Issues to Consider When Engaging
Muslim Youth in Psychiatric Care
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This document was developed by Allan Chrisman, MD, Co-Chair of AACAP's Disaster & Trauma Issues Committee, and Balkozar Adam, MD, member of AACAP's Diversity & Culture Committee, along with Farha Abassi, MD, Faculty, Muslim Studies Program, Michigan State, and Zainab Malik, MD, Resident, Duke Psychiatry Residency Training Program. The Disaster & Trauma Committee and Diversity & Culture Committee were involved in reviewing this document to ensure that the importance of cultural sensitivity was appropriately communicated.

Introduction:

Muslim youth in the United States are a heterogeneous population with varying backgrounds, experiences, and needs (1). African American Muslims comprise an often-overlooked part of Islam in America. A sizable minority — 15 to 20 percent — of those brought to the Americas as slaves originated from the Muslim-dominated nations of West Africa (2). Many Muslim youth are the children of immigrants who have adopted American cultural practices, while others are themselves recent immigrants who know little about this country and even less about U.S. cultural norms. Historically, both have been marginalized.

About two-thirds of the Muslims in the United States today (64.5%) are first-generation immigrants (foreign-born), while slightly more than a third (35.5%) were born in the United States. By 2030, however, more than four-in-ten of the Muslims in the United States (44.9%) are expected to be native-born. Children under the age of 15 make up a relatively small portion of the U.S. Muslim population today. Only 13.1% of Muslims are in the 0-14 age category. This reflects the fact that a large proportion of Muslims in the United States are newer immigrants who arrived as adults (3). In the next few decades, the Muslim population is expected to grow rapidly, reaching nearly 2.8 billion worldwide by 2050 (4). One survey showed that the majority of American Muslims are of middle-class socioeconomic status. Many are integrated into the mainstream of their communities and well educated, though a growing number are refugees, and a significant segment are underserved (5).

In order to provide best treatment and care, clinicians need to understand the cultural and religious background of a Muslim patient. For example, although religious adherence can vary greatly, Muslims typically observe, or at least recognize, the five pillars of Islam. These include 1) the belief in one God and the prophet Mohammad as His messenger, 2) praying five times a day, 3) fasting during the month of Ramadan, 4) giving charity, and 5) making the pilgrimage to Mecca. Almost two-thirds of Muslims report praying daily, and about half stated they pray all five prayers daily (6).

Muslim American youth, whether immigrant or second-generation, typically develop a hybrid cultural identity. Consequently, they will often blend or mix different aspects of mainstream American culture with the ethnic/cultural features from their country of origin i.e. some Muslim women wear makeup underneath their hijab. This is not typically obvious so sensitively asked questions should help clarify these multi-cultural features in addition to the degrees of religious adherence. This complexity of the hybrid multicultural identity makes it difficult for the clinician to be readily informed. Thus, this document has had to rely on such a diverse set of sources for the

information. Hopefully this will counteract the stereotypes which have been so widely promoted by various forms of media.

Never has the spotlight shone so brightly on Muslim youth in America. In the wake of the tragic attacks of Orlando, San Bernardino, and Boston, American Muslim youth are feeling intense scrutiny. Many Muslim youths have expressed a wide range of emotions: fear, confusion, anger, and melancholy. Now more than ever, clinicians must understand the religious and cultural backgrounds of Muslim patients in order to properly treat them.

The concept of Jihad has catapulted to the forefront after 9/11. While commonly translated as "holy war," this is an incorrect translation. Jihad actually means "to struggle" - a struggle to be kind, a struggle to be a good neighbor, a struggle to be a good citizen. War and fighting are actually a small part of Jihad. Even some Muslims do not understand the correct translation of Jihad, which is particularly apparent in the post-9/11 world. Islam has a clear and definitive prohibition against killing innocent people.

Many Muslims consider Islam a religion and a way of life. Islam spells out moral, ethical, and social justice standards that Muslims should follow, such as equality of race and gender and aiding the poor. In addition, Islam prohibits the use of recreational drugs, alcohol, and sexual contact outside of marriage. Tension within the family often occurs when youths do not observe these teachings, particularly when their parents are strict adherents. These differences may impact issues in treatment. Regardless of any differences between Muslim youth and their parents, some Muslims across generations and religious practices have expressed a concern that some non-Muslim clinicians do not have a firm understanding and awareness of Islam or a respect for Muslim beliefs and values (7).

