The Experiences of Non-Muslim Caucasian Licensed Marriage and Family Therapists Working with South Asian and Middle Eastern Muslim Clients

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Abstract

This qualitative study investigated the experiences of eight non-Muslim Caucasian Licensed Marriage and Family Therapists working with South Asian and Middle Eastern Muslim clients. Semi-structured interviews were used to examine the challenges and strengths that resulted from ethnic/racial and religious differences with clients of this population, and how the challenges and strengths were managed in therapy. The data were analyzed using thematic analysis and the themes that emerged were organized based on the areas of inquiry, which included: challenges that come from ethnic/racial and religious differences, strategies and recommendations to address ethnic/racial and religious differences and the challenges created by them, strengths that come from ethnic/racial and religious differences, and what therapists needed. Limitations, clinical implications, and directions for future research are discussed.

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Chapter 1: Introduction

The Problem and its Setting

Islam is known to be the fastest growing religion in the United States and the rest of the world (Ali, Liu, & Humedian, 2004). Estimates on the American Muslim population vary greatly. According to the Pew Research Center (2011), the Muslim population in the U.S. is expected to rise from 2.6 million in 2010 to 6.2 million in 2030. National Muslim groups report higher statistics, with 6 to 8 million Muslims living in the U.S. (Khan, 2002). Within the American Muslim population, 65% are foreign born, or first generation immigrants (Pew Research Center, 2007). Among those born outside of the U.S., 49% came from the Middle East and other Arab regions, 27% came from South Asia, 8% came from Europe, 6% came from non-Arab African countries, and 10% came from other countries. Among those born in the U.S., 21% are second generation, with at least one parent born in a foreign country.

Experiences of Muslims living in the U.S. Muslims living in the U.S. continue to be impacted since the events of September 11, 2001. They have experienced increased hate crimes, discrimination, deportation hearings, religious profiling at airports, vandalism of mosques, and physical violence (Moradi & Hasan, 2004). In a survey by Gallup (2010), American Muslims were found to be the most likely (48%) than other major faith groups to have experienced discrimination due to their race or their religion. In a national poll conducted soon after 9/11 (Zogby, 2001b), 20% of Middle Eastern Americans reported experiencing discrimination after 9/11 because of their ethnicity, 45% reported knowing about a person who experienced similar discrimination after 9/11, and 61% worried about discrimination and its long-term effects.

In 2007, the Pew Research Center conducted a study in which 53% of the Muslims surveyed reported experiencing more difficulty in being a Muslim living in the U.S. Specifically, prejudice and discrimination (19%), being perceived as terrorists (15%), ignorance about their

religion (14%), and stereotyping (12%) were the biggest problems cited. Some of the other problems cited were the negative portrayal of Muslims in the media, unfair treatment and harassment, religious and cultural problems, extremists, and being hated, feared, and mistrusted as Muslims. Roysicar argues that mental health professionals are responsible for understanding the political climate that affects their Muslim clients (2003) and Sue and Sue caution mental health professionals to examine their attitudes toward Muslims and Islam (2008).

Nonetheless, attitudes held by non-Muslims in the U.S. toward Muslims were negative even prior to the events of 9/11. In a study reporting on the perceptions of mostly Caucasian Christian Americans, participants held definite attitudes of Middle Eastern Muslims regarding gender roles and men's and women's rights, among other topics, despite their limited knowledge of Islam or Muslims (Altareb, 1997). Much of the information they possessed was obtained from U.S. media, which has been found to depict Muslims in a negative way (Madani, 2000). In a poll predating 9/11 (Zogby, 2001a), Middle Eastern Americans were identified as most likely to play the role of a terrorist or a convenience store clerk in movies or on television.

Barriers to seeking services. Ethnic and racial minorities are known to underutilize services when compared to Whites (Sussman, Robins, & Earls, 1987; Vega et al., 1998; Zhang et al., 1998) largely due to mistrust of clinicians and stigma regarding mental health (U.S. Department of Health & Human Services, 1999). Similarly, Muslims also underutilize mental health services (Altareb, 1996; Kelly, Aridi, & Bakhtiar, 1996). Abu Raiya and Pargament state that many muslims "approach psychology with doubts, antipathy, and suspicion" (p. 186, 2010) since they view it as a Western concept that is secular and anti-religious, making it unsuitable for the Islamic way of life (Abu Raiya, Pargament, Stein, & Mahoney, 2007). Thus, Muslims tend to rely on support from God (*Allah*), family members, or religious clergy (Weatherhead & Daiches,

2010). In fact, when compared to other groups, Muslims are most likely to believe in the power of their faith and social support to help manage their depression (Lowenthal, Cinnirella, Evdoka, & Murphy, 2001).

Daneshpour argues that there are many barriers for Muslims feeling reluctant to seek out mental health professionals (1998). These include negative views of Islam or Muslims, fear of stereotyping and discrimination, feeling misunderstood, shame in seeking outside help, lack of therapists' knowledge of Islam and the culture, and tendency to rely on family and friends for support. Other barriers include stigma associated with mental illness, financial issues, language barriers, and differences in cultural values with the clinician (Saleem, 2009).

However, it is imperative for American Muslims to overcome these barriers and seek mental health services given the presence of depression, anxiety, and post-traumatic stress disorder (PTSD) in this population. Although prevalence of mental illness among American Muslims is largely unknown due to limited research, there is some evidence found in literature. Compared to normative samples, Amer and Hovey (2012) found significantly higher rates of depression and anxiety amongst a sample of Arab Americans, 70% of whom were Muslim, despite being born and raised in the U.S. and being well-educated with high incomes. Half of the sample was found to be in the clinically significant range of depression. In terms of anxiety, 22% experienced mild-to-moderate anxiety, 14% experienced moderate-to-severe anxiety, and 11% experienced severe anxiety. Along with depression, PTSD symptoms have been found among American Muslims due to trauma associated with 9/11, discrimination, and wars in their native countries (Abu-Ras & Abu Bader, 2008). Based on reports from Arab therapists, severe postwar trauma exists amongst Iraqi refugees which contributes to attention-deficit hyperactivity disorder, depression, and substance use (Nasser-MacMillian & Hakim-Larson, 2003).

Additionally, American Muslims have been found to be less happy in their lives when compared to the average American population. A national demographic study of 1,050 American Muslims showed that only 78% of American Muslims reported being "happy" whereas 87% of the normative American sample reported being "happy". Immigrant Muslims reported even lower rates of being "happy" (Pew Research Center, 2007). Daneshpour (2009) summarizes a list of clinical issues that might be prevalent in the American Muslim population, which include familial issues relating to boundaries, gender roles, parent-child conflicts, intergenerational conflicts, and extended family issues. The author argues that these issues can all be a great source of distress among American Muslims due to the importance of family in Islam and Muslim cultures. The author also argues that Muslim couples struggle with similar issues faced by couples of other faiths and cultures, such as issues around communication, parenting, financing, division of labor, and decision-making.

