this project by complete by August 2021.

A purposive and theory-driven sampling strategy was used for recruitment. This form of sampling is usually employed when "it is impossible to identify sample or the population from which a sample should be drawn at the outset of a study" (Palinkas, 2015, p. 18). Using a purposeful sampling strategy is also useful when research is exploratory in nature, when little is known about a phenomenon or setting, and when a priori sampling decision can be difficult. I used snowball sampling and relied on my relationships within Muslim spaces in the Midwest to share informational fliers about the project via social media, community list-servs, and physical spaces such as the mosque and university counseling centers. A demographic questionnaire for interested participants ensured voices systemically silenced within the Muslim community, such as LGBTQ, trans, Black and Latino Muslim, convert, and Shia Muslim stories were uplifted and purposively selected. Participants from the demographic survey were selected based on the "thick description" found in the survey about positive and negative experiences at each ecological level. I gained Institutional Review Board (IRB) approval from Purdue University before beginning research procedures. Given stay-home-orders in March 2020 due to COVID-19 pandemic, all interviews were completed virtually via Zoom.

To be eligible to participate, participants had to be a) Muslim women b) over the age of 18 in the United States and c) who have sought psychotherapy with the same practitioner for at least five sessions in the last five years at a university counseling center. Participants did not need to be currently in therapy or in the university system to be eligible.

***Participants***

Over 50 participants completed the initial screening survey. After consulting my primary advisor, I created a short-list of twenty-four participants who met inclusion criteria and had a variety of intersecting identities. Specifically, I attending to identity markers such as race, sexual orientation, sect, international student status, convert status, and the importance of Islam in women's lives, as well as the depth and clarity participants were able to write about their positive and negative therapy experiences. Specifically, when reviewing written responses, I assessed writing around how women talked about their own racial and cultural identity as well as the racial and cultural identity of their therapist while describing their experiences. I then created a list of 6 participants which covered a depth and breadth of identities represented in the American-Muslim community. For example, it was important to me that at least one participant identify as Shia, identify as a convert, a first-generation college student, and one participant identify as an international student. It was also important to me to interview individuals from a wide variety of racial and sexual orientation backgrounds. Table 1 below provides a summary of the women interviewed.

Table 1. Description of six women

| Pseudonym | Age | Sexual Orientation | Race/ Ethnicity | Sect / Convert | International Student | How important is Islam in your life (1-10) | Clinical Presenting Concern(s) |
|---|---|---|---|---|---|---|---|
| Farah | 28 | Heterosexual | Indonesian (S.E Asian) | N - Sunni | Y - Indonesia | 8 | Academic distress / life transition |
| Habiba | 22 | Lesbian | Egyptian-American (MENA) | N - Raised Sunni | N | 5 | Sexual assault during study abroad program |
| Sumaya | 22 | Heterosexual | West African-American (Black) | N - Sufi / Sunni | N | 10 | Academic distress / life transition |
| Fatima | 23 | Bisexual, Queer | Biracial - White, North African (Multiracial) | N - Raised Sunni | N | 8 | Family of origin / interpersonal concerns |
| Zahra | 26 | Bisexual | Cuban American (Latina) | Y - No sect I identify as Muslim | N | 8 | Academic distress / sexual harassment |
| Maha | 20 | Heterosexual | Indian American (South Asian) | N - Shia (Ahmadi) | N | 8 | Academic distress / family of origin |

### *Data Collection and Procedure*

Data was collected between May 2020 and April 2021. Of note, data collection occurred during stay national and state-wide home orders related to COVID-19 pandemic. There were five sources of data for this project: the pre-screen survey, two individual interviews, and two pre-interview surveys. In the pre-screen survey, participants were asked if they met inclusion criteria, completed demographic questions, and were asked to describe a positive and negative therapy experience at their university counseling center (Appendix C). This screening survey also including questions such as "on a scale of 1-10, with 10 being very important, how important is Islam in your life," "on a scale of 1-5, with 5 being extremely comfortable, how comfortable were you WRITING about your positive and negative experiences?," "on a scale of 1-5, how comfortable were you writing and reflecting about YOUR IDENTITY throughout the questionnaire?", "on a scale of 1-5, how comfortable do you imagine you will be sharing these experiences ORALLY face to face on a virtual platform?" Given the sensitive and vulnerable nature of the study, participants must have included a score of three or higher on all three questions to be eligible for follow-up. Pre-interview surveys were administered before each interview to facilitate both reflection for the participants and myself around their stories, and to provide a skeleton for the semi-structured interview. For example, pre-interview 1 and pre-interview 2 responses were used to guide the open-ended questions I asked participants about their therapy experiences and institutional/community/policy factors they believe were related to their mental health (see Appendix). Questions on pre-interview 1 surveys included "How did you learn about mental health services at your college/university counseling center?," "Describe what brought you therapy. What was going on in your life at the time of seeking-services?," and "What you think your therapist did well? What do you think they could have done better." Questions on pre-interview 2 included "Talk about a time in which INTRAPERSONAL

(knowledge, attitudes, behavior, self-concept, skill, developmental history) engagement contributed POSITIVELY to your health" and "Talk about a time in which POLICY (local, state, and national laws and policies) contributed NEGATIVELY to your health."

Both interviews were audio recorded and transcribed. After the first interview transcription was complete, I gave participants an opportunity to review their transcript for accuracy and confidentiality. Specifically, I told participants if there was anything they did not want me to use in analysis or had concerns about to share these concerns with me. Only one of the participants had concerns. In this case, I removed the section of the interview she did not want me to include in analysis from the transcript. I also asked participants to provide me their preferred pseudonym for analysis. Each interview lasted between 75 to 90 min.

The purpose of interview one was to build rapport, learn more about my participants, share my intentions for the study and focus on the participants' experiences with mental health and their interpersonal relationship with their therapists. Interview two was focused on asking participants to use the SoDH model to reflect on stories within which factor related to their mental health.

After each interview one I created a personalized SoDH graphic for each participant. Creating a personalized SoDH for each participant also helped me see themes across participants, regardless of race, generational status, sexual orientation, and sect. In this graphic I categorized "small stories" they shared into the SoDH framework. Although interview one focused on the therapeutic relationship, I noticed each participant brought up how talking to me (a Muslim woman researcher) was different than talking with their UCC therapist. This made me begin reflecting on an additional research question about my overlapping roles during the interviews as

a researcher, clinician, and community member. Although, this is not the focus of this research project, this element of the researcher-community member-therapist and participant-client dynamic is an important area of continued research. For many community-centered researchers negotiating dual obligations between the academy and their community, and in my case my obligation as a therapist and researcher to both hold and hear women's experiences and answer my research question was a relational element to this work I had not anticipated (Jackson, 2008). My experience interviewing women highlighted the lack of ethical training—both as a researcher and therapist—in conducting interviews with people whom I am in community with (Brown, 1984).

### *Data Analysis Method*

While narrative inquiry techniques such as prolonged engagement and priming participants to share their stories were used in data collection, thematic analysis is the analytic method of choice given multiple stories that were shared and disclosed through the data collection process. Using thematic analysis allows participants to tell and re-tell their stories during data collection with the researcher but does not require the participants to share their stories in a linear fashion. Stories do not often "move from point A to point B" (hooks, 1997, p. xx). Therefore, data analysis and presentation for this project was done by highlighting themes within each participant's story about their experiences in university counseling centers as well as themes across the SoDH framework in regard to their definitions and experiences with health and wellness.

I used Braun and Clark (2008) thematic analysis procedure to analyze participants recruitment survey, pre-interview surveys, and two interviews. This procedure was useful in

engaging in both inductive and theoretical analysis of my data. Specifically, I begin data analysis procedures by (1) familiarizing myself with the data by reading and re-reading the data and noting down initial ideas. I then (2) generated initial codes or found "the most basic segment, or element, of the raw data or information that can be assessed in a meaningful way regarding the phenomenon" (p. 88). I then (3) searched for themes by considering how different codes may combine to form an overarching theme. Specifically, I did this by creating an individual SoDH graphic for each participant. In this graphic, I included data from their pre-surveys and interviews which I found compelling and relevant to literature around religion, marginalization, and mental health. I then (4) reviewed themes and examined internal homogeneity and external heterogeneity for each theme. In this project, this meant I reviewed themes across participants' individual SoDH graphics. During the next phase, I (5) defined and name themes in preparation for presenting the analysis. This was done as I wrote my results section. Finally, I produced a report (this paper) that will tell the story of my data using examples and quotes.

**Confidentiality**

Audio of the interviews were kept electronically in a password protected computer and password protected web portal. Transcriptions did not include any demographic information of the participant. Only the primary investigator and study personnel had access to audio and electronic transcripts of data. Improper use and disclosure was avoided by 1. Not sharing information without participants consent 2. Only conducting analysis on password protected computers 3. Reviewing the themes and data that were found from their sharing and an opportunity to retract their data. Names of participants were destroyed after data was collected with the exception of Farah who indicated she would like to use her real name rather than a pseudonym.

### *Qualitative Research Quality*

Tracy (2010) suggests quality qualitive research includes eight criteria (a) worthy topic, (b) rich rigor, (c) sincerity, (d) credibility, (e) resonance, (f) significant contribution, (g) ethics, and (h) meaningful coherence. Elements of all eight criteria were apparent in this study.

A worthy topic in qualitative inquiry as timely, relevant, and significant in context to contemporary controversies and political climates. Tracy also suggests research that is counterintuitive, and challenges well-accepted ideas are often worthwhile. In this research project, I shake readers from their common-sense assumptions that therapy is always healing, useful and productive for marginalized groups. By exploring Muslim women's experiences with therapy from a socio-cultural lens I highlight how assumptions in training and therapy culture can further marginalize this group. Furthermore, Tracy describes worthy topics as topics which emerge from disciplinary priorities. In this case, the disciplinary priority of this project was to learn how to best support Muslim women seeking therapy in university counseling centers. Research rigor according to Tracy includes the care and practice of data collection and analysis procedure as well as abundant, appropriate and complex data and time in the field. In this study, research rigor was demonstrated by the transparency regarding the process of sorting, choosing, and organizing data. My description of how participants were selected as well as how data was organized after each interview highlight this element of quality in qualitative research. Sincerity in qualitative research includes self-reflexivity, vulnerability, and honesty around research bias and goals. In this project, my biases and goals around answering this question were explicit since recruitment. For example, my recruitment document included my hopes for the project with the following "my hope is to listen, affirm, and give women a space to speak directly to the mental health training community about what Muslim women have appreciated and what Muslim

women would have liked to see changed in the mental health system and university counseling center system." Furthermore, transparency and sincerity in this project were highlighted when reflecting on my access to the population I studied. Namely, my own identity and desire to uplift stories of Muslim women both similar and unlike me drove recruitment. Credibility for Tracy includes trustworthiness, verisimilitude, and plausibility of research findings. This includes thick description, crystallization and triangulation, and multivocality, and member reflections. In this project, credibility of research findings was demonstrated by the use of thick description in member quotes, crystallization via gathering multiple types of data (interviews, post-interview reflections, and pre-interview surveys) to gather complex, in-depth, and thorough data.

