MARRIAGE AND FAMILY THERAPISTS' PERCEPTIONS AND INTERPRETATIONS OF READINESS TO WORK WITH MUSLIM CLIENTS: A QUALITATIVE STUDY

A DISSERTATION

SUBMITTED IN PARTIAL FULFILLMENT OF THE REQUIREMENTS

FOR THE DEGREE OF DOCTOR OF PHILOSOPHY

IN THE GRADUATE SCHOOL OF THE

TEXAS WOMAN'S UNIVERSITY

DEPARTMENT OF HUMAN DEVELOPMENT, FAMILY STUDIES, & COUNSELING

COLLEGE OF PROFESSIONAL EDUCATION

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DENTON, TEXAS

MAY 2021

DEDICATION

I dedicate this research to my late mother, Margaret Fanny Ikpo, and my late father, (Oha) Emmanuel Chinogunum Ikpo, the Paramount Head of Omu Owhoeke Community, Obelle, Port Harcourt, Rivers State, Nigeria.

ACKNOWLEDGEMENTS

I am grateful to the therapists who dared to participate in this study at a time when the United States and the world is experiencing a deadly disease named COVID-19, and more importantly, a period when the country was at its core of racial tension and political discourse. These participants set their beliefs and biases aside to answer tough questions about their readiness to work with Muslims.

I am thankful to my research committee members, Dr. Linda Ladd and Dr. Joyce Armstrong, for their patience, guidance, and support throughout my study period at Texas Woman's University and during this dissertation process. To Dr. Linda Brock, my research advisor, my gratitude to you for agreeing to oversee this research. You challenged my thoughts and influences that I bring to this study. Your calm and yet firm constructive criticisms of my writing style have made me a better writer today. Be rest assured that I have learned to manage my anxiety. I would also like to thank Dr. Glen Jennings, my first advisor, who took me under his wing and introduced me to the concept of "equifinality and multifinality," which has resonated with me and my approach to life events. Since his retirement, Dr. Jennings has continued to contact me and encourage me to get to the end, regardless of how I get there.

To all the professors whose classes I have taken at the Texas Woman's University, you have also contributed to my marriage and family therapy growth. Attending a graduate school where in most cases, I was the only male student in the class, gave me more appreciation of what women bring to most societies that are mostly run by men. I cannot thank enough, all the female students in the marriage and family therapy

program that shared their life experiences, challenged my beliefs, and learned from each other. Thank you, Dianne Robinson, for serving as my researcher intercoder.

I am indebted to my oldest brother, Johnson I. K. Ikpo, without whom I would not have come to the United States to pursue my academic interests. Johnson paved the way by funding my tuition, living, and travel expenses to go to the United States in 1983. To the rest of my five brothers and one sister, Boniface, Kingidi, Ekundah (sister), Ndubuisi (Shedrack), Chimene, and Chinedu, thank you for staying united and for supporting my endeavors in the United States. I may be far away from home, but I have not forgotten anyone and where I came from.

To my immediate family in the United States, my wife, Letitia Agatha Ikpo, words cannot express my appreciation for your love, kindness, and support for over 30 years of your commitment in this marriage. For many days, hours and months, you were left alone to handle house issues, including children's activities while I pursued my first career as a Probation Officer, and my years in preparation for this doctoral program. Your contributions to my success are invaluable and immeasurable. Very soon, you will reap the fruits of your labor. My children, Fleurette, Angel, and Justice, thank you for being highly differentiated. Whether I was at work or school, you stayed emotionally connected and remained focused on your studies. I have never doubted your abilities. You are great kids, and I can't wait to see what the future holds for each of you.

I am proud of Texas Woman's University for conferring upon me this Doctor of Philosophy (Ph.D.) in Marriage and Family Therapy. Memories will last forever.

ABSTRACT

FYNEFACE UCHE IKPO

MARRIAGE AND FAMILY THERAPISTS' PERCEPTIONS AND INTERPRETATIONS OF READINESS TO WORK WITH MUSLIM CLIENTS: A QUALITATIVE STUDY

MAY 2021

The purpose of this research study was to explore how marriage and family therapists perceive and interpret their readiness to work with Muslim clients. This study applied a phenomenological research approach to allow the participants to express their viewpoints and the meanings of readiness to work with Muslim clients. The participants were recruited using purposive and snowball sampling techniques. A total of 13 marriage and family therapists (12 LMFT-Associates and 1 LMFT) participated in this study.

The research interviews were conducted using Zoom video conferencing with 12 participants and a telephone interview with one participant. Each participant chose the format of their interview. The interviews were video and audio recorded, transcribed verbatim, and analyzed for emergent themes.

Seven themes emerged from the interview questions: (1) Not ready to work with Muslim clients, (2) A need for self-education about Muslims, (3) Willingness to learn from Muslim clients, (4) Concern about ethics, biases, and offending Muslim clients, (5) Lack of preparation in graduate school, (6) Opportunity to enroll in diversity/multicultural courses, and (7) Inclusion of diversity/multicultural courses requirement.

Conclusions, implications, and recommendations for future research for marriage and family therapists, MFT programs, and other mental health specialists were discussed to assist them in preparing to work with Muslims.

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CHAPTER I

INTRODUCTION

Sometimes used synonymously in the United States, Muslims and Islam gained national attention after the horrendous attacks on the United States World Trade Center in New York on September 11, 2001. This attack on the United States is usually referred to as 9/11. The federal law enforcement agency identified the perpetrators of the attacks as Muslims who claimed to be ardent supporters of the Islamic faith (Ali et al., 2004). Most Muslims in the United States have expressed opposition to this group of terrorists and indicated that they do not represent Muslim beliefs and practices (Abbott et al., 2012).

Following that attack, The United States Homeland Security put out a campaign slogan, "If you see something, say something," to encourage everyone to be vigilant and to report any suspicious activity by anyone or any group. That message resonated with most people in the United States who took the call seriously and in good faith, to report questionable acts, while others have gone beyond their civic duties by threatening, harassing, and committing violent acts against Muslims (Abu-Ras & Abu-Bader, 2008; Disha et al., 2011). Since the 9/11 incident, Muslims have become targets for attacks, violence, and discrimination in the United States (Ali et al., 2004). There have been reported incidents of hate crimes, unwarranted detention, profiling, and burnings of Mosques where Muslims worship (Arshad & Falconier, 2019).

The population of Muslims in the United States continues to grow (Pew Research Center, 2018). With the increasing number of Muslims in the United States, convergent with Muslims' current political discourse, Muslims' experiences with discrimination and marginalization remain an issue. There has been an increase in negative attitudes toward Muslims and the manifestation of mental health and relationship problems among Muslims in the United States (Abu-Ras & Abu-Bader, 2008; Haque et al., 2018). More Muslims are seeking professional mental health assistance outside the norms of going to family members and religious leaders. However, there are not enough mental health providers, including MFTs, who are familiar with Muslim spiritual practices to provide congruent services to this growing population (Arshad & Falconier, 2019; Raiya & Pargament, 2010). There is a lack of research on mental health professionals interested in working with Muslim couples (Abbott et al., 2012; Springer et al., 2009). Researchers have, therefore, placed MFTs on notice to be prepared for more Muslims coming to their clinics for assistance (Arshad & Falconier, 2019; Haque et al., 2018).

How MFTs respond to researchers' calls to be ready for more Muslims seeking their professional assistance was the goal of this study. This study examined MFTs' perceptions and interpretations of readiness to work with Muslim clients. This qualitative study helps to fill some of the literature gaps in the work of MFTs with Muslim clients. Findings from this study will help MFTs and other mental health professionals prepare to work with Muslim clients.

Statement of the Problem

Increasing numbers of Muslims in the US and Muslims' concern about the lack of marriage and family therapists who are knowledgeable about their religious practices have raised concerns among researchers. While researchers acknowledge that mental health professionals have become increasingly aware of how to treat other American minorities, the same cannot be said about Muslims, as the literature on Muslim Americans is lacking (Haque, 2004). The lack of studies on mental health professionals' work with Muslim clients has led some researchers to warn that clinicians may be left unprepared to provide services in harmony with Muslim beliefs and religious practices (Springer et al., 2009).

As a result of the lack of Muslim therapists, Arshad and Falconier (2019) have called for non-Muslim, Caucasian MFTs to "be prepared to experience challenges, but also some benefits" (p. 54) when working with Muslims. The authors echo the need for more marriage and family therapists to be ready for more Muslims seeking professional mental health assistance. In their own words, "Given the shortage of minority MFTs, American Muslim clients are likely to be seen by non-Muslim Caucasian MFTs when seeking help from an MFT" (p. 55). Haque et al. (2018) noted that the number of Muslims seeking therapy was increasing and warned that marriage and family therapists "are likely to see more Muslim clients in their practices" (p. 86). These quotes highlight the urgency for MFTs to prepare for more Muslims seeking their professional assistance. It is also a reason to explore whether therapists are ready to accept this challenge.

Statement of Purpose

The purpose of this phenomenological study was to explore MFTs' perceptions and interpretations of readiness to work with Muslim clients. More Muslim families and couples seek therapy despite their ambivalence regarding family therapy and concern that therapists may not understand their background built on culture, religious beliefs and practices, veiling, rules, and traditions of Muslim families (Daneshpour, 2009; Nassar-McMillan et al., 2011). Muslims also seek therapy to address their experience of prejudice, stereotyping, and discrimination and to resolve other mental health issues such as anxiety and depression (Chapman, 2016; Haque et al., 2018). Clinicians must be ready to accommodate more Muslims seeking treatment.

The apprehension among Muslims for the lack of therapists familiar with their religious beliefs and practices, the need for more therapists and other mental health providers to attend to Muslims, and the amplification of calls for mental health providers to be ready for more Muslims seeking therapy underscores the importance of this study. This study used individual interviews with MFTs to understand how they perceive and interpret readiness to work with Muslim clients, what they are concerned about when working with Muslims, how they perceived their training during graduate school to work with Muslims, and their recommendations on what and how university marriage and family therapy programs can prepare future students to work with Muslim clients.

Research Questions

The following research questions guided this study:

RQ 1: How do marriage and family therapists perceive and interpret their readiness to work with Muslim clients?

RQ 2: What are marriage and family therapists most concerned about when they are working with Muslim clients?

RQ 3: How were marriage and family therapists prepared in their graduate program to work with Muslim clients?

RQ 4: What do marriage and family therapists recommend for university marriage and family therapy programs to prepare for Muslim clients?

Definition of Terms

The following terms are defined because they appeared in different sections of this study. These are terms used in Muslim culture that many may not be familiar with.

- Islam means "submission" or "surrender" to the will of God (Allah) (Zainiddinov, 2013).
- Muslim is a person who believes and follows the teachings of Islam (Springer et al., 2009).
- Quran is the Holy Book of Islam that guides the Muslim faith (Springer et al., 2009).
- Salat is referred to as devotional worship or prayer, the requirement to pray five times per day (Rehman & Dziegielewski, 2003).

- Ummah is the term used to describe Muslim community ranked in the following order: the extended family; friends from a mosque; local leaders; merchants, teachers, bankers, and health care providers who are Muslims (Springer et al., 2009).
- Imam is the salat leader, appointed in many mosques (Al-Krenawi & Graham, 2000).
- Hijab/Veiling is the covering of head by Muslim women (Bhowon & Bundhoo, 2016).
- Islamophobia is the fear, hatred of, or prejudice against Muslims (Casey, 2017; Haque et al., 2018).

Assumptions

The following assumptions were made in this study:

1. Marriage and family therapists responded to questions as openly and honestly as they could.
2. Discussion of religion, especially Islam/Muslim, is a sensitive topic, and especially so at the time of data collection. Participants would like prefer to discuss their views with others, especially when they are being audio/video recorded.

Delimitations

The following delimitations applied to this study:

1. The participants were licensed marriage and family therapists and licensed marriage and family therapist associates who hold at least a master's degree.

2. Participants had to be at least 18 years old.

The Researcher as Person

In qualitative research, the researcher is a part of the study because of their involvement with the participants. Researchers bring their own life experiences, biases, values, prior professional backgrounds, and experiences with the group they are interested in studying. All these elements shape their understanding and the interpretations of the data collected (Creswell, 2014; Marshall & Rossman, 2011). Unlike quantitative research, where researchers use measurement scales as the instrument for data collection and analysis, the researcher is the qualitative research study instrument. Therefore, the qualitative researcher must collect, interpret, and present data without allowing their background and experience to influence their data (Creswell, 2014).

My parents raised me in Nigeria, where 50% of the population are Muslims. However, I had little or no knowledge about Muslims when I came to the United States with a Student Visa at the age of 21. Like most Americans, the 9/11 incident gave me a reason to begin to inquire about Islam and Muslims. Choosing a research topic for my dissertation solidified my affinity to research about Muslims and therapists.

I served as a probation officer for over two decades in the United States. During those two decades, I worked with people of all races and ethnicities, all levels of socioeconomic status, and various religious beliefs, as well as professionals such as judges, prosecutors, defense attorneys, directors and managers of residential and outpatient treatment centers, and the Texas Department of Criminal Justice, Criminal

Justice Assistance Division (CJAD) professionals. I held different positions, including a supervisory role, until my retirement in 2014.

I grew up as a Christian with religious beliefs that being and practicing Christianity is the gate to heaven. Over the years of my life experiences and academic training, I have evolved and have become a better person who welcomes everyone, regardless of their beliefs, religion, national origin, or social status. I have some prior exposure to Muslims, but little knowledge about the faith. I know some Muslims from my previous occupation and some academic colleagues who are Muslims. I have no close Muslim friends, but have professional relationships with the Muslims that I know.

I have had great life experiences in the United States as an immigrant and a United States citizen. I have also experienced prejudice and discrimination and will continue to encounter such incidents as a minority group member in the United States. I have, however, better, and more positive experiences in the United States than negative experiences. I learned from my experiences that everyone is not prejudiced, and there are more good people in this world. Despite my negative experiences, I have been able to achieve my goals in the United States. As a husband, married for over 30 years, and a father of three American-born children, I have had the experience of parent-child relationships, tradition, and cultural conflict with my children. I am continuing to adjust, and negotiate boundaries with my American family while pursuing my doctorate in Marriage and Family Therapy.

My background puts me in a better position to understand both sides of Muslims' experiences and therapists' experiences working with individuals from different ethnic

and cultural backgrounds. As a qualitative researcher, however, I must acknowledge and reflect on my own ethical and personal values, personal knowledge, and experiences of dealing with prejudices and discrimination. These are qualities that I must bracket as I conduct my study because they will help shape my investigation (Creswell, 2016).

I am a doctoral MFT student pursuing both MFT-A and American Association for Marriage and Family Therapy (AAMFT) approved supervisor licensures. I was curious to know what marriage and family therapists thought about Muslims seeking therapy and what that meant to them as therapists. I wanted to know the concerns of therapists when working with Muslim clients. My other inquiry in this study was to know what therapists thought about how they were prepared in graduate school to work with Muslims, and their contributions to what university marriage and family therapy programs can do to prepare students to work with Muslim clients.

I understood that interviewing therapists could pose some challenges because some people may not feel comfortable discussing Muslims and Islam. Many individuals are not willing to express their views of Muslims to others because of fear of being judged. However, I believed that therapists understand the importance of addressing families' issues and the need to assist families in getting back to their everyday life. Hence, I thought that some therapists would be willing to participate in this study. I designed my interview questions to allow participants to express their views and meanings and elicit responses that would enable participants to contribute to solutions and serve Muslim clients better, rather than testing their knowledge about Islam. This

experience will help me grow as a therapist and contribute to the literature on how therapists can work with Muslim clients.

Summary

This study examined marriage and family therapists' perceptions and interpretations of readiness to work with Muslim clients. The introduction provides a glimpse of the need for MFTs to be able to work with Muslim clients. The information gained from this study will help MFTs and other mental health professionals to work with Muslim clients. This study adds to the limited research on the work of therapists with Muslim clients.

CHAPTER II

LITERATURE REVIEW

The purpose of this study was to examine MFTs' perceptions and interpretations of readiness to work with Muslim clients. The literature on therapists' work with Muslims is limited, but growing. A handful of literature addressed Muslims' attitudes, but the data were based on cross-national surveys on Western attitudes towards Muslims (Strabac et al., 2014; Wike & Grim, 2010). Other studies focused on the stigma associated with being Muslim (Casey, 2017; Chapman, 2016), while others discussed fear and hatred of Muslims (Islamophobia) and discrimination towards Muslims in their study (Arab American Institute, 2014; Disha et al., 2011; Haque et al., 2018; Nassar-McMillan et al., 2011).

Some studies address Muslims' health beliefs and attitudes toward mental health and psychotherapy (Vu et al., 2016; Walton et al., 2014; Weatherhead & Daiches, 2010). Several authors recognized the need for cultural competency, awareness, and sensitivity while working with Muslim clients (Aga & Jaladin, 2013; Al-Krenawi & Graham, 2005; Cook-Masaud & Wiggins, 2011; Hodge & Nadir, 2008; Seponski et al., 2013). Other scholars suggested and provided guidelines on incorporating Muslims' religious beliefs and spirituality into psychotherapy (Brown et al., 2013; Hamdan, 2007; Hatch et al., 2016; Hodge, 2011; Raiya & Pargament, 2010).

Considering the limited literature on therapists' work with Muslim clients, marriage and family therapists must understand Muslims and their beliefs in Islam to provide treatment congruent with Muslim culture and traditions. This chapter covers literature reviews that will help MFTs and other mental health providers work with Muslim clients. The review covers Muslims in the United States, stigma and veiling, Muslim beliefs (religious and practices, and health and seeking therapy), incorporating religion and spirituality into family therapy, integrating religion with Muslim clients, multicultural and gender issues in counseling and therapy, Muslim families, and therapists' experiences working with Muslim clients. I have also provided structural family therapy theory as the theoretical framework guiding this study. The chapter ends with a summary of the literature reviews.