Ethnicity/race of therapists. When American Muslims do seek mental health services, they are likely to encounter ethnically/racially different therapists due to the underrepresentation of ethnic/racial minority mental health professionals. Majority of the clinicians practicing in the United States are Caucasians of European descent (U.S. Department of Health & Human Services, 2001). According to estimates by SAMHSA's Mental Health U.S. report (U.S. Department of Health & Human Services, 2004), only 24.2% of psychiatrists, 17.5% of psychiatric nurses, 15.4% of counselors, 6.2% of psychologists, 5.3% of school psychologists, 8.7% of social workers, and 5.5% of marriage and family therapists (MFT) are racially and ethnically diverse (i.e., Hispanic, Black, Asian, and American Indian). According to these estimates, MFTs are among the least ethnically diverse mental health professionals.

Religiosity of therapists. In addition to encountering ethnically/racially different therapists, American Muslims are also likely to encounter religiously different therapists when seeking services. In a survey exploring the religiosity and spirituality of 320 MFTs (Winston, 1991), 58% reported affiliation with various denominations of Christianity, with Protestant being the most common, 18% reported affiliation with no religion, and 7% reported affiliation with Judaism. Similar findings have been reported in other studies (Prest, Russel, & D'Souza, 1999; Bergin & Jensen, 1990). MFTs have also consistently reported high levels of religiosity and spirituality in several studies (e.g., Carlson et al., 2002). In a study by Bergin and Jensen (1990), it was found that MFTs were the most religious compared to psychologists, psychiatrists, and social workers.

Ethnic/racial differences in therapy. In the American Psychological Association's "Ethical Principals of Psychologists and Code of Conduct" (APA, 2003), differences in ethnicity, race, and religion have been cited among the human differences that practitioners must be aware of and prevent from impacting their work. Considerable differences due to ethnicity/race and religion are likely to occur in cross-cultural therapy, resulting in challenges and strengths. Research on ethnic/racial differences has found mixed results regarding treatment satisfaction (e.g., Chang & Yoon, 2011), treatment outcomes (e.g., Flicker et al., 2008; Erdur, Rude, & Baron, 2003), and client preference for ethnically/racially similar or dissimilar therapists (e.g., Horst et al., 2012; Chang & Yoon, 2011), which suggests the presence of both challenges and strengths in cross-ethnic therapeutic encounters. However, much of the research on ethnic/racial differences focuses on client perspectives rather than therapist perspectives, which limits the understanding of the phenomenon. Furthermore, with respect to ethnically/racially dissimilar therapist and client dyads, a few studies, such as Comas-Diaz & Jacobsen (1991), have identified

some possible transference (e.g., over-compliance and mistrust) and countertransference (e.g., denial of ethno-cultural differences and guilt) issues.

Religious differences in therapy. Research on religious differences shows that religious clients prefer religiously similar therapists (e.g., Worthington et al., 1996). Highly religious clients have been found to report treatment satisfaction with religiously similar therapists (e.g., Bergin, 1985) and experience less successful outcomes with nonreligious therapists (e.g., Welkowitz, Cohen, & Ortmeyer, 1967). This suggests the presence of challenges between therapists and clients belonging to different religious affiliations. From the therapists' perspectives, literature on religious differences also discusses challenges related to countertransference issues, such as anger (Aten, 2011), when working with religiously different clients. In terms of strengths, clients may achieve personal growth as they are afforded space for acceptance and freedom to choose their own path when working with a religiously different therapist (Kellems, Hill, Crook-Lyon, & Freitas, 2010). Clients might also feel more freedom in expressing religious struggles with a therapist who belongs to a different religion and more comfort in discussing topics that are stigmatized by their religious culture, such as substance use (Ali, Liu, & Humedian, 2004).

Literature on South Asian and Middle Eastern Muslims in therapy. Majority of the Muslims in the U.S. are foreign born, and among those who are foreign born, majority are South Asian and Middle Eastern (Pew Research Center, 2007). South Asians are typically from Pakistan, India, Bangladesh, Sri Lanka, Nepal, Bhutan, and the Maldives (Inman & Tawari, 2003). Middle Easterns are typically from Iraq, Iran, Saudi Arabia, Yemen, United Arab Emirates, Qatar, Oman, Bahrain, Kuwait, Turkey, Syria, Lebanon, Palestine, Israel, Afghanistan, Jordan, and Cyprus (The Cambridge Encyclopedia of the Middle East and North Africa, 1988).

Thorough and systematic research on the American Muslim population is insufficient and, despite the prevalence of South Asian and Middle Eastern Muslims in the U.S., research on cross-cultural therapy with clients of this population is scarce.

Literature provides some basic knowledge of Islam, cultural issues, suggestions on how to do culturally competent therapy (e.g., Graham, Bradshaw, & Trew, 2010; Johnson, 2013; Keshavarzi & Haque, 2013; Sauerheber, Nims, & Carter, 2014), and case examples of different types of religious psychotherapy with Muslim clients (Azhar, Varma, & Dharap, 1994; Azhar & Varma 1995a; Azhar & Varma 1995b; Razali, Aminah, & Khan, 2002; Vasegh, 2011; Hamdan, 2007; Hamdan, 2008). However, much of this literature lacks an empirical basis as it is mostly a collection of pieces of advice suggested by Muslim therapists and informed by Islamic beliefs and practices, Muslim cultures, and the personal experiences of the authors. Thus far, the focus in literature has been on developing guidelines for clinicians on how to work with South Asian and Middle Eastern Muslim clients rather than asking clinicians about their experiences with this population.

With the exception of Cook-Masaud & Wiggins (2011), virtually no literature exists that focuses on the actual experiences of non-Muslim Caucasian therapists working with South Asian and Middle Eastern Muslim clients. Literature provides limited discussion of challenges and strengths dissimilar therapists encounter with this population. However, these discussions lack an empirical basis. Furthermore, to the researcher's knowledge, there is no research investigating the challenges and strengths encountered by ethnically and religiously dissimilar mental health professionals working with American Muslim clients. Given the high prevalence rates of non-Muslim Caucasian MFTs and South Asian and Middle Eastern Muslims in the U.S., more research is needed on this therapist-client dyad.

Recommendations. Sue and Sue (2008) provide several recommendations for therapists on how to work with ethnically/racially and religiously different clients. The authors state that clients cannot be understood without their cultural, social, and political contexts and it is important for therapists to understand their clients' realities. The therapist should make a "concerted and conscientious effort to learn as much as possible about their definiton of family, the values that underlie the family unit, and your own contrasting definition" (p. 206). The authors particularly caution therapists against imposing their Western values on ethnic/racial minority clients.