Ethics in qualitative research can be defined by procedural ethics, situational ethics, and relational ethics. My commitment ethics by completing procedural ethics via Purdue IRB as well as a relational ethic to ensure participants were treated with mutual respect, dignity, and connectedness highlight my thoughtfulness in this area of qualitive research. Specifically, during recruitment procedures, I asked all prospective participants to reflect on what it was like to write about and speak about their therapy experiences on a scale of 1-5 (1 being extremely uncomfortable). Participants were ineligible if they endorsed a score of 1 or 2 to ensure participants who were selected for this study were not pushing beyond their emotional limits to share their story with me. Furthermore, at the end of pre-interview surveys I included a question for participants to reflect on their internal emotional experience. I offered participants an option to engage in mindfulness and distress tolerance activities if completing the survey and reflecting on their experiences were overwhelming. At least two participants took advantage of these exercises after completing the survey. Finally, I ended interviews with an understanding that difficult feelings may arise as participants continue to reflect on their experiences. In doing so, I

normalized challenging emotions and invited participants to share reflections which airse from interview one during our second interview. This ensured participants had a holding space post-interview. Finally, at the end of the project, I sent participants a copy of the report and asked how they would like to stay in touch. I also offered a final meeting to "close" out the research relationship and invite participants to become collaborators in work related to their stories. These examples of relational ethics embody Christians (2005) concept of feminist communitarianism of connectedness, caring, collaboration, intimacy, and promise keeping.

Resonance according to Tracy refers to the research's ability to affect an audience by promoting empathy and identification by readers who have no direct experience with the topic. The potential of research to transform the emotional dispositions of people has been termed empathic validity. While this element of quality qualitative research is meant to be assessed by readers, the feedback I received during my dissertation defense by committee members suggests the writing and analysis I did with this study moved them to greater understanding and mutual regard for my participants. Finally, meaningful coherence and significant contribution includes research which provides contributions either conceptually, practically, morally, methodologically, or heuristically, and research which interconnects literature, research questions, and interpretations with each other. In this study, meaningful coherence is visible as I utilize a methodologically novel strategy in counseling psychology to uplift the voices of a marginalized community and make sense of women's stories with literature across several disciplines including but not limited to: community psychology, counseling psychology, and curriculum and instruction. Finally, I provide a unique and significant contribution to the field of counseling psychology as this is likely the first dissertation and research project to investigate Muslim women's experiences in therapy at university counseling centers.

## Results and Discussion

Results of this study are organized by the social determinants of health including intrapersonal, interpersonal, institutional elements of what women shared with me. I chose these three factors not because all five factors were not present in the women's stories but because focusing on intrapersonal, interpersonal, and institutional follows E.J. R David and Annie Derthick's operationalization of oppression as internalized, interpersonal, and institutional (David and Derthick, 2017). I chose to integrate results and discussion in this section to help readers interpret and connect findings to larger themes in counseling psychology literature.

### Intrapersonal: Internalized Oppression and Spirituality as Strength

Intrapersonal or individual's factors in the SDoH model consists of knowledge, attitudes, beliefs, and personal traits within an individual which inform health outcomes. In this sample, religion proved to be a salient strength for participants, in that they shared how Islam has shaped their spiritual identities and ability to be spiritually grounded. In regard to intrapersonal or individual factors which negatively contribute to Muslim women's experiences, several participants highlighted the ways in which internalized messages about themselves as queer Muslim women, as dark-skinned Muslim women, as Muslim women living in the United States, and Muslim women with mental health concerns, informed their sense of self. I connect these internalized messages to a broader theme of how internalized oppression appears to be operating in nuanced ways for these women given their unique positionalities. Intrapersonal themes therefore included: (1) Islam as a grounding force and (2) experiences of internalized oppression or what I call "internalized -isms" including (2a) experiences of internalized gendered islamophobia and (2b) internalized and horizontal heterosexism and racism.

**Islam as a Grounding force: "patience, humility, and growth"**

Several participants talked about the grounding force of Islam in their lives. In the quotes below Zahra, Maha, and Farah share the ways in which religion and religious experience—internally with *dua* (supplication), interpersonally (within the family), and within a virtual community space has supported the creation of an authentic practice of Islam. Interestingly, Zahra, a cis-bisexual, first-generation, Cuban American, convert to Islam, shares that even though she put Muslim on her intake paperwork for her therapist, her therapist was unable to utilize Zahra's internal strengths as a Muslim in the therapeutic relationship. Instead, the therapist asked if Zahra has a "mantra." Specifically, she shared:

> And, yeah, she definitely doesn't even talk about or consider religion. Like, I put on my papers that I'm Muslim. And she never talks about it. And I even talked to her, like, she asked me that, like, maybe you should think about, like, having a mantra, or something. And I remember I told her, you know, I don't know if this is a mantra, but I remember when I was, like, really consistent with my prayers, after I would, you know, make *dua*, I would tell myself, you know, patience, humility, and growth. And I would ask God for those things. And that was kind of, those were the kind of like, the three things that I would ask after all my *duas.*

Zahra's response highlights that although well-intentioned, the therapist asking about her mantra was unable to explore spiritual and religious practice Zahra was already engaging in such as prayer, *dua*, and a relationship with God, to ground her outside of therapy. The emphasis on a mantra also erases the Buddhist origins of this concept. Sumaya supports the notion that faith is a grounding force for her given how often religious practice has been talked about within the home. She says:

> Um I don't know religion just always been like my like, like my grounding my parents had always instilled in us like, this is your grounding. This is your foundation, like, even though they didn't go into teaching us about it formally. Every other word had something to do with religion. So it just kind of naturally happened that every other thing that I do, has to do with God.

Similarly, for Maha, a cis-heterosexual, first-generation Pakistani, Ahmadi (Shia) woman who wears hijab, practicing Islam is something she feels connected to and feels certain about.

> I feel really strongly connected to things like fasting and like when I, you know, go to *Jumah*, I hear a sermon or something like that, like, it like gets me, those are the things that I feel like most connected to just like my *hijaab* and stuff like that, like I've never really like questioned that. And like I've you'll have my ups and downs in that journey, but you know, that's something that I've always felt really sure about. Yeah, so those are things I guess I feel connected to. Yeah.

In all three cases, Maha, Sumaya and Zahra highlight the importance of God as a grounding force. While literature on the role of religion has demonstrates it is both a strength and at times a barrier for Muslim women (Ciftci, et al., 2012; Shawahin, 2016), it is important to note that within these quotes a relationship with God is mentioned. This also supports literature around individual's attachment styles and their relationship to God (Kirkpatrick, 1998) as well as literature and workshops by Muslims which suggests Islam is an embodied practice and one which relies on a personal relationship with God (Auston, 2017; Azmat, 2016; Chan-Malik, 2018; The Village Aunty Institute, 2021). Maha and Sumaya's acknowledgment and

commitment to their faith and faith practice also highlights the role of Islam in mental health practice.

For Farah, a cis-heterosexual, Sunni, Indonesian international student, reading Quran is one way she stays connected to faith. She shares about an opportunity through the organization Feminist Islamic Troublemakers of North America (FITNA) to recite Quran:

> I did it [read Quran] with other girls, with other queer women of color who look like me, think like me, and also read Quran beautifully. So, I love, I love my Ramadan this year. Even though I can't go anywhere, but I feel like I am closer to God in a way that I've never expected…I think that goes back to me just having a big, personal value of like being authentic and telling the truth. And just feeling so passionate about this. And like, so sure.

Farah's quote about the importance of reading Quran and being a part of a virtual community in which she could read Quran with other queer Muslim women of color highlights the importance of virtual spaces which allow a multitude of Muslim women to be seen, heard, and given permission to practice Islam authentically. Earlier in the conversation she shared that both in Indonesia and the United States, she found herself reading Quran in a corner as not to be heard by others. However, when Muslim and non-Muslim peers heard her recitation, they responded in ways which questioned her faith identity:

> So, I remember there are some times for example, the one when my friend was so shocked that I would do ablution or *wudu* for prayer, she just came to me said, "You don't look like a Muslim, your face doesn't *laugh* doesn't give an impression that you're a Muslim."

> And to my friends, coworkers, I am not only not wearing hijab, but they already know my stances in different situations [i.e premarital sex, hijab]. So, it becomes so extra for them to uh, finally see me pray and reading Quran and they'll be like, it's like mind blowing for them, not in a good way.

Farah's second quote, similar to Zahra, suggests that within the Muslim community, Farah's commitment to prayer and Quran is surprising to her Muslim and non-Muslim friends given her beliefs about premarital sex and requirements around hijab. What is not noted in this quote is the pain and desperation I heard in Farah's voice in her sharing this with me. Moreover, Farah is an international student from Indonesia, one of the largest Muslim majority countries in the world (Pew Research Center, 2019). Although not quoted here, Farah shared that she was surprised that women in the United States did not have experience with female scholars and leaders, given her experience growing up in Indonesia and how normalized women *shaykhahs* were for her as a child as well as the plethora of Islamic scholarship she had access to growing up. For Farah and Zahra, although Islam is a grounding and authentic element of their identity, others around them—in Zahra's case her therapist, and in Farah's case her friends and coworkers, appear to be contributing to their experiences of being delegitimized as people of faith. Moreover, Farah's experience and early exposure to *shaykhahs* (female scholars of Islam) may suggest Muslim women in the United States do not have the same knowledge and exposure to religion as someone who spent early childhood in a predominately Muslim majority country.

**Internalized -isms: "I have never felt comfortable discussing religion in my sessions"**

Internalized oppression or a response to oppression in which members of oppressed group internalize negative stereotypes and expectations of their group (Bailey, Chung, Williams,

Singh, & Terrell, 2011; David and Derthick, 2017) leading oppressed individuals to act out negative stereotypes, internalizing hatred of self and members of their group, and understanding oneself based on membership to an inferior group. In this study, Muslim women across race, sexual orientation, and self-rated religiosity shared the ways in which they have internalized oppression across various matrices of domination (Collins, 2000) including their own religious practice. Internalized oppression related to gender, mental health, sexual health, and religion were apparent in conversations I had with Maha, Farah, Sumaya, and Habiba. Participants alluded to intrapersonal forms of Islamophobia when they talked about the tension in sharing openly and honestly around their anger and experience with Islam, as well internalized forms of heterosexism, sexism, and racism when they shared the ways in which community members perpetrate cycles of violence around their mental and sexual health.