Muslims in the United States

The believers and followers of the teachings of Islam are called Muslims. Practicing Islam means submitting oneself to the will of Allah (Springer et al., 2009). Muslims in the United States believe that others outside their religion do not fully grasp the faith and their understanding of Islam is contrary to what Islam means. In other words, non-Muslims do not fully understand the difference between Muslims and Islam (Haque et al., 2018). Many Americans have been wary about Muslims and perceive Islam as anti-American. Muslims are concerned about the increase in violent attacks, threats of violent attacks, and discrimination (Ali et al., 2004). The members of this religious minority are often subjected to unnecessary and unlawful profiling and detention by law enforcement officials (Abu-Ras & Abu-Bader, 2008).

Muslims draw unwarranted attention partly due to their tradition and religious attire/clothing, veiling by women, head wrapping by men, men's facial hair, Arabic language, and the negative media coverage of Muslims (Chapman, 2016). Muslims worship in the mosque, but because Muslims pray five times per day, some Muslims pray in public and open places. Muslims' overt identification makes them susceptible targets for violent attacks, stereotyping, discrimination, and marginalization by those who despise and do not fully understand Islam (Abbott et al., 2012; Arshad & Falconier, 2019; Haque et al., 2018).

Muslims account for about 25% of the world population (Springer et al., 2009). The real number of Muslims in the United States is not fully known; however, a recent estimate from The Pew Research Center (2018) puts the Muslim population in the United States at about 2.75 million in 2011. It projected that number to reach 8.1 million by the year 2050. Islam is the fastest-growing religion globally (Rehman & Dziegielewski, 2003) and is the world's second-largest religion (Zainiddinov, 2013).

The population of Muslims in the United States continues to grow to include Muslims from different parts of the world, including American-born Muslims and Americans who convert to Islam. Muslim immigrants include individuals from countries like Iraq and Morocco (Middle East), Afghanistan and Turkey (Asia), Iran (Western Asia), Pakistan (South Asia), Indonesia (Southeast Asia) with the largest population in the world, India (South Asia), Egypt (Northeast Africa), and immigrants from West Africa such as Nigeria (Abbott et al., 2012; Al-Krenawi & Graham, 2005).

The Muslim population is diverse. Because Muslims come from different countries, they are not monolithic, as individual, cultural, and traditional differences exit. Despite the individual and cultural distinction, Muslims are "connected by faith and membership of the Ummah" (Weatherhead & Daiches, 2015, p. 2399). The Muslim population consists of White Muslims, accounting for about 41%, most of whom are from Arab and Middle Eastern countries. Muslims from Asia make up 28% of the Muslim population, while Black Muslims account for 20%. Hispanic Muslims are only 8%, while 3% of Muslims identify themselves as other (Pew Research Center, 2017).

In a survey of 1,001 Muslim adults in the United States, Muslims indicated that they are not satisfied with the current U. S. administration and policies. The report recorded an increase in Muslim stereotyping, prejudice, discrimination, and profiling since the 2016 U.S. policy banning Muslims from entering the United States. Despite Muslims' negative experiences, about half of the study participants indicated having received some support for their religion from the public. Muslim Americans said they are positive, optimistic, and proud to be Americans (Pew Research Center, 2017).

On Muslim perceptions and experiences with discrimination survey, 83% of the Muslim women surveyed stated that Muslims experience discrimination, while 68% of the men also agreed that there is much discrimination against Muslims in the United States. Of the men, 42 % reported having experience with discrimination, while 55% of the women said they have gone through similar experiences. The study concluded that about 57% of Muslim women and 43% of Muslim men expressed having experienced discrimination (Pew Research Center, 2017).

An Arab American Institute study (2014) conducted an online survey on American attitudes towards Arab Americans. The study found that more than 50% of 1,110 participants reported that they are not knowledgeable about Arabs, Islam, and Muslims. The study noted that participants who had previous exposure to Muslims or Arab Americans reported more favorable attitudes towards Arabs and Muslim Americans. Casey (2017) bluntly puts Muslim experiences in the United States as "to be Muslim (in the eyes of some Americans) is to be oppressed, backward, or a terrorist, among other undesirable identities" (p. 116). The literature on Muslims shows an increase in discrimination, racism, marginalization, and hatred against Muslims since 9/11, and more Muslims are reaching out to professionals for assistance to address their concerns (Haque et al., 2018).

Stigma

In a study of Muslim women's experiences with stigma, abuse, and depression, Budhwani and Hearld (2017) analyzed self-reported data of 373 Muslim women, ages 18 to 69 living in the United States. The sample consisted of 44% American-born Muslims, and 42% of the participants attended graduate school or professional school. Participants identified themselves as Sunni Muslims (45%), Shia Muslims (38%), and 15% as general Islam. The authors found that about 31% of the participants experienced physical abuse, and 16% reported the experience of sexual abuse. 63% of the participants said they were careful on what they said, and 48% refused to go to some public places and avoided some social gatherings. 38% of the participants were concerned about their appearance in public places, and 22% expected and prepared for insults from others due to their

appearance. The study found that stigma was associated with the lack of interest in seeking mental health assistance (Budhwani & Hearld, 2017).

Muslims in the United States are highly stigmatized, wrote Casey (2017). In his study of 23 Muslim Americans living in the Houston, Texas area, the author found that Muslims are stigmatized by non-Muslims and Muslims themselves. The Muslim community often perceives American Muslims as not real Muslims because of their western values. The American Muslims are often not fully embraced by their Muslim peers in the Muslim community. They are accused of being too westernized. Some Muslim Americans avoid identifying themselves as Muslims to prevent stigmas associated with being a Muslim. Others say they realize the consequences of presenting themselves as Muslim in public places. Despite not being fully received in the Muslim community, the American Muslims still experiences prejudice, discrimination, stereotyping, and marginalization like all other Muslims (Casey, 2017).

Veiling

Most Muslim women practice veiling. Muslim women experience prejudice in public places partly due to veiling. Veiling is the wearing of and the covering of the head with scarves by Muslim women. The overt and visible perception of veiling and Muslim names put Muslims at a higher risk of being stigmatized and vulnerable to discrimination (Chapman, 2016). Muslim's head covering is associated with negative attitude and hatred towards Muslim women (Everett et al., 2015).

In a qualitative study, Bhowon and Bundhoo (2016) examined the reasons for veiling by young Muslim women in a social context where ethnic and religious identity is

not threatened. Using an in-depth, open-ended interview, the authors asked 10 Muslim undergraduate students (women) who have been veiling the last five years to explain what veiling means to them. Some participants stated that they started veiling after marriage, and some indicated that wearing the hijab was to prepare for the pilgrimage. After attending the pilgrimage to Mecca and learning to commit to Islam's teachings, most participants reported that veiling became a common daily practice and a symbol and commitment to their religious beliefs and practices.

Participants also indicated that while their parents may have encouraged them to veil, the decision to wear hijab was entirely theirs. However, participants reported that their veiling was also inspired and influenced by their peers. Also, that veiling served as a symbol of who Muslims are, and reveals their commitment to their religion. Participants indicated that veiling shows that Muslim women are not afraid and is a message that they are not and will not be intimidated (Bhowon & Bundhoo, 2016).

In a similar study on veiling, Alghafli et al. (2017) examined the Muslim practice of wearing the hijab to understand their views, the meaning, and the impact on their relationships. The authors interviewed 20 couples (20 wives and 20 husbands), a total of 40 people. Six couples were Shia Muslims, and 14 couples were Sunni Muslims who lived in the United States. One of the themes that emerged from this study was the belief that the hijab serves as a symbol of religious commitment that protects instead of oppressing women and their families.

Muslim Beliefs

Religious Beliefs and Practices

Muslim beliefs and practices are well understood by Muslims. Most individuals outside the Muslim community do not fully grasp what is involved. Rehman and Dziegielewski (2003) delineated seven principles that Muslims adhere to in order to help others better understand Muslim beliefs and religious practices.

1. The faith in one God (Allah), who is the only creator of the heaven and the earth;
2. The idea of Divine Will (Al-Qadr/ fatalism);
3. The belief in the angels of Allah;
4. The belief in the revealed books of Allah (the Torah, the Psalms, the Qur'an, and the Gospel);
5. The belief in the messengers of Allah;
6. The faith in the judgment day and life after death; and
7. The Five Pillars of Islam (Rehman & Dziegielewski, 2003).

Embedded in the seventh principle (The Five Pillars of Islam) are additional five requirements that Muslims must accept. They are:

1. The shahadah-the profession of faith—there is no other god but God;
2. Devotional worship or prayer (salat). The requirement to pray five times per day;
3. Zakah (charity). Muslims must donate a percentage of the acquired property of profit to those who need it most;

4. Fasting during the month of Ramadan, known as Sawm. The ninth month of the year is Ramadan. During this period and from sunrise to sunset, Muslims will not eat, drink, smoke, or engage in sexual activity; and
5. The pilgrimage to Makkah (Hajj). Muslims are who are physically and financially able are encouraged to make at least one pilgrimage to Mecca during their lifetime (Ali et al., 2004; Springer et al., 2009; Walton et al., 2014).

Also, important to note is that when an individual identifies himself or herself as a Muslim, they must have taken 'the shahadah,' a declaration of faith, conducted by the Imam (at the mosque) and witnessed by two other Muslims. When an individual has accepted Islam, it means that the person has declared "there is no God but Allah (SWT), and Mohammed is his messenger" (Rehman & Dziegielewski, 2003, p. 34). These principles are presented here to give readers some basic ideas about Muslim tenets and what Muslim clients may bring up in therapy or at other services. Discussing each principle in detail would require more space than is needed in this study.

Health Beliefs and Seeking Family Therapy

Many American Muslims seek therapy to navigate the dynamics within their family and Muslim community (Casey, 2017). More Muslims are adding professional assistance such as therapists to address issues related to anxiety, stress, and family feuds. But despite the increase in Muslims seeking therapy, Muslims are trepidatious about treatment and have some barriers that prevent many from seeking mental health assistance (Haque et al., 2018).

Several studies have explored Muslims' health beliefs and behaviors toward getting mental health assistance. Khan (2006) conducted a descriptive cross-sectional study to understand the variation in attitudes toward help-seeking and the perceived need for and use of professional counseling among Muslims in Toledo, Ohio. In a 459 Muslim sample, 44 were African American Muslims, 240 Arabs, 119 South Asians, and 56 classified as Other. The participants completed Fischer and Turner's Attitudes Toward Seeking Professional Psychological Help Scale (1995). The Fischer and Turner instrument measured their attitudes towards seeking mental health assistance.

After data analysis, Khan (2006) found that sex (gender) is associated with participants' behavior in seeking counseling. Age, attitude, and the perceived need influenced the use of professional counseling. Furthermore, there was a relationship between race/ethnicity and professional counseling for the African American and Arab subgroups. For support sources, findings indicated that all three groups stated that using prayer was a regular source of comfort for them.

Results also revealed that while most participants reported positive attitudes toward counseling, Muslim females were more likely than Muslim males to have positive attitudes toward counseling and the need for counseling. Analyzed separately by age groups, older Muslims were more likely than younger Muslims to see the need for counseling services. Overall, findings indicated that positive attitudes and the need for counseling services predicted Muslims' use of counseling (Khan, 2006).

Weatherhead and Daiches (2010) examined Muslim views on mental health and psychotherapy to understand Muslims’ mental health beliefs and treatment concepts. The

authors interviewed 14 Muslims (seven men and seven women). After analyzing the data, the themes that emerged include causes of illness, illness/problem management, barriers to services, therapy content, and therapist characteristics. Most of the study participants indicated that the causes of psychological problems depended on how people handle the problems they experience in life. Participants indicated that people usually do not attempt to resolve problems such as stress and drugs until it is too late, before they take any action.

Participants viewed relying on their religious beliefs and practices as means of handling their health and other issues. The view is that religious beliefs and practices gave them the confidence, peace, and psychological confidence to take care of their problems. Participants believed that their faith allowed them to communicate with and submit to Allah. They also believed that while psychological services may be necessary to address mental health issues, the strategies they use to manage mental health issues accounted for better results. Some of the reasons for not seeking professional services include shame, embarrassment, and stigma, in addition to family and the Muslim community's view that seeking mental health assistance is a sign of physical and psychological weakness (Weatherhead & Daiches, 2010).

Walton et al. (2014) conducted an exploratory study with 14 Muslim women on their health and beliefs to see how it relates to medical, psychological evaluation, and treatment. The goal was to determine whether Muslim women's beliefs and attitudes influenced their decisions to seek treatment. The authors found that Muslim women preferred making their own health decisions without the assistance and influence of a

male family member. Muslim women would rather have a female health care provider than a male health care provider. Having the same gender provider increased the likelihood of Muslim women to seek medical assistance. Muslim women prefer a female physician to provide examinations. All the participants indicated a female provider's preference and said they would be uncomfortable with male service providers. Muslim women preferred taking care of their health problems through praying, reciting Quran, and fasting.

In a similar study to understand why Muslim American women may delay seeking health care assistance, Vu et al. (2016) surveyed 254 Muslim American women. They found that 129 (53%) of the respondents indicated that they failed to seek mental health assistance because they believed that there were not enough female practitioners. The study also found that Muslim American women who expressed strong religious values were more likely to delay getting health assistance than those who are not highly religious.

Other studies suggest that Muslims do not seek mental health assistance as needed, and when they do, they do not complete treatment due to premature termination. Research shows that fear of therapy, shame associated with counseling, and lack of trust in the treatment provider are some of the reasons for Muslims' unwillingness to seek treatment. Other barriers include fear of not being treated fairly, inability to communicate due to language barriers, cultural and religious differences, as reasons for Muslims' lack of interest and early terminations of treatment (Carolan et al., 2000; Daneshpour, 1998; Inayat, 2007).

Incorporating Religion and Spirituality into Family Therapy

There is a growing literature on how mental health providers can integrate religion and spirituality into therapy, but more research is needed. Several scholars have written and emphasized the importance of incorporating Muslim religious and spiritual beliefs into treatment to assist clients struggling with balancing their religious beliefs with other aspects of their life (Al-Krenawi, & Graham, 2000; Ali et al, 2004; Brown et al., 2013; Hamdan, 2007; Hatch et al., 2016; Razali et al., 2002). Studies show that using certain spiritual psychotherapy types with Muslims effectively treat their anxiety and depression (Razali et al. 1998).

While these publications have outlined ways of incorporating Muslim beliefs into psychotherapy, some researchers asked to approach available literature on merging Muslim religious practices into therapy with caution. According to Raiya and Pargament (2010), "Efforts to incorporate Islamic teachings, beliefs, and practices into psychotherapy are still in their very early stages" (p. 187). The authors argue that theological principles have influenced most of the studies on integrating religiosity into therapy, and that interventions based on empirical findings are scarce (Raiya & Pargament, 2010).

Brown et al. (2013) conducted a study on integrating religion and spirituality into psychotherapy. They interviewed 15 psychologists to know their willingness to incorporate religion and spirituality and identify barriers and enablers to integrate religion and spirituality into therapy. Nine of the psychologists were counseling psychologists, five were clinical psychologists, and one was an educational psychologist, all with an

average number of years in practice at 6.63 years. All participants except one, who did not indicate religious affiliation, were Christians. Out of the 15 participants, 6 were White, 6 Xhosa, 2 Black, and one Sesotho.

After data analysis, Brown et al. (2013) found that ethical issues and therapists' lack of knowledge and training were among the barriers to incorporating religion and faith into therapy. Additionally, balancing therapists' religious beliefs and the clients' beliefs poses obstacles to integrating spirituality into treatment. Clients' resistance and therapists' uneasiness about discussing religion and spirituality impede integration of faith and spirituality into treatment. Challenges aside, participants reported enablers using religion and spirituality in therapy to include using religion to explore the client's journey and attend to their needs. Other enhancers are therapists' own religious and spiritual beliefs, and therapists having similar religious and spiritual beliefs with the clients.

Some psychologists indicated a willingness to join their clients in both therapeutic and religious activities. Others were inclined to participate in therapeutic but not religious activities with the clients. Most psychologists were concerned that participating in religious and spiritual activities may send the wrong message of validating the clients' theory of illness. The study reported psychological approaches such as the person-centered approach, the systems approach, the narrative approach, and the holistic and positive psychology as useful for integrating spirituality into psychotherapy (Brown et al., 2013).

In a case study of a Muslim client, Hamdan (2007) presented how counselors can incorporate religious beliefs and practices into treatment. Some of the techniques include

learning some necessary information about the Islamic faith because "religion is often pervasive and central in the life of a Muslim" (p. 95). Others include assessing their faith and how their behaviors connect to their faith, and having the clients use their religion to handle their problems because "the goal of religious psychotherapy is to revive spiritual strength as a way of coping with the illness and situation" (p. 96).

Therapists should encourage their Muslim clients to do the prayer of repentance, known as 'salaat altawbah,' which allows them to ask for Allah's forgiveness. This prayer is most useful to the client if the client feels a sense of wrongdoing and wants forgiveness. Therapists must work with their clients to develop a plan for action to include reading the Holy Qur'an and seeking assistance from religious leaders, Imams. Hamdan joins other researchers on calls to increase mental health providers' numbers for the growing Muslim population seeking mental health assistance (Hamdan, 2007).

In another qualitative study, Hatch et al. (2016) interviewed 184 religious couples, 184 families, for a total of 368 wives/husbands in the study. Participants were Christian, Jewish, and Muslim families. The goal was to explore how powerful praying is in transforming individuals and relationships. The themes that emerged include participants indicating that prayer helped them to process and manage change. Praying enabled them to remain humble and accept their ways of dealing with the issues. Through praying, the couples communicated and understood each other, which invariably resulted in conflict resolution and unity. It is also worth noting that Muslims report not being afraid to admit their Islamic faith practice, the authors noted.

Integrating Religion with Muslim Clients

While working with Arab Muslim couples, Al-Krenawi and Graham (2000) recommend that therapists remain cognizant of acculturation and re-acculturation. Therapists can assess migration and immigration conditions, the levels of acculturation and re-acculturation, and signs of trauma and depression. At the beginning of therapy, therapists must decide who will lead the therapy process because clients see the therapists as the person with the power. The therapist should expect to balance both the wife's and her husband's chances to communicate their marriage concerns. The therapist must focus on their strengths rather than remaining problem focused. Therapists must be very active throughout the therapeutic process and pay attention to the extended families' influence. A systemic view of the issues is recommended (Al-Krenawi & Graham, 2000).