With American Muslim clients, the authors suggest that therapists should identify what their attitudes are towards this population and recognize that discrimination is faced by many due to their clients' ethnic/racial and religious backgrounds. The authors recommend that therapists should recognize the diversity within the Muslim culture, avoid stereotyping, and collaborate to understand their lifestyles and beliefs. The authors also recommend asking their Muslim clients about the importance of religion in their lives, being open to exploring their clients' beliefs, and incorporating prayer and other religious activities to reduce clients' distress. Using cognitive-behavioral techniques to reduce negative or distressing thoughts by modifying them with beliefs from the Quran is also recommended. Furthermore, the authors suggest that this population may have greater acceptance of holistic approaches where family members and religious and social dimensions can all be incorporated in treatment. Lastly, the authors suggest that therapists should determine the family structure and, with more traditional Muslim clients, address the husband or male first. The authors warn therapists that they may experience reluctance from some of these clients in sharing issues related to their families or expressing negative feelings to the therapist.

Additionally, research has found that ethnic/racial minority clients perceive their therapists more positively when the therapists address ethnic/racial differences with them. Zhang and Burkard (2008) found that Caucasian therapists who discussed ethnic/racial differences in therapy received higher ratings for credibility and therapeutic alliance by their clients when compared to those therapists who did not discuss the differences. This finding suggests the importance of addressing differences with clients during treatment.

Conclusion. With the lack of empirical literature regarding the experiences of mental health professionals working with Muslim clients, therapists are at a disadvantage to work successfully with this population. MFTs are at a further disadvantage due to scant literature on Muslims in the field of family therapy. One such study presents guidelines on how to work with Muslim couples and provides application of Bowen's Family Systems Theory to a hypothetical case example of a Muslim couple (Springer, Abbott, & Reisbig, 2009). However, the suggestions provided by the authors lack an empirical basis. Similary, Sauerheber et al. (2014) discuss experiences of Muslim couples living in the U.S. and provide suggestions on how to apply Bowen's theory with this population in a culturally sensitive way but without an empirical basis.

Moreover, MFTs are among the least ethnically/racially and religiously diverse mental health professionals and they frequently recognize a lack in culturally competent training regarding American Muslims (Azar-Salem, 2011). It is likely that more challenges and strengths related to cultural and religious differences may present in therapy for MFTs as they have a greater likelihood of seeing multiple Muslim client systems (individuals, couples, and families). Investigating the experiences of licensed MFTs will contribute to informing the work of other MFTs and mental health professionals who are interested in working with the South Asian and Middle Eastern Muslim population but do not share their ethnic or religious background.

Significance

Contribution to knowledge. Given the prevalence of highly religious Christian Caucasian therapists in the MFT field and the prevalence of South Asian and Middle Eastern Muslims in the U.S., research on the actual positive and challenging experiences of non-Muslim Caucasian licensed MFTs seeing South Asian or Middle Eastern Muslim clients is much needed. The present study focused only on the experiences of non-Muslim Caucasian therapists since the majority status of a non-Muslim Caucasian therapist and the minority status of a South Asian or Middle Eastern Muslim client presents sharp differences and, therefore, unique implications for therapy, which may not necessarily present between a minority therapist and a minority client. This study aimed to offer insight to therapists regarding challenges and strengths that may arise in therapy as a result of these sharp ethnic/racial differences, as well as religous differences, and how the challenges and strengths can be managed in therapy. Such knowledge may contribute to increasing the cultural competence of therapists, helping them to provide more culturally sensitive treatment to South Asian and Middle Eastern Muslim clients.

Training in cultural competence has been found to increase the willingness of therapists to recognize cultural differences between themselves and their clients, to view these differences as valuable, and to acknowledge the impact of these differences in therapy (Parker, Moore, & Neimeyer, 1998). Moreover, attendance of a brief seminar on cultural sensitivity has been found to significantly increase the knowledge of Islam and levels of comfort among MFT students and therapists working with Muslim clients (Azar-Salem, 2011). It is hoped that the findings of this study will help inform the work of therapists by contributing to their cultural competence, which may increase the trust among American Muslims towards the mental health field.

Rationale for Methodology

In order to address the gap in research, a qualitative methodology was used to make it possible to explore the lived experiences of licensed MFTs working with South Asian and Middle Eastern Muslim clients. Creswell (2013) argues that a qualitative design should be used when investigating a topic that lacks research. The author also states that qualitative research is useful when thorough and nuanced information is desired to understand the experiences of participants within their context. Conducting in-depth qualitative interviews provided rich, descriptive details, demonstrating the challenges and strengths that a sample of therapists encountered with the South Asian and Middle Eastern Muslim population. Furthermore, use of semi-structured interviews allowed the researcher to probe for relevant information that was useful in understanding the nuanced details within the participants' experiences.

A phenomenological methodology was used to guide the process of qualitative research in this study. Such methodology created opportunities for the researcher to analyze the experiences of therapists within their context and extract meanings from the ideas they presented (Creswell, 2013). The themes that emerged provide descriptions of the challenges and strengths that the therapists encountered and how they managed them in therapy. The descriptions of themes were based on the ideas presented by the therapists. Thus, the themes were generated inductively and corresponded with the reality of the therapists, providing the reader with the essence of the therapists' lived experiences.

Theoretical Framework

Phenomenology was used as the theoretical framework to guide the conceptualization of this study. This approach reduces the lived experiences of different individuals to what is known as a universal essence (Creswell, 2013). The description used to describe the essence includes "'what' they experienced and 'how' they experienced it" (p.76).

Phenomenology is based on certain philosophical perspectives (Creswell, 2013). One perspective is that an object's reality can only be perceived "within the meaning of the experience of an individual" (p. 78). In other words, the reality of an object is understood through an individual's experience of it. Another philosophical perspective is that in a true phenomenological approach, there are no presuppositions. That is, all judgments are suspended until a more concrete basis is found for them. In order to suspend all judgment, the primary researcher, who also conducted the interviews, bracketed personal experiences and assumptions regarding therapy with Muslim clients. This allowed the researcher to approach all data from a fresh perspective.

By conducting in-depth interviews with licensed MFTs, clusters of meanings were extracted from the data which allowed for themes to emerge (Creswell, 2013) regarding the challenges and strengths the therapists encountered and how they attempted to manage them in therapy. The themes that emerged helped to explain the reality of therapists through their own experiences.

Purpose of the Study

This study was intended to address the gap in cross-cultural literature by providing an in-depth look at the experiences of non-Muslim Caucasian licensed MFTs working with Muslim individuals, couples, and families from South Asia and the Middle East. Given that this population is continuing to grow, there is a critical need to understand how to better help this population in the mental health field. The literature that has been published up to this date consists mostly of guidelines or advice derived from anecdotal knowledge about Muslims and authors' personal experiences. The literature is also mostly focused on either Muslims or South Asians or Middle-Easterns but not on the particular challenges or strengths that non-Muslim

Caucasian therapists encounter when working with South Asian and Middle Eastern Muslim clients.

In addition to investigating the experiences of therapists working with this population, this study also addressed therapists' perceptions of their experiences with South Asian and Middle Eastern Muslim clients compared to their experiences with other ethnic/racial and religious minorities. Given the literature on the experiences of discrimination, stereotyping, negative media portrayals, and hate crimes experienced uniquely by Muslims within the post-9/11 context, it was important to understand whether the therapists perceived differences in their experiences with South Asian and Middle Eastern Muslim clients when compared to experiences with other minority clients.