### *Internalized Gendered Islamophobia*

Omar Suleiman (2017) highlights intrapersonal, interpersonal, and systemic factors in young Muslims experiences of internalized islamophobia. He suggests that at intrapersonal level, trauma in an individual's relationship with faith and how individuals are educated about Islam in the family may impact resistance to internalizing Islamophobic messaging and their ability to construct an integrated and authentic Muslim identity. At the interpersonal level he highlights the unique challenges Muslim women experience, concerns around gender justice in Islam, and the reinforcement of Islamophobic messaging in Islamic spaces. This form of gendered Islamophobia, or "ways the state utilizes gendered forms of violence to oppress, monitor, punish, maintain, and control Muslim bodies" (Justice for Muslims Collective, 2019, p. 2) is also important to consider when assessing how Muslim women in therapy talk about their relationship to faith. For example, Habiba speaks to the impact of not having a Muslim-identified

therapist and alludes to Suleiman's suggestion that familial trauma may impact identity development for Muslim women. She shared:

> And I think what I, what I realized now that I didn't realize at the time but wish I had been able to explore is that being Muslim...I never, it was really rare for me to feel like I could talk about my frustration about how I was raised, and my frustration about the community because I felt like if I was talking to a non-Muslim, I would I couldn't say those things like I couldn't say like, "I'm really angry that I was always raised like…" for example, something I would hear a lot in the community, and even from my own parents was like, "women should dress modestly because it's like, if you have a nice house, you have to lock it there like no one should break in. But if someone does, it's easier if the house is unlocked", you know, things like that, like super damaging, but when I would share with a non-Muslim, they would be like, "Oh, my God", and they already had all these stereotypes. And I was like, this is not where I wanted to go.

Habiba's quote is important for two distinct reasons – first, her quote highlights internal barriers to speaking openly about her experience with religion, including culturally-sanctioned forms of misogyny such as "if you have a nice house, you should lock it." Habiba shares that not being able to explore this in therapy because of a hesitation and fear about how a non-Muslim therapist would respond, prevented her from deepening her work around her Muslim identity and expressing frustration about the way she grew up. Second, Habiba's quote confirms familial trauma maybe a risk factor around internalized Islamophobia. As Suleiman (2017) and Raja (Justice for Muslims Collective, 2019) suggest, Muslim women are impacted differently by Islamophobic messaging given their personal experiences within and outside of the Muslim community.

Similarly, Maha also shared that she never felt comfortable discussing religion in her therapy sessions out of fear and anticipation of negative reactions or microaggressions. She shares that although she is visibly Muslim, she never felt connected enough to her therapists to explore this part of her identity.

> I have never felt comfortable discussing religion in my sessions, even though it's important to me and I'm visibly Muslim (I wear a hijab). Neither of the therapists I saw at my university ever said anything to suggest that they wouldn't be understanding, but the anxiety of bringing it up and having negative reaction has always been too much for me to even risk that.

Maha's quote highlights that the therapists she worked with did not do anything to make her feel unsafe in the therapeutic relationship but the silence around asking directly and explicitly about faith communicated this was not something that could be explored in therapy. In this way, both Maha and Habiba engage in self-silencing, a form of relational disconnection in which an individual restricts self-expression within an intimate relationship (Jack, 1991). Some scholars have suggested self-silencing is a form of internalized sexism or gendered oppression (Azmat, 2018; Maji & Dixit, 2018) and have suggested that an inability to express oneself relationally perpetrates cycles of internalized anger and resentment towards others (Jack, 1991). More broadly however, Maha and Habiba's self-silencing also appears to be rooted in protecting themselves and their Muslim communities from negative feedback and potential microaggressions.

### *Internalized and Horizontal Heterosexism and Racism and Sexism*

Internalized heterosexism is defined as negative attitudes and beliefs that lesbian, gay, or other same-sex attracted individuals have internalized about same-sex romantic, emotional, and sexual relationships (Szymanski, Kashubeck-West, & Meyer, 2008). Similar to internalized racism in which there is a conscious and unconscious acceptance of a racial hierarchy in which whites are consistently ranked above people of color (Johnson, 2008), internalized racism and heterosexism includes internalizing negative attitudes and beliefs about oneself. For women, this can take the form of form of feelings of powerlessness, competition between women, objectification, and the invalidation and derogation of women (Bearmna, Korobov, & Thorne, 2009). Likewise, horizontal heterosexism and racism refers to the racism or sexism perpetuated by members of minority groups toward members of their own minority group or one of equal or lesser privilege (Bryant & Schram, 2009). All four of these concepts were apparent in my interviews with women. Horizontal sexism was a part of a conversation Maha had with her mother about wanting to start therapy at age 17. In this quote, Maha's mother suggests women in their family do not go to therapy. Maha shared:

> She started talking about how, about um how the women in our family are just supposed to like, just, like, bare the suffering without doing anything about it. She said this thing that like stuck with me, that she was like, like, "Do you think I don't want to get help? Like, do you think I don't want to go to therapy? Of course, I do. But we can't, because that's not something that we do." And I was like, "I'm sorry, what?" Like, there's so much to unpack and I don't know where to start.

Maha continues to share that she believes the pattern of believing therapy is inaccessible to the women in her family is a form of generational violence and trauma. She explained that this

pattern was interrupted by her sister who introduced Maha to services she was eligible for through her university counseling center:

> So it wasn't until a couple months later that my sister forced me to start going once I found out that it was available for me on campus. But yeah, so that is like the biggest example of like continuing this generational violence and trauma. Because it was so, it was so clear, even in what she was saying that like, the women in my family, especially on my mom's side, like I mentioned, my *khala*, my Nano like they all, talking to them now, after having been diagnosed with mental health issues, like, it is so clear that that's what they're all struggling with.

Horizontal sexism also appeared in a story Sumaya shared about her relationships with other women:

> Yeah. I feel like any community you go to, though really, like, you'll find that. Like, there are [women] always like trying to one up each other or, not even like really having genuine friendships, because you don't even know who you could be vulnerable with, you know?

In this quote, Sumaya shares competition between women can contribute to fears and hesitations about sharing vulnerably. Across race and religion, women in many communities engage in social competition between each other—a form of internalized sexism (Bearmna, Korobov, & Thorne, 2009). Sumaya continues to share that this competitive energy has made it challenging for her to have genuine relationships because of feelings of mistrust and uncertainty about which women she can be vulnerable with. Sumaya also shared openly, and vulnerably with me about the impact of internalized racism in her understanding of herself, her understanding of her community, and in particular dating relationships. She shares:

> Relationship wise. I don't trust men because of colorism…Colorism is like our own little form of racism that makes black people like it's just, I see it all the time. It affects like, who for the longest time it affected who I wanted to be my spouse, like, I was like, I'm not marrying a black person. I don't want my kids to be dark. Like I don't want my kids to go through what I went through…. I don't think like that anymore alhamdulillah but it affects…like, everything.

Sumaya's honest reflection above demonstrates the ways in which internalized oppression operates in unique ways for Muslim women. As a Black Muslim woman, Sumaya shares the painful reality that she has previously considered and how her children will be impacted by colorism and how this has impacted her relationship to dating. She continues, also sharing:

> Like, the first thing when I think of what someone tells me, or if I find someone that I like, the first thing I asked is "Oh, like, do they like dark skinned girls? Like, do they like women of darker color?" Like, will they be okay with that? Like, are they okay with having potentially darker children? You know, like, that's the first thing that crosses my mind.

Colorism and self-perceived desirability has also been written about in scholarly literature (Howzell, 2019). As such, it is important to note these concerns may not arise immediately in a therapeutic relationship. As Maha and Sumaya demonstrate, the anxiety, trust, and vulnerability required to share these elements of their lived experience should be attended to with care, concern, and compassion as therapists and researchers conceptualize concerns around identity and personhood for Muslim women. Notably, as the only Black Muslim participant in this study,

Sumaya was also the only participant who spoke about colorism. However this does not suggest other participants did not struggle with internalized racism.

Finally, for Habiba, internalized heterosexism impacted her ability to process her sexuality. In one of her therapeutic relationships, she described her therapist as the individual helping her process her assault and come to terms with her sexuality as a gay woman. She shares:

> I also was coming to terms with my sexuality. And so I had like, well meaning, but still wrong people, kind of like insinuate well, like, "Oh, of course you think you're gay? Because this happened." Or you know, or like, "Oh, do you think that you're feeling this way because you hate men now or like you're so afraid of men." And that just confused me and like made me mad, but also made me doubt myself. And so having that therapist just validate that, like, “that's not true. And even if that is true, that doesn't really matter. Because if you feel like you want to be with a woman that's valid, and that's enough reason to be with a woman, you don't need to over analyze it and like justify it to outsiders.” That was super helpful.

Habiba’s quote is powerful in that it highlights the complexity of being a queer survivor of sexual assault. She describes the conflict, confusion, and doubt which she experienced after being violated by a male perpetrator and the ways in which “well-meaning, but still wrong” individuals in her life supported a highly problematic narrative that individuals are queer or gay because of sexual trauma. Habiba’s therapist skillfully shared that “even if that is true, it doesn’t matter” and in doing so invites Habiba to reject the narrative around sexuality from her peers and the internal confusion about her sexual orientation. In doing so, she challenges internalized

heterosexism and homophobia Habiba was experiencing as well as horizontal heterosexism Habiba was experiencing from individuals in her community.

### Interpersonal: Microaggressions and Cultural Openings

Another salient theme across participants were interpersonal cultural connections and missed opportunities between themselves and their therapists. Specifically, interpersonal factors refer to formal and informal social networks and social support from family, work, and friendship networks in women's lives. Participants talked about the ways in which their therapists microaggressed one or more of their identities, the impact of being able to talk with someone who shared one or more of their identities, and the ways in which therapists of color provided comfort, and familiarity, and did not perpetuate harmful narratives around their cultural sense of self.

### Microaggressions: "Well, actually women in burkas still get catcalled"

Throughout our time together, Zahra, a Cuban-American and convert to Islam shared how the saliency of her identity as a first-generation Cuban-American Muslim has impacted her life experiences, her academic work, and her romantic relationships. Naturally, within the therapeutic relationship, these parts of herself were also salient. However, her therapist at the time had assumptions both about her Muslim identity and her identity as a Latina. She shares:

> You know, I also would like to mention, I talked about how she like told me about her experience going to Mexico. But, since I told her [about my heritage and Muslim identity], she said, like, "Oh, both, both of these cultures don't respect women." And then she was just like, "Yeah, I mean, the Muslim community is like, you know, we don't even

> want to go into that." And like, she could literally see my face, just like how disgusted I was with her saying that because she put them back to back. Like, she was like, she took both of my identities and just basically shat on them. I just didn't have the energy to go into it. And so she kind of backtracked a little bit. But, it wasn't, it wasn't to the extent that she needed to….And, you know, I've only had one experience where I was just I told my therapist like, "listen you said something really uncomfortable to me. I don't appreciate that." And I,I felt weird even doing that.

