Experiences of Muslim Women in Therapy - A Qualitative Exploration

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The world is becoming more aware of mental health and well-being. However, mental illness continues to be stigmatised and mental healthcare is inaccessible to a large population, to most marginalised communities. This is also linked to social exclusion and is often considered a consequence of economic marginalisation. A number of studies have found that the prevalence of psychiatric disorders is higher in marginalised groups than in the age-matched general population (Priebe, Matanov, Schor, et al., 2012). Further, providing mental health care for people from these groups represents many challenges. They face significant administrative and financial obstacles in accessing health services. These groups are often neglected in the distribution of health resources. Furthermore, mental health service providers also struggle to reach people with mental disorders in such groups and offer support. Moreover, to add to these varied difficulties, there is limited research evidence to guide interventions and mental health provisions for marginalised groups.

One such marginalised group is the Muslim community. Muslims and Islam are a central feature of global news and often find themselves in narratives associated with national and international terror. In India, with a Hindu right-wing government passing laws like NRC-CAA, Muslims are openly “othered”. The Indian Muslims are navigating their national, ethnic, religious, cultural identities. Mental health issues, relationship issues, and substance misuse are hence prevalent. However, mental health services are a) deficient; and b) underutilised. Barriers that exist include stigma, shame, lack of familiarity with services, and the fear of being misunderstood among others. Therefore, there is a lack of insights into Muslim's experiences in psychotherapy due to limited scholarship in this area. To begin exploration in this research area, our study focused on Muslim women and their experiences of seeking psychological help.

Muslim women are very often portrayed as “disempowered”, “inferior to men" and “veiled”. This results in the homogenization of their identities, and their diversity is ignored.

Nida Kirmani (2009) writes that the dominant narrative of Muslim women in India is in relation to *parda* and personal law - they are frequently positioned as the symbolic bearers of the identity of the Muslim community. Factors such as class, regional affiliation, age, education, health, and so on are not taken into consideration. Such narratives limit and

ill-represent the stories of Muslim women and their identities. However, exploration of all of these stories and identities is not possible, our study focused on being a Muslim woman and seeking mental health support. We attempted to explore the experiences of Muslim women in psychotherapy and present their unique experiences of therapy using qualitative methodology.

We conducted semi-structured interviews with 4 participants between the ages of 20 to 35 from various educational, professional backgrounds residing in Hyderabad, recruited at Pause for Perspective. We analysed the collected data using thematic analysis.

The analysis revealed four major themes which narrate the story of Muslim women's experiences in therapy: 'perception of therapy', Identity; Muslimness and therapists identity location', and 'privilege'. Each theme is supported by examples and quotations describing the experiences and structures which impact the experiences of Muslim women in therapy.

1. Perception of Therapy

   The three of the four participants started therapy when they realised their lives were unravelling because of institutions such as marriage, family, and dominant discourses of health, productivity and success in life. The fourth participant began therapy as a course requirement and continued to explore their identities and well being. The perceptions of therapy included that you only seek help when something is wrong with you, it is for people with serious mental illnesses, and it is to cure your disorder or fix you.

   "Whoever went to therapy had major problems that they had to address. So if you didn't have obvious issues, I didn't see why anybody would need to go to therapy…"

2. Identity; Muslimness and therapists identity location

   The participants shared that there is an existing rhetoric that if you are a good practicing Muslim, you shouldn't need therapy because your faith in Allah should be enough for you. If this is not the case, then going to therapy is often seen as a sign of weakness and not being a good Muslim. The concept of going to therapy is not accessible, there is a lack of knowledge and awareness about it. Muslim women face a constant invalidation of their experiences - they are shamed for having depression or anxiety - may be you have done something wrong.

   "with Muslim women, especially, there's this constant narrative that whatever like you, you have to be put in your place. This is what you're supposed to do. This is who

you're supposed to be and if you're doing that and being back, then everything is fine. If not, if you're praying everything is fine. If you're not praying, then you have like all of these issues coming up. So your solution is just go pray or visit some, you know, Maulvi or something and get rid of whatever is happening to you."

With respect to the therapists identity location, gender, age and area of expertise stood out to the participants. They were comfortable with an older female counsellor as other female relationships such as bond with an aunt or mother was a part of the therapy process. There was an assumption that a younger person may not be equally competent. The participants shared that the therapists Chirstian and Muslim idenitities helped them in opening up and sharing their experiences.

"Like it mattered to me that she was a woman. I knew that I wanted my therapist to be a woman."

3. Privilege

   The participants acknowledged that it was possible for them to seek professional help because they belong to a privileged group within the Muslim community. The privileges included their education, social support, financial resources, access to places of therapy like Pause for Perspective.

   "I think at this point I recognize that, you know, and not just my education, but the way maybe I look, I speak the way that, you know, I think that made things a lot easier because I think generally I am privileged enough to be accepted. Therapy is expensive, it's not cheap. Not everybody can afford 2000 for an hour. The economics would be largely applicable to Muslims."

These findings resonate with the existing literature. Muslim women, as a minority in the Indian context have relatively low literacy and employment rates and limited access to healthcare services compared to women from other minority communities (Ohlan, 2020). Such disparity undoubtedly impacts the help-seeking attitudes of the community and access to mental health services such as therapy. Another study found that Muslim beliefs about both the content of therapy and the preferred characteristics of an ideal therapist. Most of the participants agreed that "cultural sensitivity", Islamic understanding and trust were of key importance in the therapeutic alliance (Weatherhead & Daiches, 2010).

What can be done? Few things that can increase access are: 1) Having more trained professionals from the marginalised community, 2) professionals working from the lens of intersectionality and a social justice stance, 3) emphasis on community engagement to spread awareness about mental health and its services, 3) more research and documentation of experiences of peoples from marginalised communities.

References

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