Research Questions:

1) What are the challenges and strengths encountered by non-Muslim Caucasian licensed MFTs as a result of ethnic/racial and religious differences with their South Asian and Middle Eastern Muslim clients?
2) How are the challenges and strengths managed in therapy?
3) How do therapists perceive their experiences with South Asian and Middle Eastern Muslim clients when compared to experiences with other ethnically/racially and religiously different clients?

Chapter 2: Literature Review

The following review of literature includes research findings on how differences in ethnicity/race between therapists and clients impact therapy and how differences in religious affiliation between therapists and clients impact therapy. In particular, the literature review

focuses on the challenges and strengths that arise as a result of the differences. The review concludes with a discussion on existing literature on South Asian and Middle Eastern Muslim clients in therapy.

Ethnicity/Race in Therapy

McGoldrick, Giordano, and Garcia-Preto define ethniticy as, "...a group's commonality of ancestry and history, through which people have evolved shared values and customs over the centuries. Based on a combination of race, religion, and cultural history, ethnicity is retained, whether or not members realize their commonalities with one another" (p. 2, 2005). Race is commonly associated with physical traits of a group of people (e.g., skin color, hair, or facial features) but the U.S. Department of Health and Human Services (DHHS) argues that a very small percentage of our genes defines the physical traits that are used to identify people as belonging to different racial groups, thus, it does not hold much meaning as a biological category (2001). DHHS further argues that race does, however, have implications as a social category. McGoldrick, Giordano, and Garcia-Preto present a similar argument, stating that race is "...a political issue, operating to privilege certain people at the expense of others. It is a bogus construct, created and kept in place by White people and it creates walls that lock us all in...race is a construct which imposes judgment on us from the outside in, based on nothing more than our color or physical features" (p.20, 2005).

Ethnicity and race are both important constructs in cross-cultural research. However, much of the literature does not create a distinction between the two and combines them into a single category. One reason could be that both ethnicity and race impact therapeutic encounters but they are often hard to tease apart from each other. In reporting findings from previous

research, the researcher will use the terms consistent to how they were used in each respective study.

Ethnic/racial matching. There are some studies suggesting a significant impact of ethnic/racial matching on treatment and therapeutic processes (Coleman, Wampold, & Casali, 1995; Wintersteen, Mensinger, & Diamond, 2005). Several studies report greater utilization of services and higher retention rates when therapist and client are of the same ethnicity/race (Maramba & Hall, 2002; Sue et al., 1991; Yeh, Eastman, & Cheung, 1994). For example, Wintersteen, Mensinger, and Diamond (2005) report that only 55% of adolescents seeing therapists of a different race completed two thirds of treatment in comparison with 79% of adolescents seeing therapists of the same race. However, this finding was not supported in a study by Ruglass et al. (2014) where ethnic/racial matching was not associated with session attendance.

Some studies have reported a relationship between ethnic/racial matching and positive treatment outcomes (e.g., Ricker, Nystul, & Waldo, 1999). Flicker et al. (2008) found a strong relationship between ethnic matching and reduction in substance use in Hispanic clients being treated by Hispanic therapists. On the other hand, some studies have not found symptom improvement to be associated with ethnic matching (Erdur, Rude, & Baron, 2003; Sue et al., 1991). Additionally, some meta-analytic studies have found small effect sizes in relation to ethnic/racial matching and treatment outcomes (Maramba & Hall, 2002; Shin et al., 2005). Such findings suggest that when it comes to effectiveness of treatment, matching is a weak predictor as it is not a necessary or sufficient component, nor is mismatching inherently problematic.

Wintersteen, Mensinger, and Diamond (2005) found that therapists consider racial matching with their client to be a significant factor influencing early therapeutic alliance while

clients do not appear to hold the same view. The authors found that Caucasian therapists perceived a much greater early alliance with Caucasian clients than with minority clients, and minority therapists perceived greater early alliance with minority clients than with Caucasian clients. Furthermore, Caucasian therapists provided higher alliance ratings with Caucasian clients than minority therapists did with Caucasian clients. However, there were no differences in the clients' early alliance ratings in association with being matched with a ethnically/racially similar therapist.

In a study by Chang and Yoon (2011), some clients assumed that similarity with their therapists would facilitate understanding and the development of a therapeutic alliance. In fact, several studies indicate client preference for similar therapists (Abreu & Gabarain, 2000; Coleman et al., 1995). In a meta-analysis of 81 studies, ethnic/racial minorities strongly preferred and had more positive perceptions of ethnically/racially similar therapists even though matching was not associated with treatment outcomes (Cabral & Smith, 2011). Consistent with such research, African American clients prefer seeing African American therapists as opposed to Caucasian therapists (Thompson, Bazile, & Akbar, 2004).

On the other hand, some ethnic/racial minority clients prefer to have a dissimilar therapist, some believing that certain issues are perceived as being easier to talk about with a Caucasian therapist and others believing that challenges would arise in building a therapeutic relationship with a similar therapist (Chang & Yoon, 2011). In a study investigating the experiences of British South Asian clients attending family therapy, one client being treated by a White therapist stated clear preference for an ethnically different therapist due to lack of trust towards a similar therapist (Pandya & Herlihy, 2009). However, in a study by Horst et al. (2012), some clients expressed ambivalence when they were asked if it is better to be racially matched

with a therapist. A couple discussed that although there are benefits of being able to identify with a therapist due to racial similarity, there are also strengths in seeing a therapist of a different race as he/she can help the couple to see and understand things from a different perspective.

It is important to note that clients also perceive certain characteristics of therapists to be of more importance than ethnicity/race in building and maintaining a strong therapeutic relationship, such as, "self-esteem, perceptive abilities, compassion, being supportive, having good listening skills", and expertise (Horst et al., 2012). Chang and Berk (2009) found that all the satisfied clients emphasized therapeutic competence and skills (e.g., compassion, empathy, nonjudgment, skillful communication) when praising their therapists. From the clients' perspectives, these qualities transcended any challenges that resulted from racial differences.

Ethnic/racial differences and challenges. Ethnic/racial minority clients seeing dissimilar therapists have been found to experience challenges, despite their overall satisfaction with treatment (Chang & Berk, 2009). Although some ethnic/racial minority clients are satisfied with their experience of therapy with a Caucasian therapist, many still perceive the racial difference to be a significant obstacle in building a strong therapeutic relationship. In a study investigating recent experiences of 23 ethnic/racial minority clients being treated by a Caucasian therapist, majority of the participants, including those who were satisfied with treatment, felt that their therapists were unable to understand them on a deeper level since the therapists could not fully appreciate the impact of the clients' minority status on their lives (Chang & Yoon, 2011). Subsequently, these clients did not bring issues related to ethnicity, race, and culture in therapy due to concerns that their therapists would not respond with empathy, validation, or cultural sensitivity. Chang and Berk (2009) report findings where some of the unsatisfied ethnic/racial minority clients described their Caucasian therapists as not being aware of the power and

privilege dynamics in the clients' lives and in the therapeutic context. Several unsatisfied clients shared instances of when their experiences related to oppression or discrimination were minimized by their therapists. Other participants lacked trust because they perceived their therapists as being racially biased or holding racial stereotypes, which also undermined the credibility of the therapists.