Principles for working with Muslim patients

Principle 1: Clinicians should consider and address language/communication barriers for Muslim youth who seek psychiatric care.

Muslims around the world are from diverse backgrounds. Muslims have reached the 1.6 billion mark in the world population, spanning approximately 50 predominately Muslim countries and 5 continents. They are a diverse group from many different ethnic backgrounds speaking many languages. This reinforces the importance of the translator, interpreter, and cultural consultant when interacting with this population in psychiatric care. Consequently, as recommended in AACAP's Practice Parameter for Cultural Competence in Child and Adolescent Psychiatric Practice, "Clinicians should obtain linguistic support through qualified interpreters or possess demonstrable proficiency in the target language. Language brokering, the common practice of having children act as interpreters between parents and medical and school authorities, should be avoided, particularly when the patient is the language broker" (8).

Principle 2: Clinicians should learn about the importance of acculturation and immigration status of Muslim youth.

Acculturation, or the transition to adapting to a new culture's behaviors, values, customs, and language, is an adaptive developmental process but can be a source of stress for some Muslim youth and their families. Additionally, acculturation will have an effect on the developmental task of identity, which is crucial to mental health outcomes (9).

Because of diversity within the Muslim population, it is important that clinical understanding and strategies for the care of Muslim youth vary in accordance with the particular client. For example, some Muslim youth arrive in the United States as children, others as adolescents, and still others are born in the United States. It is essential to use a developmental approach to understand how

these differing cultural backgrounds and experiences may be contributing to current adjustment and presenting problems. The more recent the immigration, the greater the risk of acculturative stress.

This stress is associated with discrimination, stereotyping, racism, marginalization, and prejudice. Discrimination can be institutional, i.e. in schools, or occur with implicit bias (9,10). These challenges contribute to mental health difficulties.

Many Muslims are refugees who came to the United States to escape ethnic, cultural, or religious persecution, civil war, and international conflict. Other Muslims emigrated to the United States in search of economic and educational opportunities, to reunite with family, or to join a growing ethnic community (11). Despite their common Islamic religion, Muslim immigrants vary in religious affiliations, e.g. Sunni, Shi'ite, Sufis, Bahai'is. These differences result in different religious practices (5). Approximately half of the Muslim immigrant population and their children in the United States identify as Sunni Muslims, with 22% not identifying with a particular sect, and 16% identified as Shi'ite Muslim (11). Knowledge about why the client or client's family may have come to the United States and his or her expectations is important to a comprehensive intake assessment, which can inform treatment planning.

Adolescents from immigrant families often blend their family's cultural practices with that of their new community, creating a unique cultural viewpoint and set of practices (12). Recent studies have shown that Muslim-American youth often have a hyphenated sense of identity, with both American and Muslim identities differing in degrees at home and in the mainstream community (13). This may contribute to acculturation stress.

There is a deeply rooted stigma of mental illness and its treatment in the Muslim immigrant community. This is compounded with a cultural mistrust of the Western mental health system. Thus, there is an underutilization of mental health services, leaving many members of the Muslim community to live with untreated mental health conditions that not only impact themselves, but also impact their family and the larger community (11,15).

Principle 3: Clinicians should recognize culture-specific stressors experienced by Muslim youth and avoid negative stereotypes.

American Muslims have fallen victim to increased and even extreme prejudice and discrimination following 9/11. As Islamic extremism attracts increasing attention, they remain under the strain of harassment, hate crimes, and negative perception from many of their peers and colleagues. There have been reports of bullying at school, attacks on Muslims' place of worship (mosques), and attacks on women wearing hijab (15). This has contributed to the further marginalization of Muslims and has adversely affected their access to care. Such "Islamophobia" (not a psychiatrically identified phobia) has contributed to health disparities among American Muslims (16). For example, Muslims and even non-Muslims who look to be Arab or from South Asia have been viewed as threats, some even arrested on terrorism-related claims with scant or no evidence (17). This has resulted in anger among some Muslim youths and confusion among others. Clinicians need to be aware of such dissonance and must explore social, religious, cultural factors when assessing Muslim youth patients. In addition, this discrimination against American Muslims is perceived by some as justifiable as "collateral damage" of war on terror (18).