In this example, Zahra's therapist was explicit about her assumptions regarding the racial and religious communities Zahra belonged to. Rather than explore Zahra's experience with these identities and invite conversation about the role race and religion plays in Zahra's life, the therapist shared her disdain for the relationship Muslim and Latinx cultures have with women. Moreover, Zahra shared she "did not have the energy to go into it." Similar to calls in organizing spaces for marginalized people to not have to educate their peers, we see a similar dynamic appear in this interpersonal exchange between Zahra and her therapist. Furthermore, in this moment Zahra did not want to educate or "fix" the ruptured relationship. Later she reflects that when she did share with the therapist that they said something which made her uncomfortable, she "felt weird" doing that. Habiba, an Egyptian-American participant, shared a similar moment with her therapist when her therapist told her:

> "There's only two people who aren't cat-called...like women in burkas and really old women."

Later, Habiba shared that she responded to her therapist by saying:

> "Well, actually women in burkas still get catcalled like, I've seen it with my own eyes." You know that was kind of frustrating.

Habiba shared with me that given her rapport with her therapist she was able to confront her therapist about this statement in the moment. Her therapist responded saying "oh, okay, well then I guess everyone does." However, within our conversation Habiba spoke to how the incident impacted the therapeutic relationship as it prevented her from continuing to explore her Muslim identity within the session. The language and quotes highlighted above demonstrate the ways in which assumptions about Muslim women were apparent in both Zahra and Habiba's therapeutic relationship. In Zahra's case, the therapist's comment highlighted an underlying belief that women in both Muslim and Latinx cultures are not respected. In Habiba's case, the comment made by the therapist suggests Muslim women and older women cannot be victims of sexual harassment. Given both Habiba and Zahra were in therapy to address trauma around sexual violence and sexual harassment, these quotes are concerning when thinking about how therapists working with Muslim women have internalized notions of who a "perfect" victim of sexual violence looks like and that Muslim women, by virtue of choosing Islam, are deserving of violence (Raja et al., 2017).

**Cultural Openings: "The burden was lifted and it feels so comforting"**

Another theme apparent throughout participant stories were elements of what I will call "cultural openings." A cultural opening in the therapeutic relationship described by my participants included a level of vulnerability by their therapist which demonstrated to the participant that their therapist had a deep understanding, or at least awareness, of their own

cultural and/or racial identity. This connection and willingness to share from their own lives was often well-received by participants. Specifically, Habiba shared about one of her therapists:

> She was a Colombian immigrant. I don't know how long she had been in the country, but she was very connected to her culture and would go back which was nice and comforting and felt familiar to me. And she would bring back worry dolls that one of the indigenous groups in Colombia would make and you basically like, give your worries to this doll and kind of try to like compartmentalize whatever you're going through, which honestly worked but it was really sweet to receive that and for someone to have such a nice intention behind it. And it put me at ease too that she was so open about her culture and sharing it with me. Because that means I could be more open too.

The final line of this quote "that means I could be more open too," highlights the way in which a therapist's understanding of themselves and willingness to share about themselves can be meaningful and touching to clients. Moreover, Habiba describes the "worry doll" as a way in which her therapist helped her contain and compartmentalize difficult memories, flashbacks, and anxieties—a core element of stage one trauma work (Clark et. al, 2014). The notion of finding relief in a shared identity was also described by Maha, a South Asian woman who talked fondly about her relationship with her East Asian therapist, and Sumaya, Black Muslim woman who describes the relief she experienced when she found out she was matched with a Black Muslim woman therapist. They both share:

> I think there were things that I just I didn't need to explain more. Like even through like, my tumultuous relationship with my parents and you know, the different or I guess the effect that that had on my mental health, you know, she never like, pushed me to talk

about like, "Why? Why, why is it important that you still have a relationship with your parents" which I think I've talked to some of my other South Asian friends, you know about therapy, their therapy experiences and they've always felt like there White therapists push them to be like, "Why? Why can't you just like stop talking to your parents?" But I think because we're both Asian, we're both just like, understanding that, like, your relationship with your parents is incredibly important. And you don't just like leave when they're mean to you. (Maha)

And so I was, I completely forgot about the note that they had put in my file that I wanted someone of color. I was like, yeah, I'll take someone of color or even someone Muslim, I don't even mind if she's Arab. Like, I'll even take that like, it's okay. Um, and they're like, guess what we have both! And I was just like, okay, they're like, yeah, we have a black Muslim woman and I lie to you not I started crying. I was just like, this is exactly what I need, like, sign me up soon as possible. Can I go talk to her today? Like, I want this all…I want everything to do with her. Like, I need her. And so I did and spent the next six months with her. (Sumaya)

Maha and Sumaya's quotes highlight another important element of cultural openings—the embodied experience of sitting across to someone who shares one or more similar identities. Specifically, both women describe experiences they have had in the past with the mental health system which allude to their distrust that a therapist would be able to completely understand their lived experience. When Maha shares that she has heard several of her friends share that other White therapists have pushed them to re-examine their commitment to family values, she attributes her therapist's Asian identity as the reason for their understanding that you "don't just leave" family relationships. Similarly, Sumaya describes in desperation that she will even

consider an Arab therapist when she states “I’ll even take that like, it’s okay” assuming the center would not have a Black therapist or a Muslim therapist to meet her needs. When she shares the center has both, Sumaya shares she started crying in relief. Across all four participant’s stories, the burden of “explaining” appears to be lifted when they are matched with a therapist of color or a therapist which can hear, see, and attend to racial and cultural needs with one or more shared identities.

This sense of familiarity and openness Habiba, Sumaya, and Maha share about their interpersonal relationship with their therapists is also highlighted with Farah in her relationship with her Mexican American male therapist and her relationship with me:

> I don't recall my therapist saying anything about his faith. But now let's have a Venn diagram again between faith and family relationship especially extended family culture. I'm glad that Mexico I mean, Mexican and Indonesian culture is really similar when it comes to extended family we have big numbers of cousins, aunts, uncles, and then people who you thought you don't know but turns out they're still family members.

Towards the end of our interview, I expressed my gratitude to her for being so open with me about all her experiences. In her response she shared:

> Yeah, I'm open because your openness well, and I believe that the shared identity part is really important. Like, I think, now that I think back, I think the way I share to you was pretty different than how I shared with my last therapist. I mean, even though he's, he's good and all that his still a male, you know, like, I don't know I just I just feel open and I hope that we have more diverse identities. In with mental health professionals because it really helps like even even for people who are assertive or open or brave sometimes it's

> tiring, you know, to just to push yourself to push yourself to talk and when you finally talk with someone that you share identity with, like the burden was just lift just that and it feels so comforting.

Earlier in the interview Farah shared that she was "tired of being brave," tired of advocating extensively for her mental health and reproductive needs and a desire for the systems she was in (e.g., hospitals, OBGYN, therapy) to be more thoughtful about the way they engaged with patients. In the quote above, she references this notion of being open, vulnerable, and brave and acknowledges the sense of relief and comfort which can occur when talking with and being in relationship with someone with a shared identity, in this case, even in a researcher-interviewee relationship.

### Institutional: On Feeling Fully Seen, Diagnosis, and Paperwork

Themes within the institutional factor demonstrated that Muslim women expected more exploration and inquiry from their therapists in regard to using paperwork to ask about their lived experience. Women also highlighted how hiring staff of color was impactful in seeing the university counseling center as a source of a support. Finally, women described the impact of limited resources around diagnosis at the center. Participants were both confused and grateful around completing paperwork which asked them to disclose about their identities and shared the impact of having an institutional advocate in the center when managing triggers occurring in the larger campus environment.

**Paperwork: “I kind of just assumed, oh it will come up."**

Zahra and Habiba both shared experiences in which they were required to disclose parts of their identities, including race, sexual orientation, and religion, on intake paperwork but were surprised and confused when therapists did not address these elements of identity with them during their course of therapy. For example, Zahra shared:

> My second therapist has like, done exceptionally little, to even been acknowledged my identity as a Latina. She's been very, like, every single time I say something, it's just from a white feminists perspective, I can't even, it just comes, it's textbook. It's literally textbook. And I just don't have the energy to even go into it. I just kind of... okay. And I think if she had even taken a moment, at the beginning of our sessions, to even ask a little bit about who I was, or even go over my papers, I don't even think she really went over my papers. Because *pause*  you know *sigh*, like, I don't know, did she even see, like some of the boxes that I was checking? Because if she did, I think she would know a little bit more about me. And it's. it's like, I've had I feel like I've had to mention to her, like, by the way, I'm Cuban American. Or by the way, I'm revert, and it's been a little uncomfortable.
>
> Alia : Yeah. So it seems like there was like a completely missed opportunity, even in the beginning to get to know who you were based on your paperwork.
>
> Zahra: I don't know what it is. I don't know if she just didn't take the time to even read through it. Or she just didn't ask. And there are, there are a lot of times that I just feel like she just doesn't ask.

Zahra's quote highlights the ways in which the role of the individual therapist in reading, conceptualizing, and asking clients about how their identity informs their worldview and lived experience, Specifically, even if a university counseling center system asks about identity during an intake, individual therapists may not be asking or reading this source of data. In this example, Zahra's frustration that her white therapist did not think more or ask about her identity as a Latina woman and a convert to Islam felt incredibly invalidating. The statement "she didn't even take the time to read through it" also highlights the ways in which individuals' therapists not reading client demographic paperwork before working with someone new can contribute to feelings of erasure within the therapeutic space. Moreover, Habiba shared a similar sentiment about completing demographic paperwork during an intake and then not having direct conversations about her sexuality in session. She shares:

> So the therapy experience that I talked about on the survey didn't touch on sexuality at all. Which is partially me not like explicitly bringing it up, but was a little bit confusing because on the intake forms they asked like one or two questions about sexuality. So I kind of just assumed like "oh it will come up."

As Habiba and I continued to talk, she shared that given how recent the assault had been, the focus of her treatment was around grounding, coping skills, and managing triggers. However, she also shared that as a gay woman her perpetrator being a man challenged her ability to process her sexuality. Both women shared feelings of frustration and confusion as to why the counseling center would ask about these salient parts of their identities if they were not going to follow up.