Some studies report that clients receiving treatment from an ethnically different therapist are less likely to exhibit post-treatment change. Flicker et al. (2008) investigated treatment outcomes in a sample of Hispanic and Caucasian adolescents with substance abuse in functional family therapy. Despite the sample being highly acculturated, Hispanic clients who were matched with Caucasian therapists reported fewer changes in their substance use from pre-treatment to post-treatment when compared to the Hispanic clients who were matched with Hispanic therapists. It can be implied that challenges were present even for the acculturated clients working with dissimilar therapists. The authors cite Yeh et al. (1994) to state that this finding contradicts research which suggests ethnic matching is less important among those clients who speak English as their primary language, such as the clients in their study.

Specific challenging transference and countertransference processes have also been identified in cross-cultural therapy. Comas-Diaz and Jacobsen (1991) identified mistrust as a common transference issue in ethnically/racially dissimilar therapist-client dyads. The authors describe it as the reaction, "How can this person understand me" (p. 394). The authors argue that unacknowledged ethnic/racial differences can promote mistrust and suspicion in the client. Moreover, client mistrust of therapist is well documented in cross-cultural literature, especially among Black clients receiving treatment from White therapists (Terrell & Terrell, 1984; Thompson, Worthington, & Atkinson, 1994). Overcompliance and friendliness are identified as

transference reactions that occur when there is a social power differential between clients and their therapists, such as a Caucasian therapist with an ethnic/racial minority client. Denial of ethnicity and culture is idenified as another transference issue where clients may avoid any issue that is relevant to clients' ethnic/racial and cultural background. Some other possible transference reactions are ambivalence and hostility. A common countertransference reaction in an ethnically/racially dissimilar therapist – client dyad is the denial of ethno-cultural differences, where therapists believe, "all patients are (or should be treated as if they are) the same" (p.396). Guilt is another countertransference reaction identifed as possibly occuring in therapists due to the lower status of their clients' ethnicity/race as dictated by social and political realities. Some other countertransference issues discussed by the authors include pity and aggression.

Ethnic/racial differences and strengths. While many clients view ethnic/racial differences to be challenging, some find strengths in the differences. In the study by Chang and Yoon (2011), some clients expressed that the differences helped to build a positive therapeutic relationship. However, this strength was only reported by half of those participants who were satisfied with their experience and only a small minority of those who were dissatisfied. Participants also expressed feeling special since their experiences were validated as being unique by Caucasian therapists. For example, a Hispanic male reported being grateful for having a Caucasian therapist because he received support and compassion when discussing his experiences of being discriminated, which he thought he would not have received from a Hispanic therapist who would have likely been desensitized to issues related to discrimination. Participants perceived their Caucasian therapists as being more accepting and open-minded towards varying lifestyle choices. The Caucasian therapists were viewed as having more expertise than minority therapists and were also seen as providing unique perspectives which the

participants found useful in dealing with acculturation issues. Moreover, several of the participants reported having positive expectations of their Caucasian therapists based on ethnic/racial stereotypes, which helped to develop a working alliance, at least at the start of therapy.

Conclusion. Research on ethnic/racial differences has found mixed results regarding treatment satisfaction, treatment outcomes, and client preference for similar or dissimilar therapists, suggesting the presence of both challenges and strengths in cross-ethnic therapeutic encounters. Some clients perceive obstacles in therapy with ethnically/racially dissimilar therapists whereas others perceive benefits. Additionally, many clients perceive certain therapist characteristics, such as compassion and empathy, as being more important than ethnic/racial similarity or dissimilarity.

Much of the research on ethnic/racial differences focuses on client perspectives rather than therapist perspectives, which limits the understanding of the phenomenon. While knowledge of clients' perceptions and experiences of differences is important, it does not necessarily inform therapists about challenges and strengths they might encounter in therapy with ethnically/racially and religiously different clients. Furthermore, research focuses more on ethnic/racial matching than it does on ethnic/racial differences in therapy.

Religion in Therapy

Previous surveys have suggested that therapists are less devoted to traditional religious affiliations, values, and beliefs when compared to the population at large (e.g., Bergin, 1980a). Khan and Cross (1983) conducted a study in Australia where data from over 400 therapists and over 400 clients indicated that therapists emphasized values regarding liberal lifestyles, especially in the area of sexuality, more than the clients. Furthermore, therapists were more

likely to support items related to individual growth whereas clients were more likely to support items related to obedience and self-control. Additionally, therapists have been found to note improvement in clients only after some values of the clients shift to become similar to their own values (Rosenthal, 1955).

Religious similarity. Research has consistently shown that religious clients prefer having therapists with similar religious beliefs (Worthington et al., 1996; Keating & Fretz, 1990). For example, religious Christian college students preferr discussing personal and social problems with counselors who share their faith (Guinee & Tracey, 1997) and do not challenge their religious beliefs (Worthington, 1988). Highly religious clients have been found to report satisfaction with treatment more often when their religious values are similar to the values of their therapists (Bergin, 1985; Beutler et al., 1983). Moreover, religious clients are more responsive to treatment when it is consistent with their religious beliefs (Propst, Ostrom, Watkins, Dean, & Mashburn, 1992).

Religious differences and challenges. Highly religious clients have been found to terminate services sooner with nonreligious therapists and experience less successful outcomes in comparison to nonreligious clients (Welkowitz et al., 1967). Other empirical studies also suggest that religious dissimilarity between therapists and clients may be the reason for unsuccessful therapeutic outcomes (Arizmendi et al., 1985; Kessel & McBrearty, 1967). These findings indicate that challenges exist in therapy when therapist and client affiliate with different religions.

Smith (1998) investigated whether the religious and spiritual experiences of therapists influence treatment of clients. It was found that 38% of therapists believed that their religious or spiritual experiences had little influence on their work, 39% believed there was moderate

influence, and 23% believed their work was influenced greatly. Majority of the therapists who believed there was little influence had a more secular belief system whereas those who believed there was moderate to great influence were high in religiosity. Christian therapists, both Catholics and Protestants, were most likely to report that their work was influenced moderately or greatly by their religion while Jewish and nonaffiliated therapists were most likely to report little influence. With treatment being influenced by the therapist's religion, challenges may present in therapy, especially with religious clients.