This discrimination puts Muslim youth at a greater risk for depression, high distress, low self-esteem, and alienation (19). Some Muslims have reported that they no longer felt safe or wanted in the United States. As a result, they may have difficulty acculturating. They also reported difficulty in trying to reconcile what they see as contradictory identities (20).

For African American Muslims, who are the largest percentage of native-born Muslims in the United States, (21) there is a complicated intersectionality of multiple discriminatory and traumatic factors. Black youth ages 12 to 19 are victims of violent crime at significantly higher rates than white youth, as reported by the U.S. Department of Justice. Black youth are three times more likely to be victims of reported child abuse or neglect, three times more likely to be victims of robbery, and five times more likely to be victims of homicide, (22) with homicide being the leading cause of death among African American youth ages 15 to 24 (23). Institutional racism is evidenced by African-American youth being disproportionately profiled, policed, arrested, and incarcerated (24). There are higher rates of juvenile incarceration, with one in three African-American men going to prison in their lifetime (25), where there is a high rate of conversion to Islam. They also face racism by some immigrant American Muslims, directly in the form of name-calling (*"abeed"* or "slaves") or indirectly by assuming the person has limited knowledge of Islam based on their skin color (1). These complex forms of historical and current community-based trauma pose unique challenges to the mental health clinician. A trauma-informed, multicultural perspective, often provided by specialized centers or multidisciplinary teams, is needed for such care. Consultation that addresses treatment-resistant care is frequently required.

This youth exposure to victimization is directly linked to negative outcomes for young people, including increased depression, substance abuse, risky sexual behavior, homelessness, and poor school performance. Youth victimization increases the odds of becoming a perpetrator of violent crimes, including felony assault and intimate partner violence, doubles the likelihood of problematic drug use, and increases the odds of committing property crimes (22).

One benefit of the spotlight on Islam and Muslims has been that it has piqued people's curiosity. While some have taken steps to learn about the religion and not succumb to stereotypes, unfortunately the average person knows very little about Muslims (6).

Principle 4: **Clinicians should demonstrate humility and respect when they address cultural differences in clinical encounters with Muslim youth.**

Mental illness stigma can be more complicated for those from racial and ethnic minority groups. The concept of "double stigma" occurs when both prejudice and discrimination are caused by an individual's racial identity and their mental illness. Here Muslim youth experience an intersectionality of complex relationships between different identities (e.g., race, gender, sexual orientation, class, and disability) (16).

Discrimination, a behavioral component of stigma, against Muslim minority groups has continued to increase since 9/11 and the war on terrorism. Some members of the public believe that prejudice against the Muslim community is justified (14).

Muslim immigrants are more likely to look to their religion for healing (11,26). Thus, it is critical for the mental health care provider to be able to give the client the option of integrating religious and traditional healing practices into the therapeutic process. This may involve the mental health care provider collaborating directly with local religious or traditional healers and acquiring knowledge about traditional healing practices common in the immigrant client's culture (27,28,29).

Ethnic minorities are sometimes thought not to access particular health services because of religiously based explanations of illness or disability that the family believes [16]. However, not accessing health services can also be related to parents' poor economic status and an associated lack of access to appropriate services for their children, compounded by the fear of being misunderstood by "out-group professionals." (16).

Muslim immigrants may question the intention of the counselor, believing that the non-Muslim and American mental health counselor lacks an ability to understand the cultural and religious context in

which they live. They may then fear that a counselor may steer the individual in the wrong direction or encourage them to take action that may be in conflict with their values and belief system (11).

Principle 5: Clinicians should understand the dynamics of the parent-child relationship and family characteristics that contribute to both strengths and vulnerabilities of Muslim families.

One of the most important features of Muslim society is the family. The family unit is regarded as the cornerstone of a healthy and balanced society. The family forms the basic building block of Muslim society. Despite the many pressures it faces, the family institution remains strong. The future of the extended family, however, is under considerable threat. Traditionally, family structure has been closer to the extended, rather than the nuclear, model. This is the result of continuity and not the outcome of innovation by Muslims (30).

Thus, clinicians should not be surprised if multiple family members attend sessions. Some are there for linguistic support, and others may be there for emotional support and to help the patient make treatment decisions (28,31). It is imperative, however, that clinicians speak to the patient alone to understand if he or she wants the other family members there or is agreeing only out of a sense of obligation. Some patients may have adopted more Western attitudes regarding individuality and/or may not want other family members knowing they are not practicing Islam.