**Hiring and Training: "She gave me the sense of community I needed"**

Another institutional level factor and theme across participants was the importance of having women of color at the center. Having a therapist of color for participants supported identity development and a sense of community. Zahra and Sumaya shared explicitly about their experiences with women of color at the centers they sought services:

> And I was just like, I need other Black Muslim women specifically because I don't know what's going on. And I remember telling her this I was just like, I need community like I don't, I don't know how to explain how I'm experiencing this world correctly, because I don't have anyone else to compare it to, you know, I want to know about the experiences of other Black Muslim woman and I just don't know how to do that without looking like a creep and just like hitting up every Black Muslim woman that I know…..what I can say is she gave me the sense of community that like I needed afterwards…and I will forever be grateful for her in that aspect. (Sumaya)

> And so being able to actually have access to a woman of color, who can relate to questions that I had about identity, and all the things that I was thinking about at the time, she was just a very empowering person for me. (Zahra)

For both Zahra and Sumaya, sitting across someone who shared one or more of their identities, created an immediate sense of community. Zahra shares the notion of "relating" to questions about identity, and Sumaya shares having a Black Muslim woman therapist immediately gave her a sense of community and validation around if she was "experiencing this world correctly." Both of these quotes also highlight the importance of hiring therapists of color in effort to meet student activist demands of supporting students of colors lived experiences (the demands, 2016). However, Zahra also stated that shared racial or religious identity is not always enough. Zahra

stated that after her experience with the white therapist who “shat” on both her identities, she requested a reassignment. Unfortunately, the reassignment experience was unhelpful for her as she had been paired with a clinician of color who fundamentally disagreed with her politics. She described the situation stating:

> And after having such a poor experience, I decided to Google them, just to you know, see what they're about what I'm getting myself into. I just didn't want to be like retraumatized, I guess. And so after Googling that person, it turned out that they were, have, they had some social media posts being quite active about their involvement with pro-life movement. And like them actually being active in, in protesting and going to DC and stuff. And I was like, well, you all heard at my intake, what I've been through….I called the center again, and I said, "Why would you, why would you match me with someone, especially after I had discussed this as an area of concern and something I would like to talk about?" And, you know, I don't want to throw anybody under the bus and no mean, I think they ended up remedying the situation. But… [it felt like] they were just like, well, we need to put her with another woman of color, regardless of like, all the other intersecting points that that there was.

Zahra’s self-advocacy in the therapy room included asking for a reassignment after experiencing microaggressions from her white therapist to challenging the center around why she was reassigned to a clinician of color who did not share her values. Her story problematizes that simply hiring more staff of color will “fix” diversity concerns for students of color seeking care. Specifically, her story problematizes the notion that being paired with a clinician of color will automatically mean it is a good therapeutic fit and highlights how students of color must navigate institutional barriers on their own to get quality mental health care. Her story also

alludes to the emotional impact of needing to self-advocate to meet mental and sexual health needs (HEART, 2021).

**Diagnosis: "It's been a lot easier since I got diagnosed"**

Fatima, a biracial and queer Muslim woman, shared how a lack of training and education around diagnosis, particularly for women and individuals assigned female at birth, with ADHD and Autism impacted her mental health story:

> Um, I definitely wish that more of the staff at my college, not just in um, not just like at the health center, but like throughout the staff just had more awareness of what what aneurotypical people like look like. Because like I think if I've been diagnosed earlier in college, that would have helped me a lot. And I think like that would have made my experience a lot easier. Um, because um autism and ADHD in folks who are assigned female at birth tend to go undiagnosed because it doesn't fit the stereotypical presentation of what people think autism and ADHD are. And so like, so like, people end up feeling alienated for many, many years like a lot of women don't get diagnosed until they're in their 30s or 40s or even 50s sometimes. Because yeah, like a lot of times like like people who are assigned female at birth for autistic often get labeled as quirky or funny, like quirky or like, or spacey, or like those type of things, but like really, really struggling. Yeah, um, for a long time before I got diagnosed, I felt like, I really struggled a lot because I felt like, "Oh, people have friends and I don't" or like, you know, or I struggled a lot like making like friendships or like, um and it's been a lot easier since I got diagnosed.

Fatima's quote highlights how empowering it was for her to receive a diagnosis of both autism and ADHD and the ways in which she was able to make sense of her behavior, previously labelled "quirky" or "spacey", as a part of her mental health presentation. Given that many university counseling centers do not do formal diagnosis (Hodges, 2001) this quote from Fatima problematizes the role of not diagnosing at centers, and uplifts important scholarly literature that autism and ADHD maybe underdiagnosed and missed in clinical assessments especially for women (Quinn, 2005). As such, even though Fatima received mental health services at her university counseling center, the center--either because of a lack of expertise, training, or emphasis on diagnoses—was not equipped to support her through her diagnosis. She shared that it wasn't until after meeting a student and student organization which supported neurotypical folks with ADHD that she found support:

> So the way I got diagnosed is really, really interesting. Um, so, um, my last year of college I met someone who is autistic. They ran the neurodiversity society in our, in my college and was pretty active in the interfaith community. They were like, "Hey, I, I'm autistic. I'm not a I'm not a psychologist or anything, although I'm training to be, but I think you might be autistic." And they just said in a really nice way, and they said I autistic too and why he come to the Neurodiversity Association and come learn about it. And I was like, okay, so I stopped by at their meetings, and I just felt really like, welcomed and affirmed in the community. And they encouraged me to get diagnosed and they sent me like, resources and they were like, oh, here's people you can find to get diagnosed. So I just made an appointment with a neurologist and I got diagnosed.

Fatima's story of diagnosis again demonstrates the ways in which student-led organizations play a role in supporting students mental health, wellbeing, and sense of community on-campus

(HEART, 2021) and connect directly to principle 5 (encourage multiple networks of support via "third spaces."

Taken together, across the intrapersonal, interpersonal, and institutional domains, Muslim women navigate biases and assumptions within themselves, with others, and within institutions. As scholars in the past have highlighted, spirituality and religion are neglected dimensions of multicultural competency in psychology (Hage et al., 2006). As my participants share, faith and race, faith and sexuality, and faith and mental health status all impact women's experiences and ability to engage in therapeutic care. Therefore, clinicians must consider the ways in which they were socialized around their own religious practice and the faith journey, and/or how a lack of a faith journey impacts their willingness and ability to sit with clients who are committed to their faith in addition to how faith and race, gender, and sexuality intersect. In doing so, clinicians may consider reflecting on how anti-Muslim racism maybe internalized in their own consciousness as well as the consciousness of their Muslim clients. Furthermore, it is important for trainees, licensed mental health providers, and supervisors to consider the ways in which they have been socialized in learning, engaging, and working alongside Muslims as well as global and institutional messaging around who a Muslim is, what Muslims believe, and the ways Muslim identity development sits at multiple intersections.

**Connection to Nine Principles**

Interestingly, during interviews with my participants, I found the principles I created in chapter one came to life. For example, Farah described how living in both the United States and Indonesia as an international student challenged her sense of belonging to both lands and geographic areas (Principle 1). Similarly, Habiba shared that negotiating her Muslim identity as

an Egyptian-American woman was difficult given the ways Islam was practiced in both countries. Regarding principle two– racial differences within the Muslim community, Zahra, Sumaya, Habiba, Maha, and Fatima all shared how their racial identity impacted their therapeutic experiences as well as their experiences in the Muslim community. While Fatima navigated what it meant to be a biracial, white-passing queer Muslim woman, Zahra shared how it important it was for her to be in community with other Latina Muslims. Sumaya shared the impact of being a Black Muslim woman on campus and Maha shared how being a South Asian woman prevented her from connecting fully to her white supervisors at work. Principle three—honoring the caretaking roles of women was highlighted during an interview with Sumaya as she shared her experiences with me while also taking care of cousins at home. Principle 4—embodied faith and social justice activism of Muslim women was highlighted as Habiba shared about her creating a new campus organization for LGBTQ+ MENA individuals as well as Fatima's experiences organizing with the labor organization International Workers of the World. Principle 5—encouraging multiple networks of connection— was highlighted with Sumaya's participation in programming for Black Muslim youth, Fatima's connection to the organization Advocates for Youth, Farah's engagement with FITNA, Maha's virtual friendships with South Asian women on Tumblr, Zahra's relationship with Latinx Muslim organizations, and the solace and support Habiba found in virtual spaces for LBGTQ+ Muslims. Principle 6—challenging conditions of worth with scripture— was seen with Farah and Habiba's radical commitment to their faith regardless of conditions of worth from their community about not wearing hijab and being queer. Principle 7—utilizing trauma-informed principles came to life after realizing three out of six of my participants have experienced some form of sexual violence at least once in their life. Principle 8—engaging with feminist concepts such as tafsir of praxis was apparent in another

participants story related to needing support from the Muslim community around her decision to have an abortion and the lack of resources currently available which affirm this bodily choice. Finally, principle 9—emphasizing the ecological model in women's lives— was apparent given all the women interviewed were able to speak to positive and negative experiences within the social determinants of health framework during my interviews.

While it was validating to see the Muslim women I interviewed embodying elements of each principle— my research question was to describe women's experiences in therapy at university counseling centers. I briefly considered analyzing interviews through the framework of these nine principles, however, my research methodology stated I would look at women's stories through a SODH framework. Therefore, for my results and discussion sections, I chose to highlight themes across the SODH framework rather than the nine principles.

**Training-Specific Recommendations**

This study demonstrates there are several elements to Muslim women receiving culturally inclusive and culturally humble therapeutic services. Specifically, this study demonstrates how ecological factors, including internalized messaging about what it means to be a "good" Muslim woman, interpersonal microaggressions and cultural openings within the therapeutic relationship, and institutional policies and culture all inform women's experiences with therapy. Using these themes as well as my own doctoral experience as Muslim researcher and clinician as a guide, I provide five recommendations for the training community in counseling psychology to consider in supporting Muslim women clients and Muslim women trainees.

**Recommendation 1: recover historical memory of Islamophobia or anti-Muslim racism in clinical and training settings.**

Islamophobia can be defined as "a fear or hatred of Islam and its adherents that translates into individual, ideological and systemic forms of oppression and discrimination" (Zine, 2003). However, Rana and colleagues (2020) suggest the term Islamophobia frames discrimination as individual rather than systemic and structural. As such, they suggest reframing Islamophobia to anti-Muslim racism to reflect the intersection of race and religion more accurately. In doing so, they call for scholars, supervisors, and students to think critically about the history of anti-Muslim racism and connect this history to other forms of dominance such as slavery, settler colonialism, and white supremacy. Rana and colleagues have proposed an online syllabus #IslamophbiaisRacism as a pedagogical tool of resistance and an interdisciplinary launching point for scholars to engage with a core tenant of liberation psychology – *recovering historical memory* (Chavez et. al, 2016; Martin-Baro, 1994).