In their paper on Islam and understanding the religion and therapy implications, Ali et al. (2004) voiced concern over the growing Muslim population in the United States and the need for more mental health workers to work with Muslim clients. Guidelines for working with Muslim clients include the understanding that Muslims come from different parts of the world and have various cultural and ethnic differences. Their background also influences the practices of Islam. Therapists must be mindful of Muslim gender roles, traditional dress, and family values because the Muslim community emphasizes gender roles and values. Clinicians must note that Muslim women are not treated the same in each Muslim community because Muslims come from different families and countries.

While Muslim men and women may dress modestly, some cultures require women to cover themselves completely (burqua), while other cultures may allow women more options to choose or may require them to cover their heads (Ali et al., 2004).

In working with Muslims, Williams (2005) wrote that counselors should avoid making false assumptions about Muslims and their beliefs because not all Muslim believe, practice, or identify in the same way. Their values and traditions are different, and counselors must be aware of sensitive issues and work with Muslims' religious boundaries. Some ethical or moral issues to consider include caring for elderly parents, business ethics, debts, theft, family issues, and injustices. Cultural topics include food such as pork, which is prohibited in Muslim culture. Therapists must also familiarize themselves with Muslim dress/attire and artistic expression (Williams, 2005).

Springer et al. (2009) recommend that therapists conduct self-evaluation on biases and prejudices toward Muslims. The self-of-the-therapist will help therapists identify their strengths and weaknesses. Therapists must be comfortable engaging the clients in religious discussions and using their religion to address problems. Before rushing into therapy, therapists are encouraged to build a therapeutic relationship first. Muslim clients need to trust their therapist before disclosing personal and family issues. Taking a not-knowing approach and remaining curious to learn about Islam, the clients' culture and worldview will enhance the therapeutic relationship (Springer et al., 2009).

Therapists must assess acculturation levels because some Muslims are immigrants and refugees who may not speak and understand English and have language barriers. Assessing for trauma for immigrant Muslims may help understand their struggle

adjusting to a new life in the United States. However, therapists must be careful when using psychometric and diagnostic scales. These instruments were mostly designed in the West to evaluate Western clients whose beliefs and culture are different from clients from other countries. Muslim religious beliefs and practices, perception of illness and mental health, culture, and traditions, were not considered in the development of the tools for assessment. Finally, therapists must evaluate how their theoretical lens's impacts their treatment objectives and goals with Muslim clients (Springer et al., 2009).

Raiya and Pargament (2010) advised therapists not to avoid religious discussion but to engage Muslim clients in their religion. Therapists should ask their clients what Islam means to them and how they apply their faith in resolving problems. The discussion will help the clinicians learn more about Muslims and Islam. The authors encourage therapists to pay attention to Muslims' diversity and not assume that every Muslim is the same. Clinicians must pay attention to the stigma associated with mental health issues among Muslims because it is one factor that prevents Muslims from seeking professional mental health assistance. Assessment must include clients' struggle with religion, and therapists must try to normalize their clients' efforts. Therapists should consider referring their clients to a Muslim pastoral counselor or Muslim religious leader when needed. Therapists must not shy away from consulting with the Muslim community to acquaint themselves with how Muslims address problems through an Islamic perspective (Raiya & Pargament, 2010).

Multicultural and Gender Issues in Counseling and Therapy

Western psychotherapy models' adaptability and the effects on individuals of diverse cultural and religious backgrounds continue to surface among researchers. Researchers have expressed concern about the efficacy of using Western therapy models in treatment with people of various cultural, religious, non-Western background. Seponski et al. (2013) doubt MFT models based on Western values and norms. The authors acknowledged that while therapists may try to adapt to different cultural beliefs, the theoretical models and assumptions have not changed and remain influenced by Western cultures.

Wehbe-Alamah and Fry (2014) agreed that providing culturally competent services in today's health care system and mental health is essential. The authors wrote, "When caring for individuals of diverse cultural backgrounds, it is important to deliver culturally congruent care that fits with patients'/clients' beliefs and practices" (p. 5). Hall and Theriott (2016) were also concerned about the lack of cultural competency and skills, prompting the authors to conclude that cultural awareness and skills were lacking at the crucial time when the skills are needed the most.

Muslim Families

Muslims may share similar religious beliefs, mosques, rituals, and practices. These shared religious beliefs do not mean that all Muslims are the same. Muslims come from different parts of the world, they have different worldviews, speak different languages, and may comprehend and interpret things differently, including illness and methods of healing. Researchers agree that cultural differences impact an individual's

understanding of illness and the decision to seek mental health assistance (Koc & Kafa, 2019; Viswanath & Chaturvedi, 2012).

Family dynamics and gender roles play unique functions in Muslim families. The general beliefs and understandings are that everyone belong to one community (Ummah), irrespective of where they were born. Muslims value family and extended family. Their family and extended family's needs take precedent over the individual's needs (Carolan et al., 2000). MFTs should take Muslims' extended family tradition seriously and be cognizant of Muslims' basic etiquette like eye contact, rules for male-female social interactions, and family members' involvement in decision making within Muslim families (Al-Mateen & Afzal, 2004; Carolan et al., 2000).

Muslim families are patriarchal and operate in collectivism rather than individualism. Muslims' family values include heterosexual marriage between Muslims and ethnic groups. Muslims discourage close relationships or dating between their single men and women. Divorce is not fully embraced but allowed under some circumstances. It is important that therapists discuss their clients' attitudes and beliefs regarding mental health and views about seeking for professional assistance. Therapists are encouraged to become aware of these values, including negative stereotypes regarding Muslims. Therapists should not expect their Muslim clients to disclose personal information, their conflicts about the religion, or family issues without first gaining their trust and confidence. Creating a comfortable and safe environment where Muslim clients can discuss their experiences of prejudices and discrimination is a best practice (Ali et al., 2004).

Daneshpour (1998) wrote, "The most significant differences in value systems between the Muslim and Anglo-American cultures is Muslim families' preference for greater connectedness, a less flexible and more hierarchical family structure, and an implicit communication style" (p. 355). The shared sense of community surpasses individual significance. Therefore, therapists must include the Muslim client or family, their preference for change during an assessment, and setting treatment goals during the treatment process (Daneshpour, 1998).

Gender Issues

Gender roles may differ in Muslim families and Muslim women are the primarily caretakers of children who handles their needs and deals and functioning. Muslim men are financially responsible and make the family's significant decisions (Al-Krenawi & Graham, 2000; 2005). Gender roles, however, must be approached with caution as things may have changed with the new generation of Muslim women working outside their home and moving away from the traditional Muslim family. More research is needed to understand these dynamics better. But, gender, remains relevant when Muslims seek medical and mental health providers.

Research shows that Muslims prefer the same gender service provider. Studies suggest that female Muslim patients prefer female health care providers, and male Muslim patients prefer male health care providers. Muslims would only consider the opposite sex treatment provider in rare cases where the same gender provider is entirely unavailable (Walton et al., 2014). A study on the effects of client-therapist gender match on therapeutic relationship (Bhati, 2014) found that when female clients receive therapy

with female therapists, therapeutic alliance ratings were higher than dyads with a male therapist. The findings were consistent in all stages of the treatment observed.

In a qualitative study on the barriers and challenges in multicultural counseling, Aga and Jaladin (2013) interviewed 12 registered practicing counselors, five men and seven women in Malaysia. Part of the inclusion criteria was that participants have counseling experience of more than 1 year and counseling experience with a culturally diverse or different client population to that of the counselor. The goal was to determine the challenges that Malaysian counselors face and address them in cross-cultural sessions with their clients.

After thematic analysis of the data, several themes emerged from the interview: the counselors' characteristics, namely, language barrier; lack of experience; lack of exposure to diverse culture; multicultural incompetence; and value conflicts with the clients. Another theme that emerged was client characteristics, including resisting treatment due to lack of trust, views of lack of acceptance, confidence, and misunderstanding and false beliefs about counseling and counselors. The presenting problems and third-party factors include sensitive cultural issues, client support systems, lack of support systems, society, stigma, and labeling. Counseling context was also a theme that emerged from this study—providing therapy room and space conducive to therapy, the physical and organizational structure, and the work cultures that are friendly and not in conflict with the clients (Aga & Jaladin, 2013).

Therapists' Experience Working with Muslim Clients

Research shows that Muslims are seeking mental health assistance due to the increase in mental health issues. This increase is not limited to policies such as the Muslim ban in the United States, unwarranted stopping and detaining Muslims as suspects, anxiety, and fear of Muslims leaving their homes to attend worship at Mosques or to go to public places, but also relational issues (Abu-Ras & Abu-Bader, 2008; Haque et al., 2018). There is a shortage of Muslim professionals interested in starting or providing treatment to Muslims (Haque, 2004). Other researchers concur that more non-Muslim therapists and other mental health professionals are needed to serve the growing number of Muslims seeking treatment (Arshad & Falconier, 2019; Haque et al., 2018; Raiya & Pargament, 2010).

A review of the literature on therapists' work with Muslim clients show a few recent psychotherapy cases. They include Hamdan (2007) case study of a 26 year old Pakistani female in the United States dealing with depression, Khodayarifard et al. (2007) cognitive-behavioral case study of one client in Iran, and Khodayarifard and McClenon (2011) case study of one client managing obsessive-compulsive disorder in Iran. These case studies were mostly conducted in Muslim dominated countries such as Iran, Malay, and Malaysia.

Other studies on therapists' work with Muslims include Daneshpour (1998) Muslim families and family therapy, Miller and Chavier (2013) study on clinicians' experiences of integrating prayer in therapy, and Arshad and Falconier (2019) study on the experiences of non-Muslim, Caucasian MFTs with Muslim clients. Scholarly

publications are recommendations on working with Muslim clients (Al-Krenawi & Graham, 2005; Carolan et al., 2000; Weatherhead & Daiches, 2015; Williams, 2005). Researchers are concerned that the lack of literature will leave therapists unprepared to work with Muslim parents and families, resulting in unintended biases in therapy (Springer et al., 2009). Others recommend more research and evidence-based interventions in working with Muslim clients (Abbott et al., 2012; Raiya & Pargament, 2010).

Therapists and Muslim Clients

Miller and Chavier (2013) examined the experiences of integrating prayer into the therapeutic process with therapists. The authors interviewed 17 licensed MFTs, licensed MFT-As, and interns. The participants were of different races and faiths, including Muslim, Buddhist, Jewish, Catholic, Protestant, and Latter-Day Saints who lived in the United States. Several themes emerged from the interviews: defining prayer, ethical and boundary issues, the context of the therapeutic practice will determine the use of prayer, what type of prayer (direct versus indirect), using prayer as the self-of-the-therapist care, and using prayer changes based on the experience and growth of the therapist.

Many of the participants alluded that praying created awareness and made them pay more attention. Prayer gave them comfort that felt like they were communicating with God. Prayer also helped "participants feel deeply linked to clients" (Miller & Chavier, 2013, p. 87). On ethics, participants felt that integrating prayer was appropriate, and therapists took steps to care for the clients and pevent harm for the clients. The study's therapists believed that practicing at a faith-based agency made it easier to

integrate prayer in therapy because clients expected it. However, for new therapists, the study found that the lack of training on incorporating prayer and lack of training on attending to spirituality caused therapists' discomfort on integrating prayers into therapy (Miller & Chavier, 2013).

Arshad and Falconier (2019) reported the shortage of ethnically, racially, and religiously diverse mental health professionals. This shortage is a problem in meeting many Muslim's needs in seeking mental health assistance. The authors point to the 2004 statistics from the US Department of Health and Human Services. In that report, psychiatrists alone make up 24.2% of the mental health profession, and social workers take up 8.7%. In comparison, MFTs are only 5.5% of the mental health profession and are one of the least ethnically diverse. There is a need for non-Muslim therapists to prepare for Muslim clients.

In their qualitative study examining the experiences of non-Muslim, Caucasian licensed MFTs working with South Asian and Middle Eastern Muslims, Arshad and Falconier (2019) interviewed eight White, non-Muslim Caucasian licensed marriage and family therapists on their experience working with Muslim clients. The study asked participants about their specific challenges and strengths from ethnic, racial, and religious differences and how they have managed it during therapy. Participants also responded to describing and comparing their experiences with South Asian and Middle Eastern Muslim clients to their experiences with other religious and ethnic backgrounds who are not Muslims. Finally, participants were to provide recommendations to non-Muslims therapists working with Muslim clients.

Arshad and Falconier (2019) findings revealed several themes grouped as challenges, strategies, recommendations, and benefits from working with ethnic/racial and religious differences. Most participants in the study reported receiving multicultural training in graduate school; however, the training alone did not prevent them from experiencing challenges while working with Muslim clients. Among the challenges experienced is difficulty managing clients' expectations, keeping clients engaged in therapy; dealing with a lack of trust from the clients; difficult time understanding, accepting, managing cultural and religious differences; and difficulty remaining neutral.

In this study, the therapists recommended that other therapists become aware and differentiate and address the differential views in therapeutic settings. Therapists must define their therapeutic roles, create a safe therapeutic environment, and show understanding and acknowledgment of Muslims by accepting the contextual factors surrounding Muslims' challenges and challenges in the United States. Therapists who participated in the study reported the things that made therapy easier with Muslim clients as taking the not-knowing approach, remaining curious, and allowing the client to be the expert. Participants noted some benefits of counseling Muslims as learning more about the cultural and religious differences, integrating religion into psychotherapy, and building therapeutic alliance (Arshad & Falconier, 2019).

Arshad and Falconier (2019) noted that most Muslims in the United States do not seek mental health services because of discriminatory practices towards Muslims. Still, those who decide to seek therapy are more likely to see non-Muslim MFTs. The authors compared therapists who received multicultural training in graduate school and those

who did not. They found that all the therapists faced similar challenges when working with clients of diverse cultures, leading the authors to conclude that taking multicultural training alone did not make a difference in handling the challenges faced by MFTs (Arshad & Falconier, 2019).

In her paper on working with Muslims in counseling, Williams (2005) stressed the importance of not making false assumptions about Muslims because Muslims do not practice and identify themselves in the same manner. There are sects of Islam, divisions, and sub-groups whose beliefs and practices vary. Some examples are Alawi, Druze, Shia, Sunni, and Zaidi. The author cautioned counselors to be aware of the values and traditions and maintain the clients' boundaries, thoughts, and experiences.

It is recommended that therapists get some training to assist them in working with Muslim clients. Some of the recommendations include having a general understanding of Islam (knowledge of Muhammad, history of Islam, mosque, the Qur'an, and the Five Pillars of Islam) and understanding a Muslim's worldview. Exploring a Muslim health beliefs, including beliefs about abortion and infertility, background, and their understanding of Islam and beliefs in Quran, is crucial because it reveals their practices and self-fulfillment. Examining Muslims' shared rituals of praying and worship, important feasts, fasting, charity, caring for the sick, forgiveness, brotherhood, and community, are all significant to working with Muslim clients. Learning about Muslims' family and structure (i.e., marriage, hierarchy, decision making, roles, physical contacts, clothing, and veiling) will provide a good insight on how and what to expect in treatment (Williams, 2005).

To assist professionals working with Muslims gain some basic beliefs of Muslims, Carolan et al. (2000) conducted a qualitative focus group consisting of 40 Muslims in which participants were placed in a group of five. One of the findings include how Muslims sought support in the order of preference. First, Muslims will seek advice from friends and family, followed by advice from spouse family, then advice from Muslim professionals, and advice from a non-Muslim professional known to the community. Therapists must not question client beliefs on the cause of illness and suffering because Muslims believe that it is a test from Allah (Al-Krenawi & Graham, 2005). Therapists must discuss and understand Muslim ties to their family, the Muslim community (Ummah), and religious leaders' influence, irrespective of Muslim nationality. Therapists must balance the family's needs and extended family over individual autonomy when conducting therapy with a Muslim client.

While there is the Muslim community connected by faith and the family's belief, therapists are asked not to lump all Muslims as a homogeneous group of people because there are variations in religion, culture, and nationality. In working with Muslim clients, therapists must pay attention to clients' sense of self and family dynamics and connections. The family and gender roles, the belief in illness causation, and coping strategies help from religious leaders, praying, and seeking professional mental health services must not be ignored (Weatherhead & Daiches, 2015). Therapists' characteristics-ability to be flexibility, honesty, trustworthiness, confidence, warmth, and ability to show interest and openness, have been found to enhance therapeutic relationships (Ackerman & Hilsenroth, 2003).

Theoretical Framework

I used Minuchin's (1974) structural family therapy theory as a theoretical lens that guided my study. Minuchin's approach underscores family structure to understand communication and behaviors among family members. The nature of the system accounts for how family members respond to each other. Every family has a structure. Minuchin contended that for generations, families had established subsystems that serve as a protected mechanism for boundaries. At the top of the family hierarchy is the parental subsystem, which guides and protects the children.

Below the parental subsystem is the sibling subsystem. At this level, the children learn rules from the parents and learn from and support each other. According to Minuchin (1974), a well-functioning family has parents in a higher hierarchical position above the children. The essential subsystems include the spousal subsystem, parental subsystem, parent-child subsystem, and siblings' subsystem (Minuchin, 1974; Minuchin & Fisher, 1981).

Structural family therapy theory emphasizes the need to examine family boundaries and the creation of healthy boundaries within the family unit. Boundaries control how much information goes in and out of the family and within the family and how contacts should be. Boundaries protect family hierarchy and each family member's ranking and positions. Family boundaries may be rigid, transparent, flexible, and diffuse, but inflexible and diffuse boundaries limit family growth (Colapinto, 1991; Whitchurch & Constantine, 1993). A structural family therapy theory assumption is that healthy families are not defined by the absence of problems. When a family member is

experiencing problems, other family members are also affected. Minuchin, however, maintains that healthy families can modify their structure to accommodate one or more family member experiencing problems (Minuchin, 1974).

Muslims' experience of prejudice, discrimination, and religious practices will likely play out in the therapeutic processes. Understanding and working with Muslim families through the lens of structural family therapy is vital because Muslim families emphasize structure, norms, and family values. Practicing Islam requires some responsibilities, commitment, and adherence to rules and boundaries (Springer et al., 2009). According to Daneshpour (1998), "The basic objectives of marriage in Islam are (1) securing a comfortable atmosphere for the husband and wife, and (2) producing a new generation and bringing up healthy, faithful, and virtuous children" (p. 356).