Traditional Muslim values emphasize the importance of both the immediate and extended family. There also is a focus on being loyal to parents and respecting elders and authority. Many Muslim youth experience dissonance as they struggle to find the balance between their "Muslim" values and "American" values. There often is a marked difference between immigrant parents and second-generation youth. The parents are accustomed to having extended families to help in the child rearing and are likely to have family members live with them. They often struggle once they are in the United States without the support of extended family. Discipline, religious adherence, household values, and freedom of expression often arise as sources of conflict (11).

Many Muslim parents view their role as assisting their children in navigating American culture and values. Many families would prefer to seek support from other family members, the community, or religious leaders for their child's mental illness to avoid the stigma of mental illness.

Unlike cancer or diabetes, a mental health diagnosis has a negative connotation, and the decision of how to treat mental illness can split families. Different family members, especially of different generations, may view mental illness as a personal shortcoming or even the result of evil spirits. This could delay or even prevent families from seeking treatment or taking medication. As such, clinicians may need to get family buy-in to ensure adherence with treatment. They also may need to spend more time with their Muslim youth patients.

American Muslim families are also moving away from the more traditional patriarchal role of men. As first and second-generation women become well-educated, high achievers, and self-reliant, they are assuming equal roles within the family, which is consistent with the Islamic view that women are equal to men.

Principle 6: Clinicians should appreciate the role of intra-cultural coping in Muslim youth.

Cultural influences on presentation of symptoms and mental health problems need to be considered. Due to the lessened stigma of physical symptoms, as well as cultural idioms revolving around the physical body, mental health problems are often expressed as physical symptoms. In parallel, explicit mood symptoms such as hopelessness, self-deprecatory thoughts, and worthlessness are uncommon; in particular, women ultimately diagnosed with depression

frequently first present with physical symptoms and no self-recognition of psychological distress or sadness (14).

Normative cultural beliefs in existence of Jinn (evil, Satan-like spirits) may be confused with delusions of possession and control, and this may prevent patients and family members from recognizing medical or psychiatric problems (14).

Because of concerns with social standing, many researchers report that disclosure of mental illness is considered "shameful." Significant cultural differences within Muslim communities with respect to gender may put women at an especially high risk of shame for their family if they receive a diagnosis and treatment of mental health problems (14). This is not in line with Islamic teachings and is instead remnant of cultural practices. Muslim women may avoid sharing personal distress or seeking help from counselors due to fear of negative consequences with respect to marital prospects, or their current marriage.

The possibility that cultural normative beliefs may be mislabeled or unidentified due to cultural insensitivity also needs to be addressed — particularly because such mislabeling may lead to both the unnecessary stigmatization of those who, in fact, do not have psychiatric problems and the failure to help individuals who do need it (14).

Mental illness may also be perceived as a test or a punishment from God. In Muslim culture, belief in *Qadr*, or destiny, is strong. While *Qadr* may lead to fatalism in some cases, it also suggests positive acceptance of God's will and higher levels of optimism with respect to healing (14).

Principle 7: Clinicians should determine whether home and community-based therapeutic interventions can be used as alternatives to hospitalization for Muslim youth.

The role of family and religion in the intensive care of Muslim youth with severe mental illness requires the clinician to be particularly attentive to critical related issues such as language needs, gender roles, family hierarchy, family history, and spiritual practices (27).

It is important to pay attention to gender roles (e.g., pairing a female client with a female counselor) and the family hierarchy (e.g., not undermining a dominant father when providing a family intervention involving children.) (11).

Psychoeducation is a priority. The majority of Muslim immigrants come from countries where mental health services are reserved for the severely mentally ill and involve hospitalization (11).

Clinicians also should be aware of traditional healing as another model of Islamic counseling. A traditional healer who practices various rituals may be a Sheikh or Darwesh, depending on geographic location. This model explains illness or personal problems as possession by spirit (Jinn Satan-like spirits); despite the support of some studies of the value of traditional healing, many Muslims do not believe in this form of healing or consider it Islamic (29).

Principle 8: The Role of Mosques and Imams

Typically, Muslims first come to the mosque and seek out their Imam when they face problems. When Imams make referrals, people take them seriously. Some residents still struggle with the consequences of flight and the trauma of a brutal civil war, in addition to the stresses of starting over in America. Those can include loss of community status, joblessness, and family conflict. Noting the disproportionately low rates at which Muslims seek out professional help, a national survey of 63 Imams recently found lingering reservations about Western treatments of mental illness. They rated more active participation in the mosque as most effective and medication as

least helpful. Others responded, "Religion is still important, but it's also important to seek help from a scientific perspective. They are not against one another" (32).