As a clinician, anti-Muslim racism has shown up as feelings of shame and ambivalence around Muslim clients and an emphasis of religious marginalization at the expense of racial exploration. Specifically, in working with a handful of Muslim clients during my clinical internship this year and reflecting on my doctoral experiences, I have seen anti-Muslim racism show up as feelings of fear of judgement, horizontal hostility and resentment (i.e. "they aren't the right kind of Muslim"), internalized shame (i.e. "you are making us "look bad"), tokenization (i.e. "I am the only one"), anti-blackness (i.e. "I didn't know the history of Black Muslims and Islam in the United States), and identity concerns particularly around spiritual doubt and separation-individuation (i.e. "I don't know who I am without this understanding of Islam" and "I do not want to practice this way anymore"), for both myself and my Muslim-identified clients. Similar to principle 2 (recognize racial differences in the Muslim community), my

recommendation to training programs is to center the intersection of race and religion and to utilize the #IslamophobiaIsRacism within multicultural education courses.

**Recommendation 2: problematize that harm is not possible in the therapeutic relationship**

As my participants and other scholar have highlighted, microaggressions occur within the therapeutic relationship (Nadal et. al, 2012; Okosi, 2018). Specifically, in this study microaggressions were related to assumptions about Muslim women and an erasure of spirituality as a form of strength. This finding is similar to Nadal and colleagues (2012) assessment that Muslim American participants experience microaggressions related to religious stereotyping, pathologizing the Muslim religion, and assumptions of religious homogeneity. Furthermore, as Mercedes Okosi (2018) highlights, racial microaggressions in therapy with people of color can also include condescension, invalidation, and ambivalence.

As a psychologist-in-training, I heard the sentiment "you can't do harm in therapy" from professors and supervisors alike. While I believe this comment was well-intended, I believe problematizing this comment is important in building a counseling psychology of liberation (Singh, 2020). Specifically, harm can and does happen within the therapeutic space as well as doctoral training programs. Therefore, educating students, and clinicians in and out of training, about the harm that has occurred historically and institutionally in the field of psychology as well as uplifting research such as Nadal (2012) and Okosi (2018) which is explicit and specific about harm which has occurred in therapeutic relationships maybe more useful approaches to training within counseling psychology curriculum, practicum, and internship seminars.

**Recommendation 3: discuss unique challenges working within intraethnic clinical dyads**

Currently, the scholarly literature addresses multicultural issues between White therapists and racial minority clients. As a full-time clinician during internship this year, I was excited to work with Muslim women clients and Asian-identified clients. However, I found working with clients with one or multiple shared identities posed far more challenges than I had anticipated. While I was eager to connect to Asian and Muslim-identified clients because of an "unspoken level of comfort" (Goode-Cross & Grim, 2016) I also found unique interpersonal dynamics arise with same-race clients and realized formal training around same-race dyads was missing from my doctoral experience.

Literature which does address same-race, or intraethnic therapist-clinician dyads, suggests transference and countertransference between these dyads can include issues of client's seeing the therapist as an omniscient-or omnipotent therapist who may take the form as a savior or folk hero in their community, client experiences of resentment and envy at the therapist's success or belief that the therapist has "sold out" of their cultural identity (Comas-Dias and Jacobsen, 1991). Similarly, therapists may overidentify when clients are of the same race, may experience anger or survivors' guilt, and may unconsciousness collude or engage in cultural myopia around the client's dysfunctional behavior. Internship was the first time I found Comas-Dias and Jacoben's article on intraethnic dyads, but I have been working with clients of color since my first training year. Therefore, it is important that additional research regarding clinicians of color working with clients of color continues and the limited research on intraethnic dynamics is highlighted earlier in doctoral programs.

**Recommendation 4: storytelling research as a cultural opening for trainees of color**

The finding of this study would not be possible without engagement from faculty members who were interested and able to support novel qualitative methods in the field of counseling psychology. It is important that qualitative work continue to be prioritized in scholarly literature around counseling and therapy services and research paradigms continue to challenge quantitative methods of understanding ourselves, our clients, and our students. While counseling psychology has made strides in integrating Consensual Qualitative Research (CQR) into this conversation, this *cannot and should not be the only method* by which young researchers, especially researchers from marginalized communities, should rely on.

**Recommendation 5: institutionally support novel qualitative methods**

Reflecting on my own experience around this recommendation is quite painful and frustrating as I think back to my relationship with my university's Institutional Review Board (IRB). In submitting this proposal, I found myself confused as to why my positionality as a Muslim woman researcher was questioned in protecting the "vulnerable" community I was studying. I naively believed my personal investment in this community would suggest I am not going to put this group at risk. While IRB was worried about re-traumatization and confidentiality concerns with my participants, my findings suggested there was a sense of relief talking with a Muslim-identified researcher. The "cultural openings" between myself and my participants, proved that being both an insider and outsider in community and identity-focused research can be a virtue of strength rather than a vulnerability in being stewards of people's stories (Chavez et al., 2016). As such, I hope that counseling psychologists continue to invest in novel qualitative methods and research processes such as non-confidentiality (Anderson & Muñoz Proto, 2016; Mosley et al, 2021), storytelling for social action (Block & Leseho, 2005),

and disrupting traditional boundaries between researched and researchers (Bhattacharya, 2007). My final recommendation therefore is to remain open, vigilant, and supportive of creative, novel, and non-traditional methods of data collection and storytelling in effort to center the experiences of clients and clinicians of color.

## Conclusion

University counseling centers can be one of the first entryways for students with limited access and income to reach therapeutic services. University counseling centers provide both institutional support to students via individual therapy, group therapy, assessments, and outreach programming as well as interpersonal support to marginalized students via affinity spaces, stigma reduction programming, and a sense of community. This is likely the first study to investigate Muslim women's experiences in individual therapy at university counseling centers. In creating space for women to share their stories about therapy, women shared both positive and negative experiences within their therapeutic relationships at their respective institutions. Specifically, they highlight the types of gendered and racialized microaggressions they experienced in therapy as well as ways in which the individuals and institutions they sought support were able to support them through difficult moments in their lives. Furthermore, this research was conducted with someone who identifies as both a Muslim woman and therapist. Therefore, continued scholarship on doing research within a marginalized community as a therapist-researcher and member of a specific community is recommended. Finally, further research on Muslim women's experiences in therapy should explore women's experiences in group and outreach programming at university counseling centers as well as Muslim women's experiences in non-counseling center settings.

## Statement of Positionality

Kovach writes "if research is about learning, so as to enhance the well-being of the earth's inhabitants, then story is research" (Kovach, 2009, p. 102). Stories have always played a role in my identity development as a Muslim woman, as a researcher, and member of multiple communities. Stories are the ways in which I learned about women in the Qur'an, stories are the ways in which I made sense of my family history, stories shaped the way I learned about social consequences in my family and Chicago Muslim community. Stories are also the way I approach my therapeutic work—remaining curious about the stories clients have internalized about themselves, have been fed by others, and must re-write to process trauma. My story is one that is unique in some ways— ordinary in many others. My entry to counseling psychology came because of the field's position around taking a developmental and preventative approach to wellness (Packard, 2008). Imagine my surprise when I began to engage with the field seriously as a first-year doctoral student and realizing how little has been done to address the various systems of oppression that influence communities of faith and the intersection of faith, race, gender, class, and sexuality. I was particularly surprised given the role faith plays in providing strength and support to many marginalized communities (Banerjee & Canda, 2007). Imagine my surprise when I realized how little story as research was considered legitimate in my area of interest.

While I appreciated the scholarship of individuals like Bonnie Moradi, Helen Neville, and Dawn Szymanski who address the ways in which sexism, racism, and heterosexism impact psychosocial functioning (Moradi & Subich, 2002; Szymanski, Kashubeck-West, Meyer, 2008; Thompson & Neville, 1999), I wondered about women of faith in the academy, why I wasn't reading them more frequently, and why the contributions of Muslims women scholars I engaged with in and outside of counseling psychology were not more actively highlighted in my

multicultural and advanced multicultural classes. I felt alone in my experience as a second-generation Pakistani-Muslim woman, and I felt disillusioned with the field I thought would be my new home.

Kovach calls remembering location, place, and space as "centering in context, place, and time" (p. 105). Where is home for me though? I am taken back to my roots in the Chicago suburbs—Orland and Tinley Park where my maternal grandfather taught Sunday school and I spent many summers as a child, the dinner table in Naperville where my family ate together before divorce, marriage, career moves, and Ph.D life changed paths for siblings and I, where my father encouraged us to critique and challenge our own epistemological assumptions when studying religion, and Bridgeview—where my maternal uncles would call for *halaqas* after dinner or after the *Magrib* prayer. Chicago is also my relationship with Nadiah Mohajir began, where I began to seriously confront the pain religion and religious teachers have had on the most marginalized of the Chicago-Muslim community. Chicago and HEART is also where I was introduced to Aisha Rahman, Shabana Mir, Madiha Lynn, Su'ad Abdul Khabeer, Hazel Gomez, Sheeren Yousuf, and several other teachers who introduced me to alternative ways of being in community and existing as a Muslim woman.

In 2018, I attended a racial equity and liberation gathering hosted by the Buffet Foundation program "Move to End Violence" a five-year program which aimed to bring together leaders in the reproductive rights movement and anti-sexual violence prevention world. It was here I learned about the three pillars of white supremacy --slavery/capitalism, genocide/colonization, and orientalism/war and how these pillars work together to unique maintain white supremacy intrapersonally, interpersonally, and institutionally in women of color organizing spaces (Smith, 2008). This framework has been helpful in helping me understand and

align my personal and political struggles as a Muslim woman in the academy by a) recognizing the ways in which I am impacted and have internalized white supremacy, b) acknowledging not all communities are not impacted in the same way and (c) liberation for some maybe in conflict with another group. I also began to appreciate and challenge more of my own language supremacy. I witnessed Navajo women introduce themselves in their native tongue and it is from their bravery and commitment to preserving language that I intentionally integrate words from Arabic and Urdu in this article. As such, my Pakistani heritage, my Western public-school education, and Islamic school education and experiences live and breathe in this document.