Some Muslim families are immigrants who are adjusting to a new life in America. The relocation of a family member due to immigration status can affect other family members. These families also have children born in the United States with differential views of practicing Islam, raising the potential for conflict and coalitions. Parent-child conflicts, gender roles, and intergenerational conflicts, and extended family issues are likely to emerge in therapy. Interventions with Muslim families will require therapists to strengthen boundaries by blocking parents from preventing their children from speaking out, and by providing a comfortable therapy space where both parents and the children can speak freely (Minuchin & Fisher, 1981).

Nichols and Tafuri (2013) provide a 4-step structural family assessment of couples and families that therapists can use. Looking at and expanding the meaning of the

issues presented in the context, identifying the problems that are keeping the interactions or issues, focusing on exploring the past experiences, and developing a road to change that both the therapists and the clients can agree are structural assessments therapists can use with Muslim clients.

Minuchin's use of enactment, a core tenet of structural family therapy technique must be employed to assist Muslim families in therapy. Therapists must engage family members to discuss the issues they are experiencing while observing to understand the structure, communication pattern, and boundary marking within the Muslim family. Therapists then work with the family to re-engage in productive interactions (Minuchin & Fisher, 1981). This technique allows therapists to explore their Muslim clients' family subsystems, rules, and boundaries to develop healthy boundaries within the family unit.

Through noticing the demarcations in boundaries, negotiating, and agreeing on goals to get the family back into healthy functioning, the family will begin to experience a change in structure. This second-order change is the preferred change that is mostly needed to bring the desired change that brings a family to therapy (Gehart, 2018). Through this experience, Muslim families can begin to gently move from a linear approach of problem-solving to a more systemic approach of interactions, inclusive of all family members and religious leaders influencing the manifestation of illness or problems. A structural change will change the clients' experiences, and a positive change in one family member affects all other parties connected (Hanson, 1995).

Several studies have documented structural family therapy's efficacy with minorities, families, and groups with strong religious beliefs. Studies show the

effectiveness of structural family therapy with Mexican American family children with disabilities (Becerra & Michael-Makri, 2012). Structural family therapy approach was shown to be effective with Hong Kong Chinese family to address drug abuse (Sim, 2007). Other studies showing the efficacy of structural family therapy with religious group include Wieselberg (1992) case study with ultra-orthodox Jewish families, and Pinyuchon and Gray (1997) work with Thai families greatly influenced by religious beliefs, family relationships, values, roles, and sexuality.

Summary

Research suggests that more Muslims are looking for MFTs' assistance as they continue to navigate issues of prejudice and discrimination, anxiety and depression, and family issues. While there is a growing interest among researchers on Muslims' issues and the need to attend to the ever-increasing Muslim population in the United States, studies on therapists' work with Muslim clients is needed, and more research is needed.

In this chapter, I provided information on Muslims in the United States, beliefs and attitude towards therapy, research on incorporating religion and spirituality into therapy, multicultural and gender issues, and research on therapists' experience working with Muslims. Findings from this study will assist MFTs and MFT programs, counselors and counseling program, and other mental health professionals to attend to Muslims and others from a diverse community of culture and religious beliefs.

CHAPTER III

METHODOLOGY

The purpose of this qualitative research was to examine MFTs' perceptions and interpretations of readiness to work with Muslim clients. I used phenomenological research method for this study. The use of the phenomenological method allows researchers to explore, describe, and analyze the meaning of the participants' lived experiences (Creswell, 2016). This research method allows investigators to conduct in-depth interviews with a small group of participants who would contrbute to the phenomenon. The researcher would continue to interview participants until saturation is achieved.

Research Design

A qualitative research approach was a good fit for this study because it allowed me, the researcher, to gain rich and comprehensive data from a small group of MFT participants who contributed to the experience. According to Strauss and Corbin (1990), phenomenological studies are useful because researchers gain depth and detail of the concept that could prove difficult to ascertain in quantitative methods.

Moustakas (1994) supports the use of phenomenological research because it describes the participants' experiences, with less time spent on the researcher's interpretation. Patton (2002) wrote that the overarching goal of using a phenomenological method is to develop patterns and meanings and make sense of what the participants are

saying. Marshall and Rossman (2011) put the purpose of phenomenological interviewing this way, "to describe the meaning of a concept or phenomenon that several individuals share" (p. 148). The process of this phenomenological study involved conducting in-depth interviews with licensed marriage and family therapists (LMFTs) and licensed marriage and family therapist-associates (LMFT-As) to explore their perceptions and interpretations of readiness to work with Muslim clients.

Research Questions

The following research questions guided this study:

RQ 1: How do marriage and family therapists perceive and interpret their readiness to work with Muslim clients?

RQ 2: What are marriage and family therapists most concerned about when they are working with Muslim clients?

RQ 3: How were marriage and family therapists prepared in their graduate program to work with Muslim clients?

RQ 4: What do marriage and family therapists recommend for university marriage and family therapy programs to prepare for Muslim clients?

Interview Questions

Participants for this study responded to the following questions:

The population of Muslims in the United States is increasing, and more Muslims are seeking the assistance of MFTs. Therapists are asked to be ready for Muslims seeking professional mental health assistance.

1. How do you see (perceive) readiness? And (b) What does it mean (interpretation) to you?
2. What are you most concerned about when you are working with Muslim clients?
3. In your opinion, how were you prepared as a marriage and family therapist during graduate school to work with Muslim clients?
4. Finally, as a marriage and family therapist, what do you recommend for university marriage and family therapy programs to prepare their students to work with Muslim clients?

Protection of Human Participants

Before beginning this study, I obtained approval from Texas Woman's University Institutional Review Board (TWU IRB). I followed the procedures and guidelines to ensure ethical compliance and protection of the participants in this study. I sent participants my research consent form, which included written information about the study, the study's purpose, the requirements for participation, the potential risks, and confidentiality, outlined in the consent form (see Appendix D) through their email addresses. I informed each participant that participation was voluntary. Participants had the right to withdraw at any time without questions or penalties.

Because I conducted the interviews through the Zoom video conference, there was a potential risk of loss of confidentiality. However, I took all steps available to prevent the loss of privacy. Each participant was assigned a research code number, starting with T10 to T22. The interviews were conducted via Zoom and telephone, in my

private home office, using my personal computer protected with McAfee Virus and spyware protection. This software has firewall protection, McAfee web protection, and online privacy. My internet wireless router, NetGear Nighthawk, has Bitdefender security that blocks any threats and provides an extra layer of security to prevent data theft and virus from my computer.

Participants

Participants for this study were LMFTs and LMFT-As who are licensed to practice in Texas. All the participants were over 18 years of age. The targeted sample size to achieve saturation was 15. I recruited the participants through posting my research flyer and email on different MFT Facebook group pages, including MFT public Facebook group, the TWU family therapy program Alum public Facebook, and North Texas collaboration Private Facebook.

Sampling Procedures

I used purposive and snowball sampling techniques to recruit LMFTs and LMFT-As for this study. Babbie (2004) described purposive sampling as a type of nonprobability sample that allows a researcher to select participants based on their judgment of who would best provide the data needed. This sampling technique helps determine "information-rich participants" (Patton, 2002, p. 230). A second sampling technique, snowball sampling, was utilized to increase participation for this study. Snowball sampling is a nonprobability sampling technique used to collect data from the

targeted population who then refer other individuals they believe may be interested in the study (Babbie, 2004).

Once I received the approval for this study from the TWU IRB, I sought participants using my recruitment flyer (see Appendix A) and my recruitment email notice (see Appendix B). Both appendices described my research's purpose, criteria for the study, and confidentiality, along with my email address and phone number, to seek participants to volunteer for this study. I posted my study recruitment flyer and email notices on MFTs' public Facebook group with 7.3 thousand members.

The recruitment flyers were also posted on TWU Family Therapy Program Alum public Facebook, with a membership of 207 people. I contacted the TWU Student Association for Marriage and Family Therapy board members. I received approval to post my research email flyer on their private Facebook page, which has about 73 members. I also sought TWU professors' assistance who agreed to forward my study recruitment email and flyer to some practicing therapists they think might be willing to participate in this study. I made other attempts to recruit participants through the president and other officials of Relational Therapists of Dallas but received no response due to COVID-19 related closures. I sent an email to five male therapists who are members of the North Texas Mental Health Collaboration private Facebook group to get male therapists to participate in my study. None of them responded to my recruitment email/flyer.

Potential participants who responded to my flyer/email were screened for eligibility through telephone, using my telephone call script (see Appendix C). The participants who met the requirements and agreed to participate chose whether to be interviewed by phone or through the Zoom video conference meeting. Participants also chose the date and time of the interview. I sent the participants my research consent form (see Appendix D) through the email address they provided. Participants were able to sign and date the consent form electronically and returned it to me before their interview date.

Data Collection

Pilot Study

I had a pilot study of the four interview questions with one member of my research committee, who indicated that the study's questions were suitable. She recommended that I pay attention to any biases that I might bring into the research. A second pilot study was with an LMFT-A who did not participate in my research. She, too, thought the questions were appropriate and would generate useful themes. She made no recommendations.

Interview Procedures

In qualitative research, the researcher is the instrument in data collection. As the data collection tool, the researcher interviews the participants in a phenomenological study (Creswell, 2014). The outbreak of COVID-19 impacted this study's data collection process, which was initially designed to interview participants face-to-face. The pandemic led to the IRB suspending all research that required face-to-face interviews but

approved internet/online interviews to protect participants from injuries and harm from the spread of coronavirus.

I collected the data for this research by interviewing therapists to a scheduled Zoom meeting after they had signed the research consent form. I provided a Zoom meeting room ID and password. I enabled the "waiting room" that allowed me to admit the participants into the meeting room. During the Zoom interview meetings, participants were able to rename themselves by entering the assigned code number so their real name and other personal information would not appear on the screen. Only the participant and I were in the Zoom interview. As a token of appreciation, each participant received an email from Amazon to receive their electronic $20 Amazon gift card.

When therapists logged on to Zoom interviews and before recording, they were allowed a few minutes to discuss whatever was in their mind before we proceeded to the research interviews and recordings. Participants answered some demographic questions (see Appendix E). Using my research interview guide (see Appendix F), the participants responded to the four open-ended questions. When appropriate, I used follow-up questions to expand their responses to the questions further.

A total of 17 potential participants inquired about the study, and 14 met the study requirements. Three did not meet the criteria due to being licensed professional counselors (LPCs) and not LMFT or LMFT-A. Of the 14 therapists who met the requirements, one did not return the consent form and, therefore, was not interviewed. As a result, I interviewed 13 therapists and reached the maximum saturation variation needed

for the study. A study reaches saturation when additional interviews would not produce new or different information from what participants have already said. Reaching saturation means that the researcher stops collecting other data because "fresh data no longer sparks new insights or reveals new properties" (Creswell, 2014, p. 248).

Of the 13 interviews, I conducted 12 through the Zoom video conference and one interview using the telephone. Participants chose to be interviewed by phone or Zoom. I sent an electronic version of the consent form for the participant to sign, date, and return to me before the interview date. Even though the interviews were through Zoom video conference, I dressed appropriately, professional business casual, and showed concern and care for the participants' time and circumstances. I occasionally asked each participant how they were feeling and if they needed a break. I was able to complete all interviews on time and as scheduled. The interview time ranged from 40 to 55 minutes in length. All the Zoom interviews were video/audio recorded, and the one telephone interview was audio recorded using a digital voice recorder. The meeting ended when participants indicated they had no more to say, and I thanked them for their participation. I later transcribed the recordings verbatim and analyzed them for emerging themes.

Treatment of Data

Following each interview, I watched and listened to the video and took notes of participants' body language, silences, gestures, head nodding, and moments of tension and laughter. I then listened to the audio recordings without the videos to avoid

distractions from watching videos and background noise before transcribing each interview verbatim. I labeled each transcript with the participant's code number and the date of the interview. I printed four hard copies of the transcripts, each highlighted with a different color of markers corresponding to the participant's identified and coded statements. I created a spreadsheet, copied, and pasted participants' similar accounts for emerging themes.

Each participant's name appears only on their consent form, stored and locked in a file cabinet in my private home office. The assigned research code appeared on the saved audio recordings, interview transcripts, and the demographic questionnaires, locked up in a separate file cabinet in my private home office. The saved transcripts on my computer are on OneDrive Personal Vault, requiring two steps verification through an authentication App. I stored hard copies of the transcripts in a locked file cabinet in my home office. I will destroy the consent forms, the voice recordings, interview transcripts, demographic information, and any document related to this study after 3 years of completing this study.

Data Analysis Procedures

To analyze qualitative phenomenological data, researchers must: read and reread the interview transcripts several times to understand what the participants are saying. Then, organize the data into different categories or themes that make sense and relate to the data collected while bracketing the researcher's beliefs and assumptions to control for potential influence in interpreting what the participants are saying (Creswell, 2016).

Marshall and Rossman (2011) provided qualitative data analysis guidelines to include organizing the data, absorbing the data, generating themes, coding, and interpreting, and seeking other methods of understanding the data before writing the final report.

Following qualitative data analysis methods, I listened to each audio recording of my interviews within 2 days of the interview to immerse myself with what and how the participants described their perceptions and interpretations of readiness and other questions that followed. Transcription started immediately after each interview, but before transcribing each interview verbatim, I listened to each audio recordings several times, made copious notes, and noting the verbs and adjectives used in their descriptions. I read each transcript once to begin, then reread it, but that time highlighted and marked significant statements made by each participant before coding.

During the first cycle of coding, I used a short description of the participants' statements to summarize and code the words. I went over the phrases and codes assigned and organized them into groups and categories during my second coding cycle. The third coding cycle allowed me to examine patterns and identify the overarching themes that developed with each interview question to create a smaller number for the emergent themes. Using patterns is useful in grouping summaries into smaller numbers of themes that identify "an emergent theme, configuration, or explanatory" (Saldana, 2009, p. 152).

To triangulate my data, I sent four different transcripts to the graduate student who served as my intercoder, and four transcripts to my research advisor, along with the research and interview questions, to read and highlight significant statements and identify

themes. After several consultations with my research advisor and the doctoral graduate student over the phone and via Zoom to compare the transcripts' essential accounts and themes, we found similar themes. We agreed on the wording that mostly captures the overarching themes. I proceeded with organizing, coding, and narrating my findings.

In the final stage of my data analysis, I presented the data and my findings in a narrative format, using my notes and citing important statements and quotes from the transcripts to authenticate themes developed from this study. The excerpts from the transcripts illuminate the voices of the participants in this study.

Researcher as Person

I am a MFT doctoral candidate pursuing licensure as a LMFT-A. My interviews with the participants took place when the United States was experiencing the COVID-19 pandemic. Schools and businesses were shut down. Protesters took to the streets in the aftermath of the killings of unarmed African Americans by police officers. Civil unrest and racial tension were high. Young Americans of all races, colors, religions, and national origins were marching in the streets supporting the Black Lives Matter movement. Mothers of all races lined up in front of the young protesters to shield them from police assaults. There was polarization, and politicians could not agree on applying laws or benefits to those who had been marginalized and disenfranchised. Many people had lost their jobs, and some lost their homes or apartments due to the COVID-19 pandemic. Fights broke out at stores due to mask-wearing requirements. It was chaos!

I became increasingly worried about how these events would affect participation in my research and me as the researcher. What would be my next course of action? I was concerned about my research topic about Muslims when America is going through a conflict regarding race, ethnicity, and religious beliefs. Bias against immigrants resulted in young children of immigrants shown on the television locked up in what looked like cages. Tension and anxiety were high. There was a natural feeling of sadness and unhappiness for me and a reflection of my own experiences in the United States. I thought about my three American-born children and how these current events in the United States will affect them. Yet, I was comforted by knowing that these events are part of systemic changes, the long-lasting changes, and the second order changes we seek in therapy. I felt that this study could not have come at a better time to examine how therapists of all races think about working with the Muslim population so often discriminated against, disparaged, and marginalized in the United States.

I wrote down my own experiences of discrimination and my views about Muslims and bracketed those experiences. Examining my previous work as a probation officer for over two decades allowed me to objectively narrate participants' views and interpretations without bias or prejudices. Accounting for these characteristics was ingrained in me when I conducted pre-sentence investigations, writing reports, findings, and recommendations for judges and the courts. During my training as a therapist, there was an emphasis on objectivity and neutrality, which helped me put my feelings aside and present my findings with honesty and dignity.

As I interviewed the therapists, I noted excitement and enthusiasm from the therapists on this type of study's importance. I became convinced that mental health professionals like therapists can separate their feelings and experiences from the country's current state and focus on providing services to their clients, regardless of their race, ethnicity, culture, tradition, and religious beliefs. That gave me more strength to continue with my data collection during a time when some people are doubtful about their future.

Credibility/Trustworthiness

Qualitative research uses credibility, transferability, dependability, and confirmability to measure qualitative research's trustworthiness and credibility (Shenton, 2004). Other methods of ensuring reliability include data triangulation, member checking, peer debriefing, intercoder reliability, and reflexivity (Marshall & Rossman, 2011). For this study, I used triangulation to answer questions about the trustworthiness of this study. Triangulation is a form of confirmability that researchers can use to decrease bias and address beliefs and assumptions (Shenton, 2004).

I triangulated my data with my research advisor and the graduate student who also served as an intercoder. Intercoder is an additional coder who reviews the data, provide codes for the data and compare findings of coders (Creswell, 2016). The graduate student is a LPC, a doctoral candidate trained in human participants' protection, and knowledgeable about qualitative research rigor. I asked the graduate student to set her thoughts and beliefs about Muslims aside, set her emotions about the current situation aside, and set and bracket her experiences and counseling training before reading any

transcripts. Then I asked the intercoder to read and reread each transcript before identifying the themes that emerged. Both my research advisor and the graduate student reviewed my completed transcriptions and coding and verified emerging themes. I also used my demographic questionnaire to triangulate my interviews.