The main role of Imams for Muslims is to provide advice which is in accordance with the Qur'anic principles and teachings of the Prophet Mohammad. Muslims approach Imams for counseling for social and mental health issues and, particularly, marital and family problems. The Imam's role is in part to meet the counseling needs of the Muslim community (27).

Following the terrorist attacks of 9/11, communities turned to their mosques for help but were noticeably hesitant to avail themselves of services offered by the broader community. Research has shown that few mental health professionals are familiar with the Arabic language and Islamic values. Moreover, little is known about Islamic counseling and psychotherapy or techniques applied by providers in mosques to help the Islamic community cope with stressful events (33).

Imams have knowledge of Islam and seek to solve all problems through Islam (Quran/Hadith). They often have degrees in religion and not in science. They recognize a need for "psychological assistance," and express a desire for "psychologist, psychiatrist, and social workers" to support them in addressing the issues of their congregants (34). In order to minimize disparities of mental health care to the growing Muslim population in the United States, community healthcare planners need to appreciate that Imams are (a) an important source of referrals and influence on the attitudes toward mental health and help-seeking within their communities; (b) able to recognize serious mental health problems; and (c) appear more willing to collaborate with mental health professionals if they have had previous consultation experiences. With such collaboration, Muslim communities may be more likely to utilize community resources, clinicians will be more likely to provide culturally competent care, and Imams will then be more effective in their collaborative role as de facto mental health providers (34).

Principle 9: Clinicians should be aware of the need to adapt evidence-based treatments (EBTs) with Muslim youth.

For most Muslim patients, modified short-term psychodynamic therapy is a better choice than classic long-term psychoanalysis (35). Focusing on family dynamics, conflicts, and relationships is also helpful and is recommended over focusing on intrapsychic conflicts. In addition, therapy should be aligned with the patients' religious beliefs and cultural values.

Specifically, cognitive-behavioral therapy (CBT), Solution-Focused therapy, modeling and behavioral techniques, including behavioral modification, systemic desensitization, and flooding, have all been shown to be effective when treating Muslim patients (28,36). Experts have recommended that clinicians may need to adjust the approach to ensure it is in line with the patient's beliefs, particularly when dealing with immigrant Muslim youth and first or second-generation youth. For non-immigrant youth, nondirective approaches, such as Rogerian therapy, can be helpful (28). Immigrant youth may need to discuss the pre-migration and post-migration trauma, particularly if they are refugees.

Muslims, who already spend significant portions of their days involved in prayer and meditation, may find techniques like guided imagery and relaxation to be congruent with their faith (28).

Because of the lingering stigma of mental illness in the Muslim community, many Muslims turn to their primary-care physician for treatment. In addition, they may be skeptical of taking medication for a mental health diagnosis. The clinicians may need to stress the Islamic permissibility of taking such medication to ensure compliance. There are rare cases when taking medication may present a problem — if the medication (and in most cases it is only the gel coating) contains gelatin derived from pork. In that case, an alternative should be sought out. Another challenge may arise during

Ramadan, when Muslims fast from all food and water from dawn until dusk. Clinicians are urged to work with their patients to find a medication regimen that will allow them to keep their fast (37).

Principle 10: Clinicians should assess the use of electronic/social media.

Social media has become a mainstream form of communication among youth today. According to a new study from Pew Research Center, 92% of teens report going online daily — including 24% who say they go online "almost constantly." Nearly three-quarters of teens have or have access[1] to a smartphone" (38).

This represents a significant social change. Although there are many valuable aspects of social media and networking, there also some dangers. A Clinical Report from the American Academy of Pediatrics (39) cited both benefits (socialization/communication, enhanced learning opportunities and accessing health information) and risks (cyberbullying/online harassment, sexting, Facebook depression, privacy concerns/digital footprint, and influence of advertisements).

Daily overuse of media and technology also has a negative effect on children, preteens, and teenagers by making them more prone to anxiety, depression, and other psychological disorders. Social media can be distracting and can negatively impact learning. Studies found that middle school, high school, and college students who checked social media at least once during a 15-minute study period achieved lower grades (39).