As an insider in the broader community of "Muslim women" my story and positionality bring with it considerable strengths. Specifically, the shared identity and assumption of solidarity in various parts of lived experience was an entryway in recruitment and rapport building during interviews. My own experience with therapy in a university counseling center were also used to ground participants in the relevance of the study and gave me an opportunity to model vulnerability and be in dialogue with my interviewees. However, as I wrap up my Ph.D my positionality also brough unique strengths which put me in an outsider role with participants. Specifically, this last year I have been doing clinical work full time as a doctoral intern at Emory University counseling center. This means that in addition to lived experiences as a Muslim woman I also brought in a level of perceptiveness around how the counseling center system is able to support and not support Muslim women and the ways in which unique factors such as inter and intra-racial countertransference and transference may have been at work for both my participants and their therapists as well as my participants and myself. This negotiation of both insider and outsider, as well as a sense of protectiveness and anger on behalf of my participants, was most saliently apparent when one of my participants expressed a desire to be removed from

the study. She stated concerns about a lack of confidentiality given how small the Muslim community is and a desire to protect her Muslim therapist from reading parts of our dialogue. Given my own understanding of how small and easily identifiable this participant and her therapist maybe in the world of Muslim mental health I chose not to include quotes about their relationship from the start. After my participant read how she was talked about she stated she was okay with staying in the data set. My insider knowledge around how small the Muslim mental health community in this case a useful research ethic was informed by my positionality. Similarly, several participants shared with me how "life-giving" it was to be able to speak with a Muslim woman researcher and therapist about their experiences. In some cases, I believe women used the space as a form of therapy, which brought up unique questions around the difference between qualitative research and therapy. In some ways, both qualitive research and therapy are guided by the client/participant and are supported via paraphrasing, reflection of content and feeling, and theory driven open-ended questions. My positionality as both a researcher (with my own goals and assessments around data) and a therapist (centered around healing via supporting clients in feeling seen and heard) intersected.

## Statement of Limitations

While there are a number of strengths to this research, this project is not without limitations. Specifically, the longitudinal nature of the study allowed for multiple data points and a rich body of quotes, insights, and relational dialogue between myself and participants. Given the time constraints of the project, I was only able to analyze data via the Health Campus framework around intrapersonal, interpersonal, and institutional barriers and facilitators to care at university counseling centers. Additional analysis around the role of community and policy may need to be completed at another time. Furthermore, while my positionality can be seen as a strength,

another Muslim researcher may interpret findings and data differently given their worldview and cultural experiences. Finally, the stories and narratives of these six women do not represent the entire Muslim community. Additional research on Muslim women's experiences is in therapy across treatment centers is imperative.

# APPENDIX A: RECRUITMENT EMAIL

Salam,

My name is Alia Azmat, I am a doctoral student in Counseling Psychology at Purdue University interested in Muslim women's experiences in therapy (**Protocol #2019-875**). Specifically, **the purpose of this research is to listen to stories of women over the age of 18** who have attended five or more therapy sessions with the same therapist in the last five years. For this study, you must have sought therapy at a university counseling center to be eligible. **All Muslim women are eligible to participate**. I would especially love to hear from Black, indigenous, Latinx, convert, Shia, Sufi, Dalit, and queer Muslim women. I am looking for folks to speak on both positive and negative therapy experiences. My hope is to listen, affirm, and give women a space to speak directly to the mental health training community about what Muslim women have appreciated and what Muslim women would like to see changed in the mental health system and university counseling center system.

*NOTE:* Participation in this survey is voluntary. It is possible that you complete the pre-screening survey and are not selected to participate. If selected to participate you are eligible to be compensated a total of $75. If you or anyone you know is interested in participating please complete the pre-screening survey
here: https://purdue.ca1.qualtrics.com/jfe/form/SV_b7uuzvBGYweTcvb

Please feel free to reach out to me (Alia Azmat – aazmat@purdue.edu) or my advisor (Dr. Ayse Ciftci – ayse@purdue.edu) directly with any questions or concerns.

Warmly,
Alia (she/her/hers)

# APPENDIX B: CONSENT FORM

**RESEARCH PARTICIPANT CONSENT FORM**

**Muslim Women's Experiences in Therapy**

Alia Azmat & Ayse Ciftci, Ph.D
College of Education
Purdue University

**Key Information**

Please take time to review this information carefully. This is a research study. Your participation in this study is voluntary which means that you may choose not to participate at any time without penalty or loss of benefits to which you are otherwise entitled. You may ask questions to the researchers about the study whenever you would like. If you decide to take part in the study, you will be asked to sign this form, be sure you understand what you will do and any possible risks or benefits. This study is to help understand positive and negative experiences in therapy. Specifically, we are interested in hearing from Muslim women who sought therapy at their university counseling centers to share their experiences in therapy. This study will take place over a minimum of six months. If selected for this study, you will participate in individual reflective writing and oral interviews with one of the researchers (Alia Azmat).

**What is the purpose of this study?**

The purpose of this study is to understand Muslim women's experiences in therapy at college counseling centers.

**What will I do if I choose to be in this study?**

Below is a link to a pre-screening survey to assess your eligibly in this study. If you are selected to participate in this study, you will be required to complete two pre-interview reflective writing prompts and two 60-75 minute interviews. The first pre-interview prompt will ask you to complete diagram about your life. Interview one will review the diagram and your life experiences. The second pre-interview worksheet will include five reflective journal prompts. You must complete the journal prompts prior to our second interview. The second interview will focus on your experiences in therapy and your university counseling center.
***Competing this pre-screening survey does NOT guarantee participation.***

**How long will I be in the study?**

If selected to participate, you will be in this study for approximately six months to a year. During the first six months, you will be asked to reflect on your personal experiences at home, with friends, with family, and at the university. You will also be asked to reflect on your relationship with your therapist when you sought psychotherapy. These pre-interview activities will take approximately two hours. Moreover, within the first six months you will participate in two interviews about your experiences. Each interview will be 60-75min in length. After six months, researchers may follow up with you with clarifying questions and a summary of your responses. Reviewing your responses will take approximately 30min to an hour.

**What are the possible risks or discomforts?**

There is a risk of emotional discomfort associated with specific questions or topics that are raised through the questionnaire. You will be asked to rate on a scale of 1-5 how comfortable you are sharing your story in person after writing and reflecting in the pre-screening survey. If selected to participate, I will include a mindfulness exercise at the end of the pre-interview 1 and pre-interview 2 reflections. Furthermore, I (Alia Azmat) am a qualified mental health clinician who will be able to support you should you become triggered during the interview. I am happy to stop an interview and provide resources during and after our conversations. Finally, data collection will be done over two interviews to minimize distress in sharing your story all at once. Breach of confidentiality is always a risk with data, but we will take precautions to minimize this risk as described in the confidentiality section.

**Are there any potential benefits?**

You will have an opportunity to share grievances about health-care experiences that you may or may not have communicated to others. Benefits to sharing your story may include catharsis, empowerment, and the ability to re-write your personal narrative related to health and wellness. You will be a part of a novel project to reduce mental health stigma in the Muslim community and cultural humility in the non-Muslim community. Finally, data from this study may support psychoeducation of university counseling center staff.

**Will I receive payment or other incentive?**

You will NOT be compensated for taking the pre-screening questionnaire at the end of this document. Payment begins after you are selected by the study personnel to participate. You are eligible for a total of $75 in compensation for your time, energy, and commitment to the study. You will receive $30 via an Amazon gift card after completing pre-interview one and interview one. You will receive $45 after completing pre-interview two and interview two. If you decide to withdraw from the study after interview one you will not be eligible to receive $45.

**Are there costs to me for participation?**

Anticipated costs to participating in this research study is potential re-traumatization while sharing stories about your life and your experiences in therapy.

**This section provides more information about the study**

**What happens if I become injured or ill because I took part in this study?**

If you feel you have been injured due to participation in this study, please contact Dr. Ayse Ciftci (ayse@purdue.edu) or Alia Azmat (aazmat@purdue.edu).

Purdue University will not provide medical treatment or financial compensation if you are injured or become ill as a result of participating in this research project. This does not waive any of your legal rights nor release any claim you might have based on negligence.

**Will information about me and my participation be kept confidential?**

Data gathered online will be downloaded to restricted access directories. Only the research team will have access to these data. Names and email addresses will be collected in order to follow-up for interview scheduling and pre-interview assignments. This identifying information will be associated with the data collected through the online survey.

The interviews will be audio-taped and transcribed. Researchers will remove identifiable information, and assign each participant a pseudonym. Data will be de-identified during transcription including names of individuals, universities, and graduate programs, and replaced with general terms. The data will be stored in a password-protected electronic file in restricted access directories and only the key research personnel will have access to it. You also have the option of not remaining anonymous. If you would like your name and institutional affiliations to be identifiable to others, you may select this option at the end of this document.

**What are my rights if I take part in this study?**

If you agree to participate, you may withdraw your participation at any time without penalty. You do not have to participate in this research project.

**Who can I contact if I have questions about the study?**

If you have questions, comments or concerns about this research project, you can talk to one of the researchers:

| | |
|---|---|
| Ayşe Çiftçi, Associate Professor of Counseling Psychology and Educational Studies | ayse@purdue.edu |
| Alia Azmat, Doctoral Student, Educational Studies | aazmat@purdue.edu |

To report anonymously via Purdue's Hotline see www.purdue.edu/hotline

If you have questions about your rights while taking part in the study or have concerns about the treatment of research participants, please call the Human Research Protection Program at (765) 494-5942, email (irb@purdue.edu) or write to:
Human Research Protection Program - Purdue University
Ernest C. Young Hall, Room 1032
155 S. Grant St.
West Lafayette, IN 47907-2114

**Documentation of Informed Consent**

I have had the opportunity to read this consent form and have the research study explained. I have had the opportunity to ask questions about the research study, and my questions have been answered. I will be offered a copy of this consent form after I sign it.

I am prepared to participate in the research study described above.

I am eligible to participate in this study because I meet the following requirements:
a - I am above the age of 18
b - I identify as a Muslim woman
c - I have had therapy experiences at a university counseling center

A. I meet all of the requirements above
B. I do not meet all of the requirements above

# APPENDIX C: PRE-SCREENING SURVEY

1. You have the option of remaining anonymous in this study. Please select the option you feel most comfortable with at this time:
    a. I would like to participate in this study anonymously. I do not want my name or the university I am/was affiliated with to be included in the final write up of this project.
    b. I am uncertain if I want to participate in this study anonymously. Please check-in with me about this during the final write up of this project.
    c. I would like my name and institution to be used in this study. I want my name and the university I am/was affiliated with to be included in the final write up of this project.
2. What is your age?
3. Do you identify with a sect of Islam? If yes, which one?
4. What is your gender identity?
5. What is your generational status? (i.e I was born in the United States, I immigrated to the US before the age of 18; I immigrated to the US after the age of 18)
6. What is your racial identity?
7. What is your sexual orientation?
8. On a scale of 1-10 (10 being “very important”, 1 being "not very important") how important is religion in your life?
9. *This section is about you identity and experiences in therapy. Please reflect on single and multiple experiences you have had with therapeutic services and write as little or as much as you would like around the following:*
10. Have you attended at least five psychotherapy sessions with the same therapist in the last five years?
    a. Yes
    b. No
11. Where these sessions through a college or university counseling center?
    a. Yes
    b. No
12. Was this your first therapy experience?
    a. Yes
    b. No
13. Are you/were you an international student at the time of seeking services? If so, please write about how this impacted your experience in therapy. If you do not believe it impacted your experience, please denote that below.
14. Are you/were you a first-generation student at the time of seeking services? (i.e first person in your immediate family to receive a 4-year degree). If so, please write about how this impacted your experience in therapy. If you do not believe it impacted your experience, please denote that below.