Finally, I reflected on the characteristics that I bring to this research that impact my data collection, analysis, interpretation, and contributions to MFT research. They include my own biases, life experience, previous professional background, and my training as a MFT. I wrote down my beliefs and experiences regarding Muslims, my assumptions of what therapists may think about Muslims, and my thoughts and emotions during the interview process, in the form of field notes. I bracketed my experiences, ideas, and feelings, which allowed me to interpret my findings honestly without biases. Bracketing what the researcher brings to the study adds to qualitative research's credibility and trustworthiness (Marshall & Rossman, 2011; Shenton, 2004).

Summary

The purpose of this qualitative research study was to examine MFTs' perceptions and interpretations of readiness to work with Muslim clients. The study recruited participants using my research recruitment email and flyer, which targeted LMFTs and LMFT-As. I collected this research data by interviewing 13 therapists, using four open-ended questions with prompts and follow-up questions. I used Zoom and telephone to interview the participants. The meetings were video/audio-recorded, transcribed, and analyzed for emerging themes.

CHAPTER IV

RESULTS

The results of this qualitative study on MFTs' perceptions and interpretations of readiness to work with Muslim clients are presented in this chapter. I conducted a pilot study of the four interview questions with one faculty member and a licensed marriage and family therapist associate who agreed that the questions were open-ended and suitable for participants to provide descriptive responses that would generate themes for this study. The faculty member reminded me: the investigator should be careful not to agree with the participants' responses since the researcher is also a family therapy student. Data collection started on June 14, 2020, and ended on September 30, 2020, after reaching saturation level with 13 participants. In Tables 1-5, I presented a summary of the participants' demographic information. The chapter ends with a narrative of the themes that emerged from this study.

Table 1

Participants' Demographic Characteristics: Age, Gender, Ethnicity, Marital status, and Education level

Participant	Age	Gender	Ethnicity	Marital status	Education level
T10	54	F	African American	Married	Masters
T11	27	F	African American	Single	Masters
T12	29	F	White	Married	Masters
T13	45	F	Nigerian American	Divorced	Masters
T14	37	F	Afro-Caribbean	Single	PhD/Candidate
T15	27	F	Black	Single	Masters
T16	27	F	Black	Single	Masters
T17	36	F	White	Married	PhD/Candidate
T18	29	F	Latinx/Hispanic	Single	Masters
T19	30	F	Caucasian	Engaged	PhD/Candidate
T20	28	F	White	Married	Masters
T21	30	F	Caucasian	Divorced	Masters
T22	29	F	African/Mexican American	Married	Masters

Note. N = 13. Participants were on average 33 years old.

Table 2

Participants' Demographic Characteristics: Religion, Current license status, and Years licensed

Participant	Religion	Current license status	Years licensed
T10	Christian	LMFT/LPC/LCDC	5 years
T11	Christian	LMFT-A	1 year
T12	Christian	LMFT-A	1 year 3 months
T13	Sabbath/Christian	LMFT-A	2 years
T14	Catholic	LMFT-A	1 year 5 months
T15	Christian	LMFT-A	1 year
T16	Other	LMFT-A	1 year 8 months
T17	Non-Denomination	LMFT-A	4 years
T18	Christian	LMFT-A	2 years 2 months
T19	Christian	LMFT-A	1 year 9 months
T20	Christian	LMFT-A	2 years
T21	Non-Denomination	LMFT-A	1 year
T22	Christian	LMFT-A	1 year

Note. $N = 13$. Participants' average years licensed is 2 years.

Table 3

Participants' Demographic Characteristics: Diversity/Multicultural courses, Class covering Muslims, Attended conference, and Read about Muslims

Participant	Took diversity/ multicultural courses	Took class covering Muslims	Attended conference covering Muslims	Read book/ journals about Muslims
T10	Yes	Yes	No	Yes
T11	No	No	No	Yes
T12	Yes	Yes	No	Yes
T13	Yes	No	No	No
T14	Yes	No	No	Yes
T15	No	No	No	Yes
T16	No	No	No	Yes
T17	Yes	Yes	Yes	Yes
T18	Yes	Yes	No	Yes
T19	Yes	No	No	No
T20	No	No	No	Yes
T21	No	No	Yes	No
T22	Yes	Yes	No	No
Note. *N* = 13. Yes = 8		Yes = 5	Yes =2	Yes = 9

Table 4

Participants' Demographic Characteristics: Had Muslim clients, Allow prayer, Reasons for allowing prayer

Participant	Had Muslim clients	Allow prayer	Reasons for allowing prayer
T10	Yes	Yes	Respect for culture and beliefs
T11	Yes	Yes	Respect for the religion
T12	No	Yes	Honor client/respect
T13	No	Yes	Accommodate clients
T14	Yes	Yes	Respect religion
T15	No	Yes	Space, clarity, and understanding
T16	No	Yes	Honor the religion
T17	Yes	Yes	Respect beliefs, religion , opportunity
T18	No	Yes	Respect religion, their rights to pray
T19	Yes	Yes	Respectful, acknowledgement
T20	Yes	Yes	Honor their religion
T21	No	Yes	Honor religious practices
T22	No	Yes	Spirituality and religious beliefs
Note. N = 13. Yes = 6		Yes = 13	

Table 5

Participants' Demographic Characteristics: Preferred theoretical lens

Participant	Preferred theory in therapy
T10	Attachment and CBT
T11	DBT/Experiential
T12	Experiential and Client Centered
T13	Narrative, CBT, EFT, Play, and CNT
T14	Experiential
T15	Experiential and Narrative
T16	EFT
T17	Integrated CBT, Mindfulness, Strategic, and Structural
T18	Trauma-Focused, CBT, Narrative, and Experiential
T19	EFT
T20	EFT, Experiential, and Attachment
T21	EFT
T22	Trauma-Focused and Attachment

Note. $N = 13$.

Description of the Sample

The sample consisted of 13 females; no males agreed to participate. Efforts to recruit male therapists was not successful. All the participants were LMFT-A, except for one therapist who holds LMFT, LPC, and LCDC licenses. The number of years licensed for all the therapists ranged from 1 year to 5 years, with an average of 2 years. The ages of the participants ranged from 27 to 54, with a mean of 33 years old. The participants came from diverse ethnic backgrounds: Four reported their ethnicity as Black/African American, five identified themselves as White/Caucasian. There was one Afro-Caribbean, one Nigerian American, one Hispanic/Latinx, and one Hispanic/African American. Five of the participants reported being married, two are divorced, five are single, and one is currently engaged to be married. Participants reported belonging to different religious groups and faiths. Eight participants identified themselves as Christian; one participant is Catholic; another one is Sabbath. Two participants reported non-denomination, and one identified as "other." As for the education level, all the participants hold at least one master's degree, with three reporting either holding a Ph.D. or Ph.D. candidate status.

Eight participants stated they took at least one diversity/multicultural course during graduate school. The five who did not take diversity/multicultural classes indicated that such classes were either not offered or limited to a few students from other counseling programs. Five participants said they took a class that covered Muslims, two

participants attended a conference that addressed Muslims, and nine reported having read books or journal articles about Muslims.

Six participants indicated they had a Muslim client or currently have a Muslim client(s). All the participants agreed they would halt a therapy session to allow their Muslim clients to pray if asked. Reasons for allowing prayers in therapy include respect for clients' beliefs, culture, and religion; to honor their faith; and to accommodate the client. Other reasons include acknowledging their beliefs; providing space, clarity, and understanding; the client's right to pray; and praying is essential to their religion and spirituality.

Participants' theoretical preference in therapy varied from a single theoretical lens to combining two or more theoretical perspectives. Three therapists reported using only emotionally focused therapy (EFT). One therapist uses only an experiential theoretical lens while conducting therapy with her clients. Other therapists reported integrating several therapeutic modalities in therapy.

Review of Data Analysis

In this phenomenological research, I derived data from the people who have experienced the phenomenon (Moustakas, 1994). Qualitative researchers (Creswell, 2016; Marshall & Rossman, 2011) have provided guidelines for qualitative data analysis to include organizing the data through initial grouping, clustering of data, identifying and coding the themes, and interpreting themes generated using participants' descriptions and

quotes from the transcripts (verbatim) to support emergent themes and the meanings participants attribute to the phenomenon in writing the final report.

I read each interview transcript several times and immersed myself with each participants' statement, so I became comfortable fitting their comments to one of the categories. Using Microsoft word document, I highlighted participants' significant accounts using different color-coding systems and identifying 31 categories. The categories were further collapsed into the four interview questions to determine the overarching themes that emerged from the interview questions.

Findings

This study aimed to explore MFTs' perceptions and interpretations of readiness to work with Muslim clients. The research questions, interview questions, and a total of seven themes emerged from the four interview questions.

1. RQ 1: How do marriage and family therapists perceive and interpret their readiness to work with Muslim clients?

   Interview Question: How do you see (perceive) readiness? And (b) What does it mean (interpretation) to you?

   Three themes: (1) Not ready to work with Muslim clients, (2) A need for self-education about Muslims, and (3) Willingness to learn from Muslim clients.
2. RQ 2: What are marriage and family therapists most concerned about when they are working with Muslim clients?

Interview Question: What are you most concerned about when you are working with Muslim clients?

One theme: Concern about ethics, biases, and offending Muslim clients

3. RQ 3: How were marriage and family therapists prepared in their graduate program to work with Muslim clients?

   Interview Question: In your opinion, how were you prepared as a marriage and family therapist during graduate school to work with Muslim clients?

   Two themes: (1) Lack of preparation in graduate school, and (2) Opportunity to enroll in diversity/multicultural courses.

4. RQ 4: What do marriage and family therapists recommend for university marriage and family therapy programs to prepare for Muslim clients?

   Interview Question: Finally, as a marriage and family therapist, what do you recommend for university marriage and family therapy programs to prepare their students to work with Muslim clients?

   One theme: Inclusion of diversity/multicultural courses requirement.

Theme One: Not Ready to Work with Muslim Clients

Most of the therapists, 8 out of 13 (61.54%), said they were not ready to work with Muslim clients. Some therapists talked about prior experiences with Muslims, but not enough to be prepared to take Muslim clients. Below are excerpts from the transcript on how therapists expressed their lack of readiness to work with Muslim clients:

> Not ready. I see my own readiness is, un, lackluster… I just know, like, minimal knowledge of, like Muslims in general… I wouldn't even know where to start, um, with understanding. Um, so my perceived readiness would be, um, I'm not- I don't feel ready, to be honest. (T15)
>
> Another therapist echoed by saying: Honestly, I don't think that I will be ready. Um, I know bits and pieces about, um, the Muslim… I don't think that I will be ready for that at all. (T16)

Even the therapists who had Muslim clients before, responded that they were not ready for Muslim clients. Here is an example:

> No. No, no, no, no. I still, um, so much more, um, there's so much more I need to know. Um, yeah. One client certainly does not make me an expert. (T10)

Theme Two: A Need for Self-Education About Muslims

All the therapists, including the few who indicated they were ready for Muslim clients, interpreted readiness as needing to educate themselves more about Muslims. Therapists discussed the need for more training to learn more about Muslims before they would feel ready to work with Muslim clients. Some indicated that Muslims were not a topic that was discussed during their training as a therapist. Therapists explained self-education as involving reading books and available literature about Muslims and consulting with other therapists, colleagues, and the Muslim community familiar with Muslim beliefs. Other means of educating themselves, therapists said, are listening to podcasts, attending conference presentations that cover Muslims, and when necessary,

seeking supervision to prepare for Muslim clients. Below are some responses from the participants on educating themselves to work with Muslim clients.

> So, I would, I definitely need to do more reading… Um, certainly reading more literature, talk with other Muslim clinicians, right? Talking with them to help, to get their insight as to some of the, um, some of the cultural norms and, um, just, just being cognitive, my differences, right, as well. (T10)

> Another therapist said: I feel like I would need a bit more training, um, specifically when it comes to like structure of the family, um, and how it relates to, you know, Muslims and their religion, um, because I think we're trained in certain ways that may not meet up with, uh, the belief system… (T20)

Other therapists' interpretations of readiness:

> I guess my interpretation of being ready is, um, for Muslim clients, is being somewhat knowledgeable of Muslim clients and how they view, um, relationships, how they view, um, marriage and family and whether being individualistic or collectivists. Like how, what is their worldview, and how they see the world? (T22)

> I think it would be an ethical, an ethical thing consideration if I were to have a client come in that identifies as Muslim to, um, you know, do some additional education, whether that be podcasts, reading books, um, consultation, those kinds of things. (T11)

Theme Three: Willingness to Learn from Muslim Clients

All the therapists expressed some inclination to learn from their Muslim clients. Therapists also stated that while they would allow their clients to teach them about Muslims, they need to limit seeking knowledge from clients to the first or second session. They acknowledged that depending on their clients to teach them would take time away from therapy. Instead, therapists indicated that they would learn from their clients by being open, listening, remaining curious, and only asking questions to clarify areas of beliefs that contradict their understanding of the religion. Therapists agree that the responsibility to learn about Muslims falls on their shoulders and not the clients.

The excerpts below highlight how therapists say they would learn from their clients.

> Um, I'll be ready to listen. … Have the basic information and as we go, we're constantly learning and, again, let the client teach us where we need to be going more to be able to help them. (T13)
>
> I would be open to listening to learning… I would probably seek to understand. …I would, I would apologize as needed and seek to repair the relationship with the client if they would, that I think it could be a really great therapeutic opportunity. (T12)

While therapists said they are willing to learn from their clients, several were also mindful about time spent learning from the clients rather than providing treatment. Here are some quotes:

> My own, perhaps, like guilt of I needed to be more prepared and I should know this, so I'm not having to use our session with them teaching me about their faith or their values. Some of that I should already have some knowledge of. And that, I think, maybe takes away from their experience or their ability to get the service. (T19)
>
> Um, I think again it's more of a general scope like you should have a, a general idea of basic Muslim beliefs or what's important or um, you know, that way something that they would consider to be common knowledge. So, they don't feel like they're spending their time and money in session educating you. Because again, that's not their job. (T17)

Theme Four: Concern About Ethics, Biases, and Offending Muslim Clients

All the therapists voiced some form of concern when working with Muslims. They include ethics and competency issues, concerns about the nuances that may transpire in therapy that could offend their clients, and concerns about their own biases and beliefs that may affect Muslim clients' therapy. Therapists indicated that they are aware of their professional code of ethics to provide treatment to all clients regardless of race, age, ethnicity, disability, gender, religion, national origin, sexual orientation, and others. However, they worry that not knowing enough about Muslims and providing treatment to them would be incongruent to Muslims' tradition and beliefs and could potentially send the wrong message to Muslims that therapists are ill-prepared to assist them with their issues in therapy.

Concern about ethics and competency include statements like:

> We are to, to practice based on competency. It's not possible to be competent on every culture. … So being able to, again, it goes back to, I guess, what you were writing on as well, is the competence part, how do we ensure that we are competent, um, unless we're interacting with them? (T13)
>
> So I feel that, at the very least, if you are going to be a culturally competent therapist and you have no knowledge of working with Muslims, then it is the therapist's responsibility to kind of get up to speed with at least a basic knowledge of what it means to be Muslim, for them. … We have to be culturally competent. (T17).

Concern about the influence of biases and beliefs were expressed:

> I think it ties into like, again, my own personal, um, bias and just being aware of those and making sure that they don't come up as well as just being fully aware of all the different things that, that could come up, like, like the prayer thing. Um-the prayer thing, Uh, prayer. (T21)
>
> I think um, certain biases that you know, may have been learned um, through like media or even you know, some bigoted family members. … I think there might also like if, based on stereotypes, I worry that if a Muslim man came to see me, … Um, and so there's there's just stereotypes I think that I need to either unlearn or be aware of, basically. (T20)

> So, there is this perception about Muslims being bad and all of that. And like with every faith, there are bad apples in them. … um, there might be some, some biases... that may impact treatment as well as things that they enjoy about the faith, or they appreciate about the faith that can probably move the therapy forward. (T14)

Concern about offending the clients was verbalized:

> I think I would be most concerned about offending someone unintentionally. …Your fear is always like, I'm gonna mess up. I'm going to upset somebody. I'm going to say the wrong thing. … I don't want to offend anybody. … I would have all the right intentions, um, and still do or say something that would be very inappropriate. (T12)

> Concern… that I'd say saying something inappropriate... Not, mm, not having, like, the intention to be offensive or say something that is not in align... Like aligned with that faith. … I want to choose my words carefully… (T19)

Theme Five: Lack of Preparation in Graduate School

Therapists reflected on their training as a therapist in graduate school. All but one therapist felt that their MFT program failed to prepare them to work with Muslims. Therapists said they were introduced to diversity issues in graduate school, but there was not much emphasis on different cultures and spirituality issues, and Muslims were not covered. Therapists said that cultural and religious issues are important topics

because they are issues that they are experiencing with their clients. They felt that their MFT program left them alone to fill those gaps on their own.

Here are a few quotes on how therapists responded to how their graduate program prepared them to work with Muslim clients.

> Um, but I can't really think of anything that necessarily prepared me for... um, I feel like with a lot of things, as far as like culture and like different beliefs and stuff, like if it was something that you were kind of left to, to kind of go and think and look up and try and find on your own. I don't think that it was necessarily something that was coursework. (T21)
>
> I don't feel like there was much training for many different cultures, erm... like I said, I didn't have to take a cultural class. … Throughout the program, there were some articles that we had to read that, you know... they were from different cultures, and... things like that, but there wasn't things like specifics on how we should be handling them... what to expect when we have a Muslim client. (T11)
>
> We get launched out here in the real world and we're having to find out ourselves, after we spent however many thousands of dollars to read about theory. Theory, theory, theory. …what does that look like for people that look like me, for people that don't look like me? Like, these, this community still needs help, and we are coming out here ill prepared, um, because theory, theory, theory, theory. (T22)

> Not very prepared. I'd say not very prepared. Not very prepared. … I don't feel as though the course work prepared me. It felt like it was, "Oh, it's your job to prepare yourself." Like, that was the preparing part, I guess. (T19)
>
> I don't. I'm not saying that I was specifically prepared to work with Muslim clients, honestly. … I can't remember any other activity where it was specifically spoken about… We should have a class on family and spirituality, or family and religion, because I think that would have helped me to be a lot more open. (T14)

Theme Six: Opportunity to Enroll in Diversity/Multicultural Courses

Having expressed disappointment with the lack of preparedness to work with Muslim clients during graduate training, therapists were asked what their graduate school could have done differently. Most of the therapists responded that their program design to leave diversity/multicultural courses as an elective was not helpful to them. Many stated that when they tried to take diversity or multicultural classes, they were unable to enroll because of the limited class sizes, and students from other programs such as the counseling department were given preference. In addition, the courses were not offered regularly. Therapists wished their graduate school had provided them more opportunities to take diversity/multicultural courses even if it was an elective and not required for graduation, because cultural and religious issues manifest in their clients' treatment. The excerpts below entail how MFTs expressed their wishes.