Like their counterparts, many Muslim youth spend much of their time on social media and prefer popular apps such as Snapchat and Twitter. However, some Muslim youth seek an escape in the online world. Western media often covers Islam or Muslims only in the wake of terrorism or violence, which can leave Muslim youth feeling marginalized and demoralized. In addition, the religious identity of a violent perpetrator is usually highlighted when he is Muslim. This all plays a role in creating a culture where Muslim youth are bullied and discriminated against.

In rare cases where the youth is isolated and has turned away from his family and his mosque, terrorist groups have been known to use social media to prey on the youth's vulnerability to try and recruit them.

As with all other patients, clinicians have to remain cognizant of the use of social media when engaging Muslim youth in psychiatric care. As health care providers, clinicians can promote discussion and address relevant issues in order to decrease the feeling of shame and stigma that is usually associated with asking for help.

Principle 11: Clinicians should assess for a history of loss, trauma, and/or community violence in Muslim youth.

Certain Muslim youth groups (African American, Refugee, and Immigrant) are at higher risk for a variety of traumatic events, such as physical and sexual abuse, witnessing domestic and community violence, separation from family members, and re-victimization by others. Also, the stress of assimilation and acculturation (often with downward social mobility for immigrant families), negative stereotyping, and cultural acceptance of corporal punishment of women in patriarchal family structures increase the risk for trauma reactions. Complex trauma can have devastating effects on a child's physiology, emotions, ability to think, learn, concentrate, impulse control, self-image, and relationships with others (40).

African-American Muslims are the largest percentage of native-born and converted Muslims (59% of converts to Islam are African American) in the United States. [6] The majority (55%) identify as Sunni. The shared history, racial struggles, societal experiences of extreme violence in the

community, including exposure to gang-related violence, interracial violence, and adverse socioeconomic conditions, may result in African-American Muslim youth identifying with their non-Muslim African-American peers more than their immigrant Muslim peers (41). Within the Muslim community, they may also face racism by immigrant American Muslims. Such victimization is directly linked to negative outcomes of depression, substance abuse, risky sexual behavior, homelessness, and poor school performance. The recognition and acknowledgement of this type of complex trauma is important for compassionate care.

Immigrant Muslims face xenophobia and discrimination. Negative stereotypes diminish their sense of safety and well-being. One in four Muslim students reported that they "often or always" experience stress at school, while three in four students described having been "really stressed out" at some time in the past 12 months (42).

Refugee Muslim youth experience unique developmental contexts with different intersecting cultural, sectarian, tribal, and racialized implications as they attempt to integrate into the American culture. Exposure to acts of war, terrorism, or political-related violence such as bombing, shooting, and looting is traumatic. Social adjustment difficulties are associated with multiple losses, financial stress, limited parental and social support, and untreated psychological wounds. They may experience higher incidence of depression, anxiety, and post-traumatic stress disorder and are more likely to report survivor's guilt, a pessimistic outlook on life, and suicidal ideation (43).

For African American Muslim youth and traumatized immigrant youth, trauma-informed treatment is an important foundation for effective mental health care. Providing respectful, culturally sensitive care to a traumatized individual and family poses many challenges. Seeking consultation and collaboration with specialists and community members is more often than not an expected feature of practice.

Vignette 1.

R is a 16-year-old girl who recently moved to the United States with her family from Pakistan. She started high school in the fall and had been worried about "fitting in," especially as she was Muslim. She had heard from some friends back home that things were difficult for Muslims in the United States post 9/11. After the extended and thorough airport search her family experienced upon landing, she grew quite concerned. She initially thought that she would not tell anyone where she was from, as she did not cover her head and did not have an Arabic name. But she decided that her religion was part of her identity, and she would not hide it. When asked to introduce herself to the class, she did so.

Over the past few months, she has been having a hard time at school. Some boys in her class have been teasing her and calling her "terrorist," and making remarks including, "Did they find Osama Bin Laden in your house?" On one occasion, a boy threw half a cup of water on her face. She reported this to her teacher, who informed the principal. The boy's parents were called, and he was given detention.

After this incident, she felt that some of the other students became even more hostile, as the boy had been one of the "popular kids." The overt remarks stopped, but she began to notice other little things such as when one of the girls in her class celebrated her birthday, she ordered only pepperoni pizza, which R could not eat. The girl saw her with an empty plate and remarked flippantly, "Oh, I forgot...you can just pick the pepperoni off...it's not a big deal." Sometimes, she feels that other girls are laughing and making fun of her outfits, especially as she is not allowed to wear short sleeves or skirts.