15. When did you convert to Islam? (write N/A if not applicable) Please write about how this impacted your experience in therapy. If you do not believe it impacted your experience, please denote that below.
16. *The next section will require you to reflect and write about your identity and two specifics experiences in therapy. Please reflect on the experiences you had at your university counseling center*
    a. Please describe one POSITIVE experience you had in therapy. Talk specifically about how your therapist WAS able to attend to ONE OR MULTIPLE ASPECTS of your identity in the room.
    b. Please describe one NEGATIVE experience you had in therapy. Talk specifically about how your therapist was NOT able to attend to ONE OR MULTIPLE ASPECTS of your identity in the room.
17. On a scale of 1-5, how comfortable were you WRITING about your positive and negative experiences?
    a. 5 – extremely comfortable
    b. 4 – somewhat comfortable
    c. 3 – neither comfortable nor uncomfortable
    d. 2 – somewhat uncomfortable
    e. 1 – extremely uncomfortable
18. On a scale of 1-5, how comfortable were you writing and reflecting about YOUR IDENTITY throughout the questionnaire?
    a. 5 – extremely comfortable
    b. 4 – somewhat comfortable
    c. 3 – neither comfortable nor uncomfortable
    d. 2 – somewhat uncomfortable
    e. 1 – extremely uncomfortable
19. On a scale of 1-5, how comfortable do you imagine you will be sharing these experiences ORALLY face to face on a virtual platform?
    a. 5 – extremely comfortable
    b. 4 – somewhat comfortable
    c. 3 – neither comfortable nor uncomfortable
    d. 2 – somewhat uncomfortable
    e. 1 – extremely uncomfortable
20. Please leave your contact information (name, email, phone number)
21. What is the best method of contacting you?
22. You will be notified in 2-3 weeks if you are eligible to participate in the full study. Thank you very much for your time and energy on this brief questionnaire <3 Your responses will not be recorded until you click the arrow below.

# APPENDIX D: PRE-INTERVIEW SURVEY 1

Thank you for your participation! During the first part of this interview, we will focus on **interpersonal and institutional** levels of your therapy experiences. Specifically, I would like to hear about your experiences within the university counseling center system and your relationship with your therapist. To help us prepare for the interview, I have a few questions I would like you to reflect on before we schedule a time to talk.

1. What is your name
2. How did you learn about mental health services at your college/university counseling center?
3. Describe your first experience interacting with the university counseling center staff. Who were your first points of contacts at the center?
4. Describe what brought you to therapy. What was going on in your life at the time of seeking-services?
5. Describe how you were assigned your therapist. Were there identity factors you had requested to see in your therapist?
6. Describe the therapist(s) you saw at the university counseling center. How many sessions did you attend? How long did you attend? What was the racial and gender identity of your therapist?
7. What you think your therapist did well? What you think they could have done better?
8. Describe the center you sought services. Where on campus was it? Consider elements of space such as accessibility, location/distance, and décor in the center.
9. What you think the center did well? What do you think your center could have done differently to support your needs?
10. Describe any additional therapy experiences (counseling center or non-counseling center) you would like to talk about when we meet.
11. This completes the survey. Would you like to participate in a mindfulness exercise to end this survey experience?
    a. Yes
    b. No

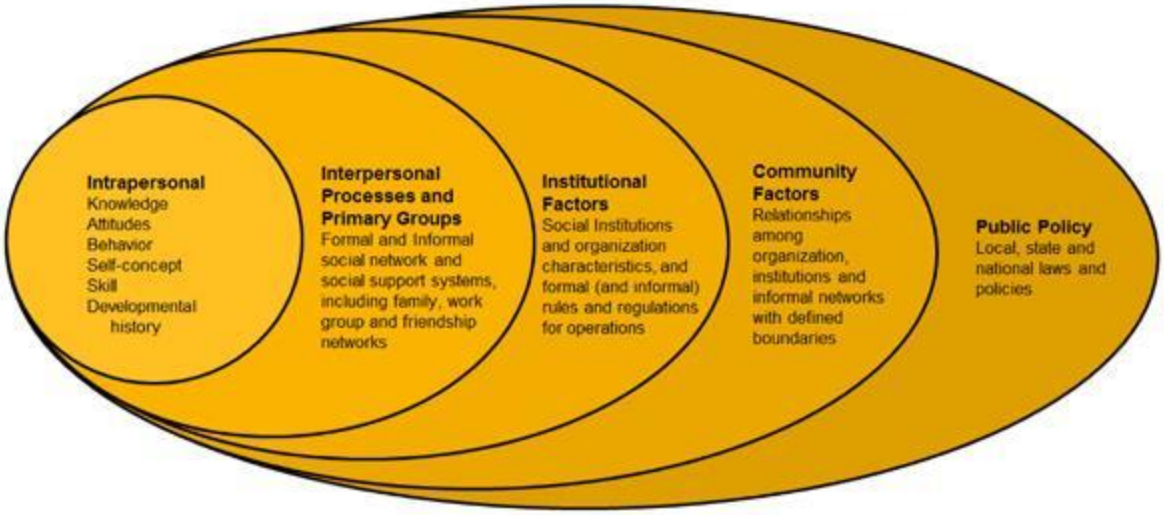
# APPENDIX E: INTERVIEW 1

1. Tell me a little bit about yourself and your interest in participating in this study.
2. What was it like to reflection on previous therapy experiences?
3. Which therapy relationship was most meaningful to you and why?
4. What had you heard about the center prior to seeking services?
5. How did your racial and gender identity impact the relationship with your therapist?
6. How did your faith identity influence the relationship?
7. How did your therapists racial and gender identity influence the relationship?
8. How did your therapist's faith identity influence the relationship?
9. What did conflict in the relationship look like?
10. How did you resolve conflict in the relationship?
11. What do you think your therapist did well?
12. What do you think your therapist could have done better?
13. What do you think the center you sought services did well?
14. What do you think the center you sought services could have done better?

# APPENDIX F: PRE-INTERVIEW SURVEY 2

Thank you for your continued engagement. The second part of this study looks at factors contribute to Muslim women's mental, emotional, physical, and spiritual well-being. Often these experiences come from multiple people, spaces, and environments. In this survey you will be asked to reflect on individual, social, organizational, community, and policy factors which have impacted your health.

Remember: there are no right or wrong answers to the questions, write what comes up for you! Once all of your responses have been recorded, I will follow up with you to schedule an interview so I can hear more about your thoughts!

1. I'd like you to think about your mental, physical, and spiritual health. How do you define each? Are they all connected? Brainstorm and write your thoughts below .
2. Below is a diagram that identifies five levels of engagement or factors in our environment. I would like you to read and review the definitions of each of the factors. Think about the factors you feel particularly connected to. What stories, events, and experiences come to mind?
3. 

4. **In the next section, each factor will appear as a question.** Write a sentence or brief paragraph about how this factor has influenced your health. Do your best.
    a. Talk about a time in which INTRAPERSONAL (knowledge, attitudes, behavior, self-concept, skill, developmental history) engagement contributed POSITIVELY to your health. For example: I have a positive self-concept that God wants me to be Muslim and that God is with me. I think that has helped me stay connected to religion on my own even when other people think I don't practice the "right" way
    b. Talk about a time in which INTRAPERSONAL (knowledge, attitudes, behavior, self-concept, skill, developmental history) engagement contributed NEGATIVELY to your health. For example: My depression triggers a lot of hopelessness and negative self-worth.

c. Talk about a time in which INTERPERSONAL (formal and informal social network and social support systems including family, friends, work groups, and friendship networks) engagement contributed POSITIVELY to your health. For example: My friend group in college was very supportive and helped me get through some difficult times.
d. Talk about a time in which INTERPERSONAL (formal and informal social network and social support systems including family, friends, work groups, and friendship networks) engagement contributed NEGATIVELY to your health. For example: Fear of judgement from my family prevents me from opening up to them about my life and mental health
e. Talk about a time in which INSTITUTIONAL (social institutions and organization characteristics, and formal and informal rules and regulations for operations) engagement contributed POSITIVELY to your health. For example: There was a Muslim woman on staff at the counseling center. The center was also very open to connecting me to resources outside of campus within my budget when I could no longer see her.
f. Talk about a time in which INSTITUTIONAL (social institutions and organization characteristics, and formal and informal rules and regulations for operations) engagement contributed NEGATIVELY to your health. For example: My counseling center only gave me 6 sessions a semester. I felt like we didn't go very deep because of that limitation
g. Talk about a time in which COMMUNITY FACTORS (relationships among organization, institutions, and informal networks with defined boundaries) contributed POSITIVELY to your health. For example: My professor was adamant that I call the counseling center on campus. She did not let me leave her office until I phoned them.
h. Talk about a time in which COMMUNITY FACTORS (relationships among organization, institutions, and informal networks with defined boundaries) contributed NEGATIVELY to your health. For example: I did not know who to talk to after my assault. My friends were supportive but I feared talking to them about my experience.
i. Talk about a time in which POLICY (local, state, and national laws and policies) contributed POSITIVELY to your health. For example: My home state of Illinois passed a law making marijuana legal
j. Talk about a time in which POLICY (local, state, and national laws and policies) contributed NEGATIVELY to your health. For example: I am an undocumented student so finding financial resources to support my education was always a challenge.

5. This completes the writing and reflection portion of the survey. Would you like to participate in a mindfulness exercise to end this survey experience?
    a. (Yes! I am interested)
    b. (No, thank you.)

# APPENDIX G: INTERVIEW 2

1. How was it to review your interview transcript? What came up for you as you read back your story?
2. Is there anything you have been thinking about since our last interview? How has your life changed or stayed the same?
3. I read your response to the first response…. tell me a more about [mental, spiritual, physical health response]
4. I read your response to intrapersonal factors…tell me more about… [intrapersonal response]
5. I read your response to interpersonal factors…tell me more about… [interpersonal response]
6. I read your response to institutional factors…tell me more about… [ institutional response]
7. I read your response to community factors…tell me more about… [community response]
8. I read your response to policy factors…tell me more about… [policy response]
9. Is there anything else you would like to share with me?

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