> I feel that we, um - I wasn't prepared at all, because you had a choice in taking, um, the multicultural class. … Looking back, a lot of things that could have been

> differently to enhance, um, us launching into, you know, therapists, … I feel like I want a do-over in terms of this prepar[ing] preparing you for... you know, working with clients who are of, um, different, um, minorities, and understanding their background. (T15)

Other therapists expressed failed attempts to enroll in diversity/multicultural courses. Here is how they put it:

> … Um, and I find that quite unfortunate, …um, as a, a black therapist, … One of my main interests was, how do I help, you know, people of color? So I thought I… that I would have a class with, … diversity and multicultural issues, … then I found out that, in that class in particular was only limited to, um, uh, a counseling program, and then you had to ask for admittance into the program. (T16)

> ...But if there was more of that course made available, because there's only so many slots and it's only so many like semesters, it's not offered every semester… And it would have been if I did multiculturalism, but the course was full each time I tried to take it. (T21)

Theme Seven: Inclusion of Diversity/Multicultural Courses Requirement

In response to how MFT programs can prepare students to work with Muslims, 12 of the 13 therapists suggested that MFT programs expose all students to cultural and religious matters by making multicultural and diversity courses a requirement for graduation from the program. To prepare future therapists, they recommended that university MFT programs require students to take a minimum of six credit hours of

diversity/multicultural courses that address racial, cultural, and spirituality issues, including Muslim religious practices. Therapists believed that MFT schools should spend more time teaching students about different cultural, religious beliefs, and backgrounds because they now face clients with diverse backgrounds and with varying views of the world.

Below are quotes from participants' expressions and recommendations.

> … But I think MFT programs need at least three or six hours of some kind of cultural class like, preparation. Like, we need that, … as MFTs because we know how important that is. And, I- I- if it's not written in anywhere, then MFT need to talk about it. … I feel like three hours isn't enough because… and it's just not enough time to focus. (T18)

> Um, I think there needs to be more than one course, so yeah. I don't think you can cover stuff like that in one semester. … it's important for you to be knowledgeable and competent in with working with diverse people. (T19)

Several other therapists responded in similar fashion:

> I think requiring a multicultural class as a part of graduation, or even more than one because I can't even remember if I had to take it or not. Um, so maybe requiring more than one multicultural class. As a requirement. Yes. Should not be an option. (T20)

> There should be, I think there should be some foundational classes that, that you're required like African American, I think, um, Latina population, um,

> Muslim population, you know, … there should be individual classes within themselves and not lumped into a multicultural diversity class, um, because there's so much for each one and those are very large populations in our country. (T10)

> Whenever I took like a multicultural and diversity class, that was actually an elective. … Um, I don't know if they actually prepared us. … Like, everything was about theory, theory, theory, theory, theory. That was the whole program, is that it was focused on theory as opposed to, um, kinda like really honing in and like spending maybe a few classes on, um, these are the things of the Muslim community. (T22)

Additional Findings

Willingness to Integrate Prayer into Therapy

Participants' responses to two demographic questions (see Appendix E) revealed therapists' inclination to incorporate Muslim religious beliefs in therapy. Demographic question #15 asked participants if they would allow their Muslim clients to pray if requested, and demographic question #16 asked to state reasons for allowing prayer during sessions. All the participants promptly agreed they would let their clients pray if requested, including accommodating their clients by finding out their prayer time and working around their schedules to meet their needs.

Here are a few examples of how participants expressed their views on allowing their clients to pray.

> That, that's a good question. I, I imagine, um, they know their set times to pray. Um, so then we would even before getting to that point to be proactive and schedule, uh, the session outside of their prayer time. 'Cause if I'm not mistaken, each of their prayer times are at a specific time of day. And I know they do have to face the East if I'm not mistaken. (T13)
>
> … My thing is like, it's it's their rights to, to pray for a moment, um, and I would allow them that space. Or I could always like work around that time. … and um, if every session they wanted to miss out 10 minutes of their session to do that, then that's their option to. (T18)
>
> Well, I would want to be respectful, respectful of their beliefs and um, if it were something that we could schedule our sessions around, that would be preferred but if for whatever reason… um, … that was the only time they could come for a session, then I would 100% honor their need to pause our session. Um, just out of respect for them. (T17)

Emergence of Self-Of-The-Therapist Work

Therapists voiced care and concerns for Muslims, worried about how their own beliefs, biases, and the influence of the family of origin may affect their treatment of Muslims. They recognized the necessity of resolving those issues to provide therapy and gain trust from their Muslim clients. They discussed the steps they would take to resolve those issues, including examining their world view, the theoretical lenses influencing

their treatment approach, and seeking supervision. Here are two quotes that support emergency of self-of-the-therapist work.

> … how can I make this person feel seen? … I mean like, see them for who they are, what they are. Um, and what that means is like, being a Muslim individual or being a woman or being a man, um, realizing that if they're identifying as a Muslim, that with everything the world has created around that religion or that stereotype, that I can see beyond that. So how can I make that person feel safe and seen? (T18)

> … in my lens, I might see that as traumatic. And for a Muslim client, that might not be traumatic for them. So I, I have to fight that sometimes and not use the language of oh my gosh, that's really traumatic. But, you know, somebody that's different, that has a different culture or viewpoint from me. … Uh, trying to fight against like the once again, that cognitive dissonance of, this is how I see the world but you see it differently. Do I reconcile them both? How do I reconcile them? And also, um, not pathologizing something that may be normal, um, in a culture that's different from mine. (T22)

No Concerns About Muslim Attire/Clothing

The topic of Muslim attire/clothing emerged after one participant raised concern about how a male Muslim client might view her own dressing if she is not covering her hair and other body parts. Following that discussion, I incorporated asking the rest of the participants to respond to their views on Muslim attire/clothing as part of my follow-up

questions on what therapists are concerned about Muslim clients. All nine therapists who were asked this question responded that they are aware of Muslim attire/clothing and the covering of the body and face for religious reasons. Therapists indicated that they are not necessarily concerned with Muslim attire/clothing because they expect Muslims to wear their traditional or religious attire to therapy.

However, some experiential therapists discussed the implications of complete coverage of the body with only the eyes visible and indicated that it may inhibit them from reading the clients' facial and body language because they rely on reading body language, facial expressions, and gestures to access what is going on with their clients and what they are trying to communicate. These therapists also indicated that while that may pose minor issues for them, they have found ways to address such issues since COVID-19 has forced them to conduct therapy through video conferencing, and therefore, Muslims' covering of their body is not a distraction for them.

The excerpts below show how therapists felt about Muslim attire/clothing.

> Um, that would not be a concern to me. Uh, and I think, um, that is the, just the, my background, my experiences in different parts of the world, um, that would not, that's not, that would not be uncomfortable or unusual. It would actually be kind of be my expectation that, that's how they would come. (T10)
>
> You know, before COVID, I would have said that I would probably have been extremely thrown off by not being able to see their like facial expressions and stuff, but-... but I've learned to read people's eyes very well now. I would have

> been concerned about it before, but now that I've, I've been through all of this, I'm not necessarily concerned about it because I just realized that it's one more thing that we just gotta learn to work around. (T21)

Here is how one experiential therapist expressed her views:

> I think the only thing that I would probably be concerned about is the ones who have on the burka, the burka, I think, I hope I'm pronouncing that correctly. But basically, the women where I can only see their eyes. Because I rely a lot on facial expression, and only seeing their eyes would be quite challenging for me. … the facial expressions, I think would be difficult for me with women who, um, whose eyes I, that's all I see. (T14)

Summary

This chapter presented the findings from this phenomenological study on MFTs' perceptions and interpretations of readiness to work with Muslims. The study included 12 LMFT-As and 1 LMFT who graduated from at least three different universities, including an online MFT program. A total of seven themes emerged from this study: (1) Not Ready to Work with Muslim Clients, (2) A need for self-education about Muslims, (3) Willingness to learn from Muslims clients, (4) Concern about ethics, biases, and offending Muslim clients, (5) Lack of preparation in graduate school, (6) Opportunity to enroll in diversity/multicultural courses, and (7) Inclusion of diversity/multicultural courses requirement. Participants' significant statements support the results. These findings will help fill the void in the literature regarding therapists and Muslim clients.

CHAPTER V

DISCUSSION OF FINDINGS, CONCLUSIONS, LIMITATIONS, IMPLICATIONS, AND RECOMMENDATIONS

Research shows that more Muslim families are seeking professional mental health assistance to address issues manifesting in their family (Abu-Ras & Abu-Bader, 2008). While MFTs can assist Muslim families (Haque et al., 2018), there is a shortage of mental health professionals interested in working with Muslims (Abbott et al., 2012). Muslims worry that therapists may not understand their religious and cultural practices, and therefore, may not be able to provide services that are congruent with their beliefs. Research shows "there are very few therapists who are well grounded in Islamic approach to treatment" (Haque, 2004, p. 53). Therapists are being asked to be ready for more Muslims seeking professional assistance.

The purpose of this study was to explore MFTs' perceptions and interpretations of readiness to work with Muslim clients. Research into this area was significant for several reasons. It provided information on therapists' readiness for Muslim clients. It also includes essential information on what therapists are concerned about when working with Muslims. The study also addressed how therapists viewed their graduate school preparation to work with Muslims and what therapists believed university MFT programs could do to prepare students to work with Muslims.

Discussion

This chapter includes a discussion of the findings in this study, previous research findings, and scholarly recommendations that support the results, the participants' voices, and my summation of the implications and recommendations. Table 6 is a summary of the themes that emerged from this study. To the best of my knowledge, there has been no study examining therapists' perceptions and interpretations of readiness to work with Muslim clients. Therefore, some findings are new, and have no prior studies to support the results. This chapter ends with the study limitations and suggestions for future studies.

Using a phenomenological research method, the participants had the opportunity to respond to their readiness to work with Muslim clients. This research method was best suited for this study because it allowed me (the researcher) to understand several individuals' (therapists) shared experiences of the phenomenon (Moustakas, 1994).

Table 6

Summary of Themes

Theme Number	Name of the Theme
Theme 1	Not Ready to Work with Muslim Clients
Theme 2	A Need for Self-Education About Muslims
Theme 3	Willingness to Learn from Muslim Clients
Theme 4	Concerns About Ethics, Biases, and Offending Muslim Clients
Theme 5	Lack of Preparation in Graduate School
Theme 6	Opportunity to Enroll in Diversity/Multicultural Courses
Theme 7	Inclusion of Diversity/Multicultural Courses Requirement

Themes

One: Not Ready to Work with Muslim Clients

Most of the therapists doubted their readiness to work with Muslim clients. They explicitly stated that they were not to work with Muslim clients. Therapists felt that they received no training and were not prepared in graduate school to work with Muslims. But even though therapists felt unprepared, they indicated that they would not refuse Muslim clients seeking treatment. They are willing to use other resources, such as seeking supervision and reading the available literature on Muslims to prepare themselves for Muslim clients. Although this finding is new, and no research has explored therapists'

perceptions and interpretations of readiness to work with Muslim clients, scholarly literature lists several issues to consider when working with Muslims. They include the presentation of self, family dynamics, causation and interpretations of illness, and strategies in coping with illness (Weatherhead & Daiches, 2015).

Other qualitative studies using focus groups and interviews to understand Muslim religious beliefs and practices provide some basic facts needed to work with Muslim families. They include an emphasis on extended family; gender respect, not gender equality; the role of Islam in Muslims' daily life; and the qualified acceptance of professional interventions. Qualified acceptance means that professional interventions offer Muslims something in return for seeking treatment (Carolan et al., 2000).

Two: A Need for Self-Education About Muslims

Therapists interpret researchers' alert to be ready for Muslims as a call to action through self-education on Islam's basic tenets and Muslim beliefs and practices. Therapists indicated they would read and research Muslims before meeting their clients the first time. They would also reach out to other therapists who have treated Muslims and are familiar with the belief system. Researchers are asking therapists to educate themselves about Muslim gender roles, attires, and family values. Clinicians must know that Muslims come from different families and countries (Ali et al., 2004). Other researchers advise therapists to learn some basic Islamic principles that guide Muslims to prepare for Muslim clients (Hamdan, 2007).

Three: Willingness to Learn from Muslim Clients

Therapists say they are willing to learn from Muslim clients. Therapists in this study said they would be open, listen, be curious, be honest, and be non-judgmental about Islam and Muslim traditions. What these therapists said will enable them to learn from their clients and expand their knowledge about Muslims. Therapists' willingness to learn from Muslim clients revealed some therapists' qualities that studies have indicated are essential to building a therapeutic alliance with clients. Ackerman and Hilsenroth (2003) have enumerated therapists' factors that enable creating a therapeutic alliance to include openness, honesty, trustworthiness, flexibility, confidence, warmth, and interest. Scholars and researchers encourage therapists to ask their clients about Islam and what their religious beliefs mean to them to help therapists know more about Muslims and Islam (Raiya & Pargament, 2010).

Therapists from one study recommend that clinicians take a not-knowing approach, remain curious, and allow Muslim clients to be experts. As a benefit, therapists learn more about Muslim culture and religious differences (Arshad & Falconier, 2019).

Four: Concern About Ethics, Biases, and Offending Muslim Clients

Therapists spoke about the ethical and professional competency requirements to provide services to clients. They were concerned about accepting Muslim clients when they know that they are not prepared to work with Muslims. As a result, ethical and competency issues may arise, and Muslim clients may doubt therapists' knowledge and skills. Therapists' concerns are valid due to the AAMFT Code of Ethics. Therapists have

the ethical obligation to provide treatment to all clients regardless of race, age, ethnicity, socioeconomic status, disability, gender, health status, religion, national origin, sexual orientation, gender identity, or relationship status. The code of ethics (professional competency section) also requires marriage and family therapists to seek and acquire new knowledge and maintain competency through education, training, and supervised experience (AAMFT, 2015). While therapists voiced concern about ethical and competency issues, they expressed interest in educating themselves by reading books and articles and seeking supervision to prepare themselves better to work with Muslims.

This ethical and competency concern is consistent with previous research studies on the use of religion and spirituality in psychotherapy. Brown et al. (2013) found that ethical concerns, professional competency, and practice scope were among the barriers to using religion and spirituality in therapy. Williams (2005) indicated that therapists should be concerned about ethical and moral issues when working with Muslim clients. Hall and Theriott (2016) were concerned about the lack of cultural competency and skills among clinicians. Miller and Chavier (2013) found ethical and boundary issues were among the problems encountered by MFTs' experiences of integrating prayer into therapy.

Therapists were also concerned about the influence of bias while working with Muslims. Therapists did not refrain from pointing out their exposure to Muslim practices through negative media coverage, their personal beliefs, assumptions, and stereotypes

about Muslims. They want to be careful not to make any false assumptions about their client's beliefs and are willing to ask the clients for clarifications when in doubt. These findings are on par with scholars and researchers familiar with Islamic practices in working with Muslim clients. Researchers and scholars have written about the impact of biases and stereotyping against Muslims in treatment. They have urged clinicians to work with Muslims to be aware of the biases and avoid making assumptions about Muslim beliefs, practices, and values. Mental health providers must be sensitive to religious beliefs and know the limits on Muslim clients' boundaries issues (Williams, 2005). Springer et al. (2009) recommend that therapists conduct self-evaluation on biases and prejudices toward Muslims.

Therapists were concerned that their lack of understanding of the practice of Islam and Muslim traditions, including family structure, would increase the propensity of unintentionally offending their clients by saying the wrong things. Issues such as boundaries, roles, values, responsibilities, and etiquette may run contrary to Muslim beliefs and practices. Consequently, the differential views and expressions could hinder progress on the objectives and goals for treatment. Some of the concerns would be reduced once therapists begin to read and learn more about Muslims.

Five: Lack of Preparation in Graduate School

Most of the therapists did not think that their MFT program prepared them to work with Muslims. Therapists from different institutions, including those who completed their graduate program online, felt that their MFT program spent most of the

time teaching theory and its application and devoted little time to cultural diversity, religion, and spirituality. The participant in this study stated that their graduate school did not cover topics like Muslims and Islam during their training. Their views were that graduate school training introduced them to diversity in general but left them to work on other issues on culture and religion.

There was an outlier, as in quantitative analysis. One therapist felt that her graduate program prepared her well to work with individuals from diverse cultures. She stated that her education helped her to become more aware of differences in multiple cultures. Her training has been instrumental at this time of racial and political division. However, she did not specify if her graduate school prepared her to work with Muslims.

Six: Opportunity to Enroll in Diversity/Multicultural Courses

Therapists were disappointed that their program failed to offer them more opportunities to take diversity/multicultural courses during their graduate training. Their MFT programs did not require them to take diversity or multicultural classes. Still, when they tried to take the course that was offered, they could not do so because the classes were limited to other students in the counseling or psychology department, causing a waiting list and inability to sign up for the classes. Therapists would like to see more opportunities for students to take diversity or multicultural courses.

Some therapists thought that if their MFT program had integrated religion into training therapists, they would have been more familiar with religious practices. They contend that religion is a significant part of their client's strength that they bring to

therapy. Incorporating spirituality as part of training therapists will help therapists prepare and approach clients with strong religious beliefs. This finding is significant and consistent with the available literature on incorporating religion and spirituality into therapy. According to Hamdan (2007), "Religion is often pervasive and central in the life of a Muslim; thus, it would be important and valuable for counselors to integrate some aspect of Islam into the counseling process" (p. 95).

Studies show that integrating religion into psychotherapy is effective in treating Muslims dealing with anxiety, depression, and bereavement (Razali et al., 2002). Clinicians working with Muslim clients should ask direct questions to see where religion ranks in their lives and their interpretations of Islam (Raiya & Pargament, 2010).