Not only do the religious and spiritual experiences of therapists' influence their work, but the religiosity of therapists and clients also impacts treatment, creating further challenges. Houts and Graham (1986) conducted a study where 24 religious clinicians and 24 nonreligious clinicians were all randomly assigned a vignette of a male client. The client as well as the contents of the videotapes were identical, other than the level of religiosity expressed by the client in each vignette (i.e., non religious, moderately religious, very religious). Clinicians were asked to provide their clinical assessment about the cause of the client's problems. The authors found that clinicians who were religious were more likely to make internal attributions for the nonreligious client when compared to nonreligious therapists. On the other hand, nonreligious therapists were more likely to make internal religious contributions for the religious clients. Based on the findings of the study, the authors infer that a nonreligious therapist might target the religious beliefs of the client for change since the therapist will be inclined toward ascribing religious dispositional factors as the cause of the client's problems.

Williams and Levitt (2008) investigated the experiences of clients receiving treatment from therapists who were different from them. The authors found that clients mostly noted challenges due to the differences with their therapist. These challenges included being vigilant

for differences, feeling threatened by the differences, actively minimizing the differences and instead focusing on factors that supported a positive therapeutic relationship, and avoiding discussing differences with their therapist.

Much of the literature reporting on the experiences of therapists working with religiously dissimilar clients discusses issues of countertransference, which also presents challenges. In Lijtmaer (2009), the author, who described herself as an atheist, felt "annoyed" and "narcissistically injured" when her religious Catholic client attributed the changes she made to her belief in God as opposed to all the work that was done in therapy. The author described another instance when she felt "envy" for a client who was able to cope with her illness due to her belief in God and "sad" for struggling to believe in something herself that can give so much strength. Aten (2011) also described the experience of the author working with an incarcerated client who belonged to a "white Aryan religion" which guided many white supremacy groups. The author described feelings of "anger" towards the client, discomfort, confusion, and even "guilt" at feeling this way towards a client.

Other authors describe similar experiences of annoyance and anger towards dissimilar clients discussing their religious views. Winton (2013) implies challenges in working with religion in therapeutic encounters due to the impact it may have on a therapist's own religious beliefs. The author states, "It may feel uncomfortable to be cast as God. Deeply held convictions may feel trampled. Clients may be seen struggling with positions that the therapist has eschewed. Doubts may be echoed. Self-awareness may be a recurring challenge." Furthermore, the author warns that being unaware of the impact of religious differences may lead a therapist to become blind to therapeutic challenges as well as opportunities.

Religious differences and strengths. Limited research exists on strengths that arise as a result of religious differences between therapists and clients. In a study by Kellems et al. (2010), a therapist with a dissimilar client discussed how different religious values afforded one of her clients a lot of space for acceptance and freedom to choose his/her own path. This is consistent with clients' experiences of achieving personal growth as a result of religious differences (Williams and Levitt, 2008). Based on their findings, Kellems et al. (2010) argued that depending on how religious similarities and differences are utilized in therapy, they both can increase the strength of the therapeutic relationship.

Conclusion. Religious clients prefer religiously similar therapists, with highly religious clients reporting treatment satisfaction with religiously similar therapists and experiencing less successful outcomes with nonreligious therapists. This suggests the presence of challenges between therapists and clients belonging to different religious affiliations. Religious and spiritual experiences of therapists have been found to influence therapy, and religiosity of therapists and clients has been found to influence clinical judgment of therapists. Limited research exists on strengths that arise from religious differences. As with literature on ethnic/racial differences, challenges related to countertransference issues are also reported in literature on religious differences in therapy.

Ethnicity/Race and Religion in Therapy with South Asian and Middle Eastern Muslims

Literature on South Asian and Middle Eastern Muslim clients. Limited research exists on Middle Eastern Muslims and even less on South Asian Muslims in therapy. Moreover, research is scarce regarding challenges and strengths encountered by non-Muslim Caucasian therapists working with South Asian and Middle Eastern Muslim clients. Much of the research on Muslims presents guidelines on how to do effective culturally sensitive psychotherapy with

Muslims and provides case examples from personal experiences of the authors (e.g., Azhar & Varma,1995a; Azhar & Varma, 1995b; Azhar, Varma & Dharap, 1994; Razali, Hasanah, Aminah, & Subramaniam, 1998; Sauerheber et al., 2014; Abu Raiya, & Pargament, 2010; Ahammed, 2010). However, most of this literature is not grounded in empirical research. Additionally, majority of the literature does not provide discussions related to challenges and strengths that arise in therapy for therapists working with Muslim clients. For example, Razali et al. (2002) investigated the effects of cognitive therapy with spiritual and cultural integration on Malay Muslims who presented with anxiety issues and Hasan and Kuluva (2006) presented a case study with cultural formulations and course of treatment with a Bangladeshi Muslim couple. Although the authors of both studies illustrated the efficacy of their treatments with a culturally sensitive approach, neither of them provided any particular discussion of challenges or strengths that came up in therapy. In fact, the ethnicity and religious orientation of the therapists providing the treatment was unknown in these studies. These examples indicate a lack of focus on issues related to cross-ethnic and cross-religious therapy in Muslim literature.

In addition, if there is discussion presented regarding the experience of the therapist working with a South Asian or Middle Eastern Muslim client, it is unclear whether the challenges and strengths are related to the impact of ethnic/racial and religious differences. As with the aforementioned studies, many authors do not clearly provide the ethnicity/race or religious affiliation of the therapists in question, or, the therapists in the research are Muslims themselves (e.g., Daneshpour, 2009a; Vasegh, 2011; Ahammed, 2010; Hamdan, 2007; Hamdan, 2008; Hasan & Kuluva, 2006; Razali et al., 2002). Furthermore, these experiences are based on anecdotal evidence rather than research. Moreover, hardly any research has focused explicitly on

the experience of non-Muslim Caucasian therapists working with South Asian or Middle Eastern Muslim clients.

One such study focused on the South Asian population explored non-South Asian and South Asian practitioners' perceptions of the presenting issues, needs, and barriers to seeking help for the South Asian population. Participants noted a variety of issues this population typically presents with in therapy, such as issues related to acculturation, gender, domestic violence, caregiver stress, and problems in managing teenagers and adolescents. Participants identified several needs of this population, such as culturally sensitive services, psychoeducation, and negotiation of marital problems. Barriers to seeking mental health services include differences in cultural values between non-South Asian practitioners and South Asian clients, stigma associated with mental illness, financial problems, and language barriers. However, this study focused more broadly on all South Asian clients rather than specifically South Asian Muslim clients and it focused more broadly on all non-South Asian practitioners rather than only those practitioners who were Caucasian and non-Muslim. Also, this study did not report findings on non-South Asian practitioners' experiences of challenges and strengths encountered in therapy as a result of differences with their South Asian clients.