She has made a few friends who are supportive of her and often tell her to "ignore it" or say "you're being too sensitive and paranoid," but she has begun to dread going to school. She often complains of a stomachache in the mornings and stays home, and now her grades are slipping. She finds herself lying awake at night and often cries herself to sleep, wishing she were back home. Her parents have noticed the change and tried to talk to her about it, but she is worried that they will call the principal, and she does not want to draw any more attention to herself. She has begun to isolate herself and in school prefers to sit at the back of the class and eat her lunch by herself. As a result, even her friends have given up on her.

There is a school dance coming up, and the majority of conversations in class have centered on what the girls will wear and who will be their date. R's parents are supportive but very conservative and have clearly told her that she cannot date. She has decided that she will skip it, though a part of her really wants to go (she has never been to a school dance before). At times, she feels very resentful towards her parents for being too strict and finds herself becoming more distant from them. She finds herself conflicted between holding on to her religious and cultural identity and being able to fit in.

Vignette 2.

S is a 16-year-old high school student who was born and raised in the United States, but her parents are from Morocco. They moved to the United States about 18 years ago and have settled in well. Her mother is an Arabic teacher who tutors Muslim children at home. S had always been quite close to her parents and would go to the mosque with them on the weekends when she was younger. Since she started high school, however, she finds that she would rather go to the mall, a movie, or a sleepover.

S feels that her mother has become more critical of her friends lately and often wants to know whose house she is going to, whether there will be parents chaperoning, and calls her at least

twice when she is out with her friends to ask where she is. S has begun to feel embarrassed by her mother's behavior and has gotten into arguments with her mother over it. Another issue of contention is that her mother continues to buy clothes for her and insists that she only wear outfits that cover her from her neck to her ankle. Her friends wear cool, "funky" outfits, and she feels dowdy in front of them. At one sleepover, her friend convinced her to try on a mini-skirt and halter-top, and she loved how she looked. She now often leaves home wearing one outfit but then changes into clothes she borrows from her friends.

At times, she feels a nagging guilt about lying and hiding things from her mother, but she really wants to be able to fit in with her friends. She has been fighting with her mother daily over one thing or the other and often thinks that her mother doesn't trust her anyway so she might as well "do what the cool kids are doing." Her friends are now starting to experiment with smoking, drugs, and alcohol. Although she does not want to try them, she is worried that she will be considered a "party-pooper" if she does not.

Vignette Clinical Pearls

- *Muslim youth may be particularly vulnerable to issues related to acculturation. While there is diversity among individual experiences based on gender, social environment, first vs. second-generation immigrants, legal and residency status, and expectations for life in the new culture, there also are certain common themes evident among youth who experience this.*

- *Muslim youth often struggle to achieve a balance between their family's religious and cultural values and American mainstream trends, values, and lifestyles. They may lead double lives, which can be a source of additional stress in a vulnerable period of their lives, when they are making a transition from childhood to adulthood.*

- *Many Muslim parents may feel a religious obligation to protect their families from cultural values different from their own. They often expect their children to comply with cultural norms, such as dress code, food habits, and socialization. This can cause conflict within the family. These youths may often experience guilt and resentment about having to hide certain aspects of their lives from their parents while they try to fit in with their non-Muslim peers.*

- *Muslim youth may feel marginalized, isolated, and misunderstood because of the stereotypes, prejudices, and myths about their religion and its practices. Immigrant youth in particular may lack a sense of belonging and feel unaccepted by peers because of their different cultural values and practices. They may find it difficult to fit into both worlds and cultures and feel that they do not belong to either.*

- *Acculturation stress can negatively impact the academic, social, and occupational functioning of Muslim youth and can also present in the form of somatic complaints.*

- *These stressors can negatively affect the mental health of Muslim youth, some of whom may not feel comfortable working with non-Muslim therapists or mental health providers who they feel do not understand Muslim culture or the religious contexts of Muslim issues.*

In many Muslim communities, the Imam (i.e., the one who leads the prayer at a mosque and/or is an Islamic scholar) addresses the mental health problems of the community members. Youth may not feel comfortable discussing topics that are considered taboo, such as issues related to sexuality and dating, with someone who is considered a religious authority figure.

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