Seven: Inclusion of Diversity/Multicultural Courses Requirement

One way to expose therapists to diversity, culture, and religion is to make diversity/multicultural courses a requirement. Therapists report that they face pressing issues of diversity, race, and religious beliefs that continue to manifest in therapy. Therapists recommend a minimum of two classes (6 credit hours) of diversity courses.

All the participants in this study echo this call for mandatory requirement of diversity or multicultural course requirement. Some participants acknowledge that adding more classes to the existing course requirements would increase costs and delay graduation. They suggest that programs cutback or substitute some theory courses for diversity/multicultural courses, which are more critical because they deal with cultural and diversity issues more in their clinical practices.

It would be difficult to dispute the impact of taking diversity/multicultural courses to work with individuals from diverse cultural and religious backgrounds. However, in a study on the experiences of eight non-Muslim, Caucasian LMFTs working with South Asian and Middle Eastern Muslims (Arshad & Falconier, 2019), the authors found that taking a multicultural course alone did not make a difference in the experiences of the participants. The participants who received multicultural training in their graduate school and those who did not, experienced similar challenges when working with their clients. Arshad and Falconier's study did not specify the number of credit hours of multicultural training that the participants received, and the sample appears small.

My study participants acknowledged that one diversity/multicultural is not sufficient to prepare students for diversity and religious issues that they face in clinical practices. Hence the recommendation for a minimum of two classes (6 credit hours) requirement for MFT students.

Additional Findings

Analysis of the demographic survey indicated that therapists are to incorporate prayers into therapy. The participants agreed to allow their Muslim clients to pray, if the clients requested for time to pray during sessions. Studies show that one of the enablers of integrating spirituality into psychotherapy is clinicians' willingness to participate in therapeutic and religious activities with the clients. Brown et al. (2013) found that most psychologists in their study indicated a willingness to participate in therapeutic but not religious activities with their clients.

There was also an indication of emergence of self-of-the-therapist work after listening to all the participants in this study. Therapists were concerned about how the influence of biases, beliefs, and media coverage of Muslims would affect therapy with Muslim clients. They recognized these factors and indicated that they would work on their own unresolved issues. The self-of-the-therapist work is needed to address conflicting views and biases that therapists bring to therapy that may hinder therapeutic relationships. The discussion signals that therapists are willing to do the work of self-of-the-therapist that is needed to address conflicting views and biases that therapists may bring into the therapeutic process that can interfere with building therapeutic alliance with the clients.

Researchers have long advocated the importance of doing self-of-the-therapist work. They insist that therapists work on these conflicting views that they bring to the therapeutic process that contributes to barriers to building a therapeutic relationship with clients of different races, ethnic backgrounds, cultures, and religions (Lum, 2002; Timm & Blow, 1999). Experiential therapist Satir (1987) wrote on the importance of doing self-of-the-therapist's work to combat issues that may prevent therapists from working with clients who are different from them. Satir used the metaphor, musical instrument, to refer to "therapist's use of the self" (p. 23). Like an instrument, Satir maintains that the therapist must be complete as a person, take care of himself or herself, and be competent in what the person is doing. She described the music as "the presentation of the patient"

(p. 24). Therefore, it is essential to know how therapists hear and understand what the clients say and determine their outcome.

Timm and Blow (1999) posited that therapists who are willing to do soul-searching on issues in their lives that may negatively or positively influence the therapeutic processes are what self-of-the-therapist's work is about. Therapists are encouraged to examine their past life events or experiences to see how those experiences inform them about their work. These experiences serve as strengths and weaknesses in the therapeutic processes. Lum (2002) adds to the self-of-the-therapists' literature by emphasizing therapists' need to work on their own unsettled family of origin issues and resolve those disputes to work better with their clients. According to Lum (2002), "Therapists who are emotionally healthy are more likely to have worked through their own personal issues" (p. 181). Therapists working with Muslims must examine the effects and influence of pervasive information about Islam to reduce implicit bias against Muslims (Haque et al., 2018).

Therapists also had no concern about Muslim attire/clothing. They expect Muslims to dress in their traditional or religious attire when coming to therapy. The therapists who employ experiential therapeutic theory were a little concern about total body covering of Muslims coming to therapy, but they also indicated it poses no major barriers in therapy sessions as they have discovered other means of reading facial and body language in treatment since the onset of COVID-19 and they had to do therapy via Zoom.

Despite the general findings that Muslims' head covering contributes to a generally negative attitude towards Muslim women (Everett et al., 2015), therapists reporting no negative feelings towards Muslims' head covering is significant for Muslims seeking therapy. Muslims can be comfortable wearing their traditional attire to treatment without fear of prejudice and therapists' stereotyping them.

Application of Theoretical Lenses

Researchers have questioned the efficacy of using Western theories while treating clients from another culture whose definitions and interpretations of illness may not fit the Western view of disease (Seponski et al., 2013). Muslims in the United States include immigrants from other countries with different world views and interpretations of illness. Using Western instruments developed for assessment/diagnosis and labeling illness may not correctly identify or address presenting issues in therapy for individuals of diverse cultural and religious beliefs. What may be interpreted as typical behavior from an individual's religious or cultural practices could be diagnosed as a dysfunctional behavior or illness, using the Western assessments and treatment tools. Clinicians may overlook the cultural and religious beliefs of the patient.

Literature review on models of therapy used with Muslim clients does not specify which models are better with Muslim clients. Most studies on working with Muslims use cognitive or Islamic modified cognitive therapy with Muslim clients (Hodge & Nadir, 2008; Husain & Hodge, 2016; Mir et al., 2015; Naeem et al. 2015).

Sauerheber et al. (2014) suggested counseling Muslims using Bowen's family systems perspective. The authors provided therapists guidance on how to apply Bowen's theory when working with Muslims. Chaudhry and Li (2011) have suggested using solution-focused brief therapy with Muslim clients as it supports Muslims' cultural sensitivity. These studies indicate that these theoretical approaches can work with Muslim clients when used systemically because family theories take a systemic approach to illness manifestation and treatment. Regardless of which theoretical lens or lenses guide a therapist working with Muslims, it is crucial to underscore that all family theories are systemic in their applications, and therapists think systemic. Therefore, therapists should not worry about changing their preferred lens when working with Muslim clients.

However, what is essential is that therapists evaluate the significance of using their theory with Muslim clients to determine if the theoretical lens is compatible with Muslim beliefs and practices. The assessment must be fair and congruent with the population that it intends to serve. Treating Muslim individuals or any other minority group with theoretical models that contradicts their beliefs would increase their symptoms and anxiety. Family therapy theoretical models that do not pathologize will be more appropriate to use with Muslim clients.

My preferred theoretical lens is structural family therapy theory. Muslim family structure takes hierarchy and patriarchal, roles, boundaries, rigid rules, and formats. Therefore, a structural family system approach is also a good fit for conducting therapy with Muslim clients. Structural therapists are continuously assessing at every session;

they do not pathologize; they examine the family structure and help the family restructure by addressing boundary issues, roles, and hierarchy. During difficult times, Muslims gravitate to the Islamic faith first. As the therapists assess, they must consider spiritual matters that the client draws meanings that shape their religious beliefs (Williams et al., 2011).

For Muslim clients, it is no exaggeration to say that religious beliefs and healthy family and Muslim community relationships are strengths that therapists must underscore as they examine the manifestation of illness or issues presented in therapy. The therapist can discuss Muslim family dynamics relating to Muslim communities' influence, the extended family, hierarchy, structure, boundaries, and power. A 4-step model for assessing couples and families, developed by Minuchin et al. (2007) involves: (1) broadening the definition of the presenting complaint to include its context, (2) identifying problem-maintaining interactions, (3) a structurally focused exploration of the past, and (4) developing a shared vision of pathways to change (Nichols & Tafuri, 2013) will assist therapists in working with Muslims.

Conclusions

This study aimed to examine MFTs' perceptions and interpretations of readiness to work with Muslim clients. The results show that, at present, most therapists are not prepared to work with Muslims, the reason being that therapists indicated that their graduate training did not cover working with Muslim clients. Therapists stated that they need to educate themselves by reading and researching Muslims to work with Muslim

clients. Therapists are inclined to allow Muslim clients to educate them about their faith and culture. However, therapists want to limit how much they would allow their clients to teach them because it would take away clients' time to address their therapy issues.

There were questions about ethical and competency issues, but therapists said they would still take Muslim clients. To address this issue, therapists said that it is their responsibility to educate themselves about Muslims and seek supervision when necessary. Therapists addressed issues of biases and concern about offending the clients by indicating that they would examine their family of origin influences and unresolved family issues.

Therapists cited the lack of opportunity to take diversity/multicultural courses as one reason they are not prepared to work with Muslim clients. Therapists wished that their programs had provided them more chances to take diversity/multicultural courses. The recommendation is to make diversity/multicultural course a requirement for graduation. MFT programs should offer a course on religion that addresses different religious beliefs.

Limitations

All the participants in this study were female therapists. Male therapists did not respond to this study's recruitment flyer and emails. Interviewing male therapists would have given this research more insight into their perceptions and interpretations of readiness to work with Muslim clients. The average number of years of practice for the participants was 2 years. The participants in this study are new therapists who do not

have a lot of experience in conducting therapy. These factors may have influenced the study outcome. The study also did not have Muslim therapists. Having Muslim therapists' perspective could have produced additional insight into how non-Muslim therapists can work with Muslim clients.

Implications

Literature on Muslims reveal a culmination of factors including discrimination and marginalization, biases and prejudice, government policy on immigration, and particularly on Muslims, and others, have created an atmosphere of distrust, anxiety, stress, depression, and interpersonal relationship issues among Muslims. More Muslims are now seeking professional mental health assistance, a deviation from Muslims' tradition of seeking assistance from their religious leaders and family members.

This study revealed information that will assist therapists and other mental health professionals in working with Muslim clients. Lessons learned from the participants' shared experiences will help university family therapy programs develop a program curriculum that addresses this research inquiry and recommendations. Some suggestions include a more pragmatic approach to expose therapists to Muslims. Reaching out to Muslim community to coordinate and verify Muslim beliefs and practices to incorporate into teaching. Family therapy professors should invite guest speakers who are familiar with Muslims and conduct workshops and activities that focus on Muslims.

While there are therapists who specialize in different areas of treatment and population, there are not enough licensed therapists familiar with Muslim traditions to

provide Muslims the services that are compatible with their beliefs and traditions. Therapists in this study indicated that their MFT programs did not prepare them to work with Muslims. Their experience in the field is that they see more clients from diverse cultures and religious backgrounds. They wish that their graduate program had prepared them more on working with these groups.

This study also revealed some therapists' concerns when working with Muslims. They worry that their lack of understanding of the religion might lead to unintended consequences such as offending their clients, ethical and competency concerns, and managing their biases about Muslims. This study adds to the limited literature on therapists' work with Muslim clients.

Recommendations

For Marriage and Family Therapists

Information from the literature review and findings from this study gives MFTs and other mental health professionals the precept to Muslim religious beliefs and practices. Learning more about Islam and Muslims will allow mental health providers to render services that meet Muslim patients' needs. Mental health professionals must be willing to provide Muslim patients with the preferred gender provider. They must have other resources and providers available if the requested gender is not currently available. There must be a recognition and acceptance by treatment providers that asking for a specific gender by Muslim clients is not a rejection of the service provider, but a religious and cultural belief within that community. Mental health professionals must be prepared

to address Muslim concerns in a professional, respectable, and reputable manner consistent with Muslim religious and cultural beliefs.

Therapists and other mental health professionals must collaborate with the Muslim community and their religious leaders and educate them on the services that they can offer to Muslims. To develop a better relationship, mental health providers should arrange with Muslim religious leaders to visit Muslim worship places (mosques). Discussions should include Islam's basic tenets and how it influences the life of a Muslim. Treatment providers can add Muslims to their social media networks such as Facebook, Twitter, Snapchat, and professional network such as LinkedIn to get a glimpse of issues that Muslims discuss and create a trusting relationship with Muslims. Having Muslim friends, visiting Muslim families, and inviting Muslim families to visit non-Muslims at home can ease the tension and create a relaxing environment where Muslims will not feel that they are only welcome by Muslims alone.

Therapists must continue to educate themselves about Muslims and other minority members not covered during their training. Reading books and articles about Muslims, attending conference presentations that entail Muslim discussions, and other minority groups workshops can improve their knowledge and fill the void in the formal training of that specific ethnic or cultural groups. Current and future students in marriage and family therapy programs can explore research options that address Muslims and other minority groups. As part of their internship training, they can arrange to visit Muslim places of worship (Mosques) to observe and learn more about Muslims.

MFTs can serve as the conduits between the mental health profession and the Muslim community to assure Muslims that therapists understand their religious beliefs and practices and consider Muslim religious leaders' insight and Muslim family recommendations on addressing issues presented in therapy. From the literature on Muslims, they may share similar religious beliefs, but like other minorities, no two Muslims are the same. Individual differences must be accounted for when treating Muslim clients.

Therapists must be careful not to fall into the politics of the divide. Therapists working with Muslims must not take a cavalier attitude towards Muslim experiences and religious beliefs as they will encounter more Muslims seeking their professional assistance. Faith, thoughts, and management of illness often manifest in therapy. Recognizing that going to a therapist is not the first option for Muslims to address the problem is essential. For Muslims, seeking mental health assistance comes with guilt and stigma. Those seeking therapy outside the Muslim family and community are considered weak. There is also a concern that therapists do not understand Muslims and Islam and may be biased. There is also the assumption that therapists are likely to stereotype Muslims due to false information about Muslim beliefs (Abbott et al., 2012; Casey, 2017; Haque et al., 2018). Therapists must take Muslim clients seriously when they break from their tradition of not going to their family and religious leaders to seek assistance. Going to an outsider and disclosing personal life, faith, secrets, and other family issues requires trust for that person, the therapist.

Therapists must consider that when Muslims do seek therapy, they consider certain qualities in the therapist to include a culturally sensitive therapist, a therapist they can trust, and a therapist who is familiar with Islam and Muslim (Ali et al., 2004; Al-Krenawi & Graham, 2000; Carolan et al., 2000). Being sensitive to cultural and religious beliefs is vital in establishing therapeutic relationships and keeping clients involved in therapy. Therapists must know that being aware of group norms for a particular group does not mean that everyone is the same. Understanding cultural differences and becoming aware of the information they inherited from their family is important to working with others who are different from the therapist (Patterson et al., 2009). These factors are essential when conducting therapy with Muslims.

When conducting an assessment for a Muslim client, therapists must assess the clients' spiritual issues because it is the avenue of their strength and comfort that shapes the experiences and meanings they bring to therapy. Therapists must be willing to explore how the clients' culture and religion influence the definitions, interpretations, and worldview (Williams et al., 2011).

McGoldrick et al. (2005) once wrote that religion is a significant source for transmitting cultural heritage for many ethnic groups. Therefore, "spiritual beliefs influence ways of dealing with adversity, the experience of pain and suffering and the meaning of symptoms" (p. 22). As a result, therapists must provide culturally congruent therapy that meets the client's needs (Wehbe-Alamah & Fry, 2014). As the Muslims' population continues to increase, and Muslims encounter issues requiring professional

assistance, therapists must be willing to accommodate Muslims in their practices. It is the ethical responsibility and duty of all therapists to attend to all clients regardless of their race, gender, or religious preference (AAMFT, 2015).

Therapists in doubt about how to work with a Muslim client should seek consultation and supervision, read studies and publications about Muslims, and consult with peers and colleagues to prevent harming their client. Therapists should think systemic and use a systems perspective of equifinality when counseling Muslims. This is the idea that "a number of different stimuli can lead to the same result" (Hanson, 1995, p. 64). With systems principles, being open and listening to different ways that Muslim clients want to achieve treatment goals is critical to sustaining therapeutic relationships and successful therapy completion. Emphasis on the therapeutic relationship in psychotherapy is not new. Overholser (2007) documented Carl Rogers' emphasis on three tenets of psychotherapy, namely: empathy, unconditional positive regard (creating a safe place, warm, tolerant, conducive environment for treatment), and congruence (being genuine, honest, and remaining open). These, Rogers maintained, are essential for growth through the therapeutic process (Overholser, 2007).

While no one is infallible, therapists must make efforts not to prescribe their only way of treatment, objectives, and goals, and establish therapeutic relationships crucial to completing therapy. Ackerman and Hilsenroth (2003) indicated that it is vital to establish trust and gain Muslim clients' confidence to build a therapeutic alliance. Some therapists'

qualities that can positively influence therapeutic alliance include being respectful, honest, trustworthy, confident, open, and flexible.

Wampold (2015) stated that while it is good to build therapeutic relationships through empathy and other ways, the treatment process must be compatible with the client's culture. Therapists must note Muslim cultural differences despite their bond on religious faith. Some Muslims share similar values such as arranged marriages, conservative attitudes on sex, patriarchal family structure, gender roles, high expectations, and shame. Understanding and respecting these factors are essential because a lack of understanding of Muslim religious beliefs, false beliefs, and fear of stigmatization are some of the reasons Muslims do not seek therapy (Abbott et al., 2012). The best practice, according to Carolan et al. (2000), is to approach each Muslim and their families as unique.

For University Marriage and Family Therapy Programs

MFT programs must begin to reevaluate their course contents in relation to the current trends in families seeking professional assistance from a LMFT. Is it time for a new paradigm shift for MFT programs to prepare students to work with individuals of cultural and religious backgrounds, specifically Muslims, relative to this study? Therapists in this study believe that family therapy programs spend too much time teaching theories and less time preparing their students on how to work with people of diverse cultural and religious backgrounds, including Muslims. Most of the participants expressed the belief that the current theoretical lenses use to train therapists are

inconsistent with the reality of the presenting problems and manifestation of illness with their clients. According to some participants in this study, MFT programs use theories based on Western models of treatment that are influenced and written for the White audience. This is consistent with researchers concern on the efficacy of using Western models of treatment with individuals from different cultural and religious backgrounds (Seponski et al., 2013).

University programs must evaluate faculty teaching multicultural courses and add more minority faculty to guide, facilitate, and teach these courses. Minority faculty brings diversity into the program, practical experience of what it means to be a minority, have more connection with the minority community, and help reduce biases and increase trust among clients in treatment. Faculty teaching marriage and family therapy courses must find ways to include activities that deal with Muslims and Islam. Inviting guest speakers who are knowledgeable about Islam and Muslims are encouraged.