Pooremamali, Eklund, Ostman, & Persson (2012) explored the experiences of Middle Eastern Muslim clients receiving occupational therapy from dissimilar therapists in Sweden. Participants discussed some challenges, such as having to conceal themselves or being a different person as to avoid judgement from a therapist of a different background. Several clients discussed the lack of cultural competence their therapists possessed and how it led these therapists' to make suggestions irrelevant to the clients' culture, ultimately leaving the client feeling misunderstood. Additionally, some clients felt that their therapists did not understand the

role of religious and spiritual activities in the clients' lives. Although this study provided insight into the challenges that arise as a result of ethnic/racial and religious differences, it is limited in a number of ways. The study does not include the perspectives of therapists working with the Middle Eastern Muslim clients in this study, specify the ethnic/racial and religious backgrounds of the therapists in question, or report any findings on strengths encountered as a result of the differences.

Challenges. Although there is not any research on challenges encountered by therapists working with the South Asian and Middle Eastern Muslim population, many authors provide suggestions based on Islamic beliefs, cultural practices, and personal experiences. Some argue that therapists might face reluctance or resistance from Muslim clients due to stigma about psychotherapy amongst this population (e.g., Abu Raiya & Pargament, 2010) and suggest addressing this early on in treatment to acknowledge and validate their feelings (Sauerheber et al., 2014). Daneshpour (2009b) states that Muslims will be hesitant to share their personal or interpersonal concerns or difficulties, and they typically expect a medical cure from therapy. Springer et al. (2009) discuss the possibility of Muslim clients responding to their therapists' advice out of deference to authority or due to shame. Abbott, Springer, and Hollist (2012) discuss the challenge therapists might experience in trying to understand the difference between how Islamic beliefs and country of origin practices influence marriage and suggest asking clients about the Islamic teachings regarding the marital issue and the cultural teachings from their country of origin to help differentiate between religious beliefs and cultural practices. Springer et al. (2009) warn therapists of the impact of their Western values on Muslim clients. The authors write, ‘‘The concept of autonomy, as encouraged by our Western Culture, would be in direct

conflict with their world view, and could lead to further alienation of that individual from his or her support group'' (p. 231).

Baum (2011) suggests that the therapeutic encounter experiences further challenges when therapists and clients belong to opposing sides in a violent political conflict. The author, a Jewish Israeli therapist, draws upon his own experiences as well as those of others providing therapy to Arab Israeli clients. The author argues that ethnic/racial and religious differences are further magnified due to the "enemy presence" within the therapeutic encounter, leading to mutual mistrust and mutual guilt between the therapist and the client. The author states that although the enemy presence can either be ignored or kept in check by the therapist, "the sense of the client as an 'enemy' and the ensuing feelings of anger, discomfort, wariness, suspicion, dislike, hostility, and so forth, are there at some level, conscious or unconscious, dormant or denied." The author cites Volkan (1994) when stating that the enemy presence tends to become salient in our thoughts, dictating our unconscious processes and potentially creating unique transference and countertransference responses that create challenges for the therapeutic relationship.

To date, one study exists that explores challenges encountered by a non-Muslim Caucasian counselor working with a Middle Eastern Muslim client (Cook-Masaud & Wiggins, 2011). The authors present a case illustration which included discussion on challenges and strengths that came up during treatment and the way the counselor attempted to manage them. For example, the authors discussed how the client presented as passive and viewed the counselor as an authority figure. As explained by the authors, "although some Muslims from collectivist cultures may seek counseling, they do so within a hierarchical framework by being passive clients, deferring authority to the counselor to set goals and establish treatment plans" (p. 250). This conflicted with the counselor's attempt at collaborative treatment. To resolve this challenge,

the counselor focused on taking time to build a strong therapeutic relationship and gaining the trust of her client by employing many therapeutic skills to build rapport, such as empathy, genuine curiosity, validation, and asking the client to share her immigration story. In-home counseling was also offered to the client to further address the perceived power imbalance between the counselor and the client. However, it is important to note that the authors presented a case example where some detail was made up to serve the purpose of their literature.

Strengths. Literature provides even less information on the strengths that present themselves for therapists working with Muslim clients. Ali, Liu, and Humedian (2004) suggest that Muslim clients may feel more comfortable in discussing alcohol-related issues with a non-Muslim therapist as they would not feel as guilty or judged. The authors also suggest that non-Muslim therapists may serve as a "safe and nonjudgemental resource" (p. 638) for Muslims to express any doubts related to religious beliefs or to cope with discrimination experiences.

Some studies present case examples where strengths are implied. For example, Vasegh (2011) presented case examples where texts from the Quran were used with cognitive therapy to treat depressive symptoms in Muslim clients. Hamdan demonstrated the efficacy of cognitive restructuring using Islamic concepts with a Middle Eastern Muslim (2008) and a Pakistani Muslim (2007) client. However, the ethnicity/race and religious orientation of the therapists providing treatment were unknown in these studies. This, once again, points to a lack of focus on issues related to ethnic/racial and religious differences in therapy in Muslim literature.

Cook-Masaud and Wiggins (2011) imply some strengths that resulted due to ethnic and religious differences between the counselor and the client. For example, the authors explain that by way of gaining deeper knowledge and appreciation of contemporary commentary on the Quran, the counselor was able to stand inside the client's circle of faith and help expand the

client's understanding of the religious material as it may apply to her new life in the U.S. The counselor was able to collaboratively join with the client by exploring Islamic texts relevant to some of the issues presented by the client. The counselor was also able to enhance her own understanding and interpretations of the Quran by seeking guidance from an Imam as well as reading current scholarship in order to understand the religious material within the historical and cultural context. Lastly, the counselor was able to advocate for the client and her husband to the Child Protective Services, explaining what she had learned about the client's beliefs and practices common in Middle Eastern Muslim cultures.

Conclusion. Literature suggests some challenges that therapists might face when working with South Asian and Middle Eastern Muslim clients, such as resistance due to stigma or shame. Literature suggests fewer strengths, such as the integration of religion in treatment. However, these suggestions lack an empirical basis. There is virtually no thorough and rigorous research that investigates the experiences of non-Muslim Caucasian therapists working with South Asian and Middle Eastern Muslim clients.

Conclusion

Existing literature and research demonstrates that ethnic/racial and religious differences between therapist and client impact therapy in various ways that result in both challenges and strengths. Therapists working with South Asian and Middle Eastern Muslim clients may also experience certain challenges and strengths in therapy, though literature does not provide an empirical basis for this. Given the lack of research investigating cross-cultural issues relating to ethnic/racial and religious differences in therapy with South Asian and Middle Eastern Muslim clients, and the lack of an empirical understanding of the challenges and strengths that therapists encounter when working with this population, the present study aimed to bridge the gap in

literature by attempting to gain insight into the experiences of non-Muslim Caucasian therapists working with South Asian and Middle Eastern Muslim clients.

Chapter 3: Methods

Design of Study

A qualitative, phenomenological design was used to explore specifically what types of challenges and strengths arose as a result of ethnic/racial and religious differences in therapy and how therapists attempted to manage them when working with Muslim clients. Conducting in-depth qualitative interviews with therapists provided rich and descriptive details which was hoped will increase the understanding of the phenomenon.