Incorporating reading, research assignments, multicultural training and diversity activities, and extra credit work using articles covering Muslims will encourage students to leave their comfort zones to learning something different. Teaching must include discussions of the increasing Muslim clients seeking therapists' assistance to encourage students to think about future specialty areas to practice. Studies show that students trained in multicultural awareness, skills, knowledge, and skills are better prepared to handle diversity issues (Hall & Theriot, 2016).

Furthermore, the future generation of therapists who are often young and less conservative, as evidenced by the participants' characteristics in this study, may find treating Muslims as an area of interest and could decide to specialize in counseling clients with strong religious beliefs. If a therapist decides to specialize in treating Muslims, they should consider choosing where to locate their clinic. The location of services or clinics can increase their chances of having more Muslim clients in therapy. According to Al-Krenawi and Graham (2000), a better way to reduce stigma is to locate mental health services less overt in the general medical clinics because seeking mental health services negatively impacts Muslim relationships, particularly for Muslim women.

Therapists spoke about requiring a minimum of 6 hours of multicultural/ diversity classes before program completion. Adding six more hours will increase the current credit hours required for program completion. Prospective students seeking admission into the MFT program may see that as too many hours, factoring the program's time and financial costs. However, university MFT programs can reevaluate portions of theory covered and substitute religion topics in theory courses. Programs can offer religious courses as electives, allowing the students the options to choose. Professionals should review the current textbooks to determine if it covers current trends in clients' therapy use.

Finally, this study was conducted when the COVID-19 pandemic consumes the United States and the world. It was also when demonstrators were calling for equality and justice for all. Demonstrations show the current political, social, and economic situation

was unbearable for some minority groups. Racial tension was pervasive and resulted in protests and calls to examine systemic racism. MFT programs must do their part in addressing these concerns. They must examine explicit and implicit biases within their programs, find ways for students to have these discussions in the classroom, and discuss the implications of providing therapy for the population for long experienced discrimination, marginalization, oppression, disenfranchisement, and dismissal. It is time to rethink, reassess, and redesign programs so that when students graduate, they are better prepared to work with clients from diverse cultural and religious backgrounds.

Future Research

The literature review section of this study has ample information regarding Muslims and suggestions on working with Muslims. Specific studies on MFTs' experiences of working with Muslims are lacking. Such findings indicate a need for future studies. There is also a need for publications from therapists whose Muslim clients completed treatment. That information will assist other therapists in seeing how to apply Muslim religious beliefs into therapy.

This study was qualitative, with a focus on LMFTs. The study excluded other mental health professionals, such as LPC, licensed psychologists, and licensed clinical social workers. Future studies should include the following:

1. Use quantitative or mixed-method research with large samples of males and females of different races, cultural, and religious backgrounds, including

Muslims, to understand perceptions and interpretations of readiness better to work with Muslims.

2. All licensed mental health providers such as LMFT, LPC, licensed psychologists, and licensed clinical social workers.
3. Questions about the number of credit hours participants earned on diversity/multicultural courses during graduate school.
4. Analysis should include comparing male and female therapists, the number of years in practice, prior experience with Muslims, and whether taking a diversity/multicultural courses make a difference in clinicians' readiness to work with Muslim clients.

The findings would allow MFT programs to decide how to approach designing classes and training therapists to work with Muslims and others from diverse backgrounds.

Summary

I launched this qualitative research in response to the researchers' calls for therapists to be ready for Muslim clients. I interviewed marriage and family therapists to examine their readiness to work with Muslim clients. This chapter discussed the data analysis, the themes that emerged from the study, conclusions, and the study limitations. It also provided recommendations for MFTs and other providers. This study adds to the limited literature on Muslims and family therapists.

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APPENDIX A

Recruitment Flyer

Are YOU a Licensed Marriage and Family Therapist (LMFT or LMFT-A)?

LMFTs are Being Asked to be Ready for Muslims Seeking Therapy. Are you Ready?

More Muslim couples, families, and individuals are seeking family therapy. I'm interested to learn how you perceive and interpret readiness to work with Muslim clients.

For my dissertation research as a marriage and family therapy student, I am interested in hearing your thoughts on how you see your readiness. Your ideas can contribute to how university marriage and family therapy programs prepare their students to work with Muslim clients.

I will conduct your confidential interview, via Zoom, from my private home office, at your chosen date and time. We'll use a code number, and your name will be known only to me. Your participation is voluntary, and you may withdraw from the study at any time without penalty. Your maximum time commitment will be about 1 hour. As a thank you for participating, you will receive a $20 Amazon gift card.

Interested to know more about this study? Please contact me, Fyneface Ikpo at 214-597-5946 or email fikpo1@twu.edu. You may also contact my research advisor, Linda Brock, PhD at (940-898-2713) or email her at Lbrock@mail.twu.edu

As with any electronic submission, there is a potential risk of loss of confidentiality in all email, downloading, and internet transactions.

APPENDIX B

Participant Recruitment Email

Hello, my name is Fyneface Ikpo and I am a Ph.D. candidate at Texas Woman's University. Currently, I'm conducting a study for my dissertation entitled "**Marriage and Family Therapists' Perceptions and Interpretations of Readiness to Work with Muslim Clients: A Qualitative Study.**

More Muslim couples, families, and individuals are seeking family therapy. Therapists are being asked to be ready for more Muslims seeking mental health assistance. I am interested in hearing your thoughts on how you see your readiness, what you are most concerned about when working with Muslim clients, and your ideas on how university marriage and family therapy programs can prepare future students to work with Muslim clients.

Criteria for Participation:

- Must be licensed as a Marriage and Family Therapist (LMFT), **OR**
- Licensed as a Marriage and Family Therapist Associate (LMFT-A).
- Currently have a mixed caseload of clients from different race, ethnic, cultural, and religious background.
- Have access to internet service.

The interview will be confidential and conducted via Zoom, from my private home office, at your chosen date and time. We'll use a code number, and your name will be known only to me. Your participation is voluntary, and you may withdraw from the study at any time without penalty. Your maximum time commitment will be about 1 hour. As a thank you for participating, you will receive a $20 Amazon gift card.

Benefits of Participation:

- You will be contributing to the research on how therapists can be ready for Muslim clients
- Contributing to how university marriage and family therapy programs can prepare future students to work with Muslim clients
- Receive a copy of the findings at the end of the study, if requested

Interested to know more about this study? Please email me, Fyneface Ikpo at fikpo1@twu.edu or call me at 214-597-5946 to set up your preferred date and time to answer your questions and/or schedule your interview. You may also contact my research advisor, Linda Brock, PhD at (940-898-2713) or email her at Lbrock@mail.twu.edu with questions regarding this study

If you do not meet these criteria but know someone who does and may be willing to participate in this study, I would greatly appreciate you forwarding this e-mail to them.

Please note that you are not obligated either to participate in this study or to forward this email. I am seeking willing volunteer participants only. As with any electronic submission, there is a potential risk of loss of confidentiality in all email, downloading, and internet transactions.

Thank you very much for your time and help.

Fyneface Ikpo, Ph.D. Candidate

APPENDIX C

Telephone Call Script

“Hello, my name is Fyneface Ikpo. Thank you for responding to my flyer. I am a doctoral student in Marriage and Family Therapy at Texas Woman’s University where I am completing this research project as a part of my degree.

“More Muslim couples, families, and individuals are seeking family therapy. Therapists are being asked to be ready for more Muslims seeking mental health assistance. I am interested in hearing your thoughts on how you see your readiness, what you are most concerned about when working with Muslim clients, and your ideas on how university marriage and family therapy programs can prepare future students to work with Muslim clients.

“To participate, you must be:

- Licensed as a Marriage and Family Therapist (LMFT), **OR**
- Licensed as a Marriage and Family Therapist Associate (LMFT-A).
- Currently have a mixed caseload of clients from different race, ethnic, cultural, and religious background
- Have access to internet service

“If you agree to participate, we’ll schedule your confidential audio/video interview, via Zoom, or an audio-recorded telephone interview on the date and time that is convenient for you. You can choose which method (audio/video, or telephone) interview, that is best for you. The interview will last for approximately 1 hour. I will email the consent forms to you before the interview. On the day of our interview, I will go over the consent forms for you to sign and email it back to me, collect some background information, and then

digitally record our conversation so that I'll be sure to be accurately describing your perceptions and interpretations of readiness to work with Muslim clients. Your name and any identifying information will not be used. To protect your confidentiality, we'll use a code number for your interview, and I will be the only one to know your name.

"Your participation is completely voluntary, and you may withdraw at any time without penalty to you."

"What questions do you have so far?" (All questions will be answered by the researcher). "Would you like to be part of the study?" (If the potential participant says yes, a time for the interview will be scheduled). "Thank you for your time. I look forward to meeting you on the date and at the time we've agreed upon." [Will re-state date/time]. [If potential participant says no]: "If you know of someone who might be interested in my study, will you share my contact info?" "Thank you for taking the time to talk with me.

APPENDIX D

Consent Form

TEXAS WOMAN'S UNIVERSITY (TWU)
CONSENT TO PARTICIPATE IN RESEARCH

Title: Marriage and Family Therapists' Perceptions and Interpretations of Readiness to Work with Muslim Clients: A Qualitative Study.

Principal Investigator: Fyneface Ikpo ..... fikpo1@twu.edu 214-597-5946
Faculty Advisor: Linda Brock, PhD ..... Lbrock@twu.edu 940-898-2713

Summary and Key Information about the Study

You are being asked to participate in a research study conducted by Mr. Fyneface Ikpo, a student at Texas Woman's University, as a part of his dissertation. The purpose of this research is to explore marriage and family therapists' perceptions and interpretations of readiness to work with Muslim clients. You have been invited to participate in this study because you are a licensed marriage and family therapist (LMFT) or a licensed marriage and family therapist associate (LMFT-A) who has clients of different racial, ethnic, cultural, and religious backgrounds. As a participant you will be asked to take part in your choice of an online audio/video interview, via Zoom, or an audio-recorded telephone interview, regarding how you perceive and interpret readiness to work with Muslims. This Zoom interview will be digitally recorded and saved on my home computer with code number, not your real name. If interviewed by telephone, a digital audio-recorder will be used. We will use a code number to protect your confidentiality. The total time commitment for this study will be about one hour. You will receive a $20 Amazon eGift card for your participation. The greatest risks of this study include potential loss of confidentiality and possible emotional discomfort. We will discuss these risks and the rest of the study procedures in greater detail below.

Your participation in this study is completely voluntary. If you are interested in learning more about this study, please review this consent form carefully and take your time deciding whether you want to participate. Please feel free to ask the researcher any questions you have about the study at any time.

Description of Procedures

As a participant in this study, you will be asked to spend one hour of your time on your choice of phone or video interview with the researcher. The researcher will ask to obtain some demographic information from you, then proceed to ask you questions about your perceptions and interpretations of readiness to work with Muslim clients. You and the researcher will decide together on the date and time of your interview. The researcher will assign you a code number. After the interview is completed, the recording will then be written down so that the researcher can be accurate when studying what you have said.

Potential Risks

The researcher will ask you questions about your perception and interpretation of readiness to work with Muslim clients. A possible risk in this study is emotional discomfort with these questions you are asked. Before your interview date, the researcher will provide you a mental health referral list through your email address. If you feel you need to talk to a professional about any discomfort, please use the list of mental health resources provided to you. If you become tired, you may take breaks as needed. You may also stop answering questions at any time and end the interview.

Another risk in this study is loss of confidentiality. Confidentiality will be protected to the extent that is allowed by law. The interview will be held at the researcher's private home office, via Zoom or by telephone. A code number not your real name, will be used during the interview. Only I, the researcher, will know your real name.

_____
Initials

To protect your confidentiality if you have chosen the Zoom interview, I will send you an email inviting you to the Zoom meeting on the date and time of our scheduled meeting, along with the consent form and a list of mental health referrals. You will logon using the Zoom password and room ID that I will send to you. A "waiting room" will be enabled so that only I (the researcher) can admit you to our meeting. If you logon using your real name, you will be able to change your name to the code number assigned to you. When you log-in, you will be able to see anyone in the meeting room, which would be you and I. If anyone attempts to crash our meeting, I will immediately mute the person and remove them from the room. The computer is protected with McAfee web protection, including virus and spyware protection, Firewall, and online privacy.

The audio/video recording and the written interview will be stored in a locked cabinet in the researcher's office. Only the researcher will listen to the recording and transcribe the data, and the advisor will read the written interview. The audio/video recording or telephone recording and the written transcript will be destroyed within three years after the study is finished. The signed consent form will be stored separately from all collected information and will be shredded three years after the study is closed. The results of the study may be reported in scientific magazines or journals, but your name or any other identifying information will not be included. As with any electronic submission, there is a potential risk of loss of confidentiality in all email, downloading, and internet transactions. Your audio/video recording and/or any personal information collected for this study will not be used or distributed for future research even after the researchers remove your personal or identifiable information (e.g., your name, date of birth, contact information).

The researchers will try to prevent any problem that could happen because of this research. You should let the researchers know at once if there is a problem and they will try to help you. However, TWU does not provide medical services or financial assistance for injuries that might happen because you are taking part in this research.

Participation and Benefits

Your involvement in this study is completely voluntary and you may withdraw from the study at any time. You will receive a $20 Amazon eGift Card gift for your participation. You will receive an email from Amazon to claim your $20 gift card. If you would like to receive a summary of the results of this study, we will email it to you. *

Questions Regarding the Study

I will email a copy of this signed and dated consent form to keep. If you have any questions about the research study, you should ask the researchers; their contact information is at the top of this form. If you have questions about your rights as a participant in this research or the way this study has been conducted, you may contact the TWU Office of Research and Sponsored Programs at 940-898-3378 or via e-mail at IRB@twu.edu.

Signature of Participant Date

*If you would like to know the summary of the results of this study, tell usyour email address to send it to you:

Email: _____

APPENDIX E

Demographic Questionnaire

Demographic Information

Marriage and Family Therapists' Perceptions and Interpretations of Readiness to Work with Muslim Clients: A Qualitative Study

Demographic Questionnaire

Interview Number:_____Date of Interview: _____

Please complete the following information.

1. What is your gender?
2. What is your age? _____
3. What is your ethnicity? _____
4. What is your marital status? _____
5. What is your religion? _____
6. What is your current licensing status? (a) LMFT (b) LMFT-A
7. How long have you been an LMFT or LMFT-A? _____
8. What is your level of education? (a) PhD (b) PhD Student/candidate (c) Master's degree
9. Do you currently have, or have you had a Muslim client before? (a) Yes (b) No
10. What is your preferred theoretical lens in therapy? (Please write in your answer) _____
11. During your graduate training as a family therapist, did you take any multicultural or diversity course/s? (a)Yes (b) No
12. Did you take any graduate class that covered information about Muslims? (a) Yes(b) No
13. Have you attended conference presentations about Muslims? (a) Yes (b) No
14. Have you read books or journal articles about Muslims? (a) Yes (b) No
15. Would you be willing to temporarily stop a therapy session to allow your Muslim client to pray if asked? (a) Yes (b) No
16. Please explain your answer to question #15

APPENDIX F

Interview Guide

INTERVIEW GUIDE

Participant's Code: _____

Date of Interview: _____

"Thank you for agreeing to participate in this study" (Pause, allow for response). The purpose of this study is to explore marriage and family therapists' perceptions and interpretations of readiness to work with Muslim clients. Do you have any questions regarding the purpose of this study? (Pause)

"I want to would like to remind you that your participation in this study is completely voluntary and you may withdraw at any point without penalty. You can take a break at any point during the interview process, and please let me know when you need to. Our conversation will be audiotaped, or video/audiotaped based on your choice of telephone interview or Zoom interview, to make sure that I present the information accurately." (Pause)

"Thank you for signing and returning the consent form. Before we begin with the interview, do you have any questions about the consent form?" (Pause). Participants' questions will be answered by the researcher.

"I am going to start by asking you some questions to gather background information. If anything is unclear, please feel free to ask me to clarify my question." [Questions will be answered by the researcher.]

"I will now turn on the digital voice recorder or video/audio recorder" (Turn the recorder on).

The researcher proceeds to obtain demographic information by asking the questions and writing down participants' answers. After obtaining demographic information, the researcher moves to interview questions.

"We will now proceed with the interview questions. I will be asking 4 questions. There is no right or wrong answer, but I would like for you to speak freely and openly. Please speak freely and elaborate as much as you are comfortable." (Pause)

I will then ask, "Do you have any questions before we begin." The researcher will

answer all questions.

Interview Questions:

The population of Muslims in the United States is increasing, and more Muslims are seeking the assistance of marriage and family therapists. Therapists are asked to be ready for Muslims seeking professional mental health assistance.

1. How do you see (perceive) readiness? And (1b) What does it mean (interpretation) to you?

2. What are you most concerned about when you are working with Muslim clients?

3. In your opinion, how were you prepared as a marriage and family therapist during graduate school to work with Muslim clients?

4. Finally, what do you, as a marriage and family therapist, recommend for university marriage and family therapy programs to prepare their students to work with Muslim clients?

Prompts will include but not limited to the following:
Can you tell me more about that?
I see
Oh yeah?
What do you mean?
Nodding
Smiling
What did you learn from that?
Did you take any action?
If so, what? How?

When the participant indicates she or he has no more to say, the interview will be concluded by thanking the participant for their time and participation. I will ask the participant if it is OK to contact him or her weeks later if I need some clarification or confirmation of what I have written. If the participant agrees, I will ask the participate for their phone number or email address, whichever is more convenient for the participant. I will conclude by saying "If you have any questions, please feel free to contact me. Thank you again."

APPENDIX G

Referral List

Mental Health Referral List

American Psychological Association Psychologist Locator
http://locator.apa.org/

National Register of Health Service Psychologists
http://www.findapsychologist.org/

Mental Health of America Referrals
http://www.nmha.org/go/searchMHA

Psychology Today Find a Therapist
http://therapists.psychologytoday.com/rms/

National Board for Certified Counselors
http://www.nbcc.org/CounselorFind