Participants

This study recruited eight non-Muslim Caucasian licensed MFTs using a combination of purposive sampling and snowball sampling. Participants were recruited through an electronic mail (Appendix A) sent out to various MFT professional listserves. The recruitment mail called on volunteers who had conducted at least one 50-minute therapy session with two different clients (individual, couple, or family) where at least one member was a South Asian or Middle Eastern Muslim. The researcher included only those volunteers who provided therapy to clients from this population within the past 12 months in order to ensure that participants were able to accurately recall rich and detailed descriptions of their experiences. Thus, this procedure established reliability and validity of the data. All identifiable participant information remained confidential. Participants were not reimbursed for participating in this research.

Procedures

Before this research was conducted, the researcher sought approval from the Institutional Review Board. After approval was obtained, the researcher sent out a recruitment mail which outlined the purpose of the study and participation requirements. The researcher conducted a brief screening questionnaire (Appendix B) over the telephone with potential participants. Once participants were recruited in the study, the researcher conducted a semi-structured interview

with each individual participant in their office. With two participants, interviews were completed over the phone on a later date after the in-person interviews. Prior to the interview, participants were given informed consent forms (Appendix C) which included information about the purpose of the research, voluntary nature of the research, potential risks and benefits involved with participation, and procedures used to maintain confidentiality. A basic demographic questionnaire (Appendix D) was also given to each participant prior to the interview. The questionnaire gathered information regarding gender, age, religious affiliation, level of education, level of multicultural training, and level of experience with ethnically/racially and religiously diverse clients, including South Asian and Middle Eastern Muslim clients.

Upon receiving the verbal and written consent of the participants, the interviews were conducted. The interviews were recorded for transcription as well as verification purposes as analysis was conducted. Field notes were also taken for verification. As each interview was completed, it was transcribed by either the primary researcher or a third party transcriber who was asked to sign a confidentiality agreement (Appendix E) prior to transcription. All documents, data, and audio recordings containing identifiable participant information were kept in a secure location and remained confidential. Each audio recording was labeled using an alias name for the participant in order to ensure confidentiality. Any data stored on the computer was password-protected in a secure location. Only the primary researcher and the committee chair of the study had access to the documents, data, and audio recordings. Upon completion of the research, audio recordings were destroyed in a secure manner.

Instruments

A semi-structured interview was conducted using open-ended questions to understand the following research questions: (1) What are the challenges and strengths encountered by non-

Muslim Caucasian licensed MFTs as a result of ethnic/racial and religious differences with their South Asian and Middle Eastern Muslim clients?; (2) How are the challenges and strengths managed in therapy?; (3) How do therapists perceive their experiences with South Asian and Middle Eastern Muslim clients when compared to experiences with other ethnically/racially and religiously different clients?

Interview outline. The following is an interview script and basic outline of questions that were asked in the interview. With a semi-structured interview, the researcher had the flexibility to deviate from the outline as needed to use probes and ask relevant questions of participants. For each question, the researcher probed for concrete examples if the participants did not provide one. When participants provided examples of clients, the researcher inquired about the level of assimilation of the clients in the examples, as known or perceived by the participants.

> Thank you for agreeing to participate in this study. Before we get started, I wanted to tell you a little bit about my background, what I am interested in learning from you, and some reminders about the interview. In terms of my ethnic and religious background, I am Pakistani and I am Muslim. I realize that it may be uncomfortable for you to share with me certain experiences you may have had with your Muslim clients, particularly, South Asian Muslim clients, as I belong to this population. I understand that there are stereotypes and certain attitudes in the U.S. regarding Muslims, South Asians, and Middle Easterns that influence many of us. However, I would like to assure you that it is okay with me for you to be completely honest about your experiences. I am interested in learning from you about all your experiences with this population, whether they are positive or negative. It is hoped that the information you provide will inform the work of other clinicians working with South Asian and Middle Eastern Muslim clients, thus,

increasing the trust of this population towards the mental health field. Additionally, I want to remind you that this interview is intended to understand your experiences working with only South Asian Muslim or Middle Eastern Muslim individuals, couples, and families. If you have experience working with both South Asian and Middle Eastern Muslim clients, please include experiences of working with both when answering the questions. If you have worked with a client system where members of the system are of multiple ethnicities/races and/or religious affiliations, please only think about your experiences with the South Asian Muslim or Middle Eastern Muslim member of the system when answering the questions. Also, please focus only on those experiences that you have had in the past 12 months in working with this population. The interview should take about an hour. Do you have any questions or concerns about the interview before we begin? If not, we can start now.

1) What challenges did you encounter in therapy as a result of ethnic/racial and religious differences with the client(s)?

a) What attempts did you make to manage each challenge?

b) Which attempts, if any, did you find to be more successful in managing the challenge? How so?

c) Which attempts, if any, did you find to be less successful in managing the challenge? How so?

2) What about any challenges related to joining with the client, such as client mistrust, reluctance to share information, shame, resistance, difficulty in getting members of the client system to attend sessions, etc?

a) What attempts did you make to manage each challenge?

b) Which attempts, if any, did you find to be more successful in managing the challenge? How so?

c) Which attempts, if any, did you find to be less successful in managing the challenge? How so?

3) What about any challenges related to client expectations from therapy and expectations of the therapist?

a) What attempts did you make to manage each challenge?

b) Which attempts, if any, did you find to be more successful in managing the challenge? How so?

c) Which attempts, if any, did you find to be less successful in managing the challenge? How so?

4) What about any challenges related to understanding and working with religion and culture in treatment?

a) What attempts did you make to manage each challenge?

b) Which attempts, if any, did you find to be more successful in managing the challenge? How so?

c) Which attempts, if any, did you find to be less successful in managing the challenge? How so?

5) What about any challenges related to Western values conflicting with client values?

a) What attempts did you make to manage each challenge?

b) Which attempts, if any, did you find to be more successful in managing the challenge? How so?

c) Which attempts, if any, did you find to be less successful in managing the challenge? How so?

6) What about any challenges related to working with multiple generations in the client system?

a) What attempts did you make to manage each challenge?

b) Which attempts, if any, did you find to be more successful in managing the challenge? How so?

c) Which attempts, if any, did you find to be less successful in managing the challenge? How so?

7) What about any challenges related to working with each gender?

a) What attempts did you make to manage each challenge?

b) Which attempts, if any, did you find to be more successful in managing the challenge? How so?

c) Which attempts, if any, did you find to be less successful in managing the challenge? How so?

8) Are there any other challenges you can think of that resulted from ethnic/racial and religious differences in therapy, such as challenges with marital issues, gender roles, family dynamics, domestic violence, etc?

a) What attempts did you make to manage each challenge?

b) Which attempts, if any, did you find to be more successful in managing the challenge? How so?

c) Which attempts, if any, did you find to be less successful in managing the challenge? How so?

9) What strengths did you find in therapy as a result of ethnic/racial and religious differences with the client(s)?

a) How did you utilize each strength in therapy?

b) Which strengths, if any, did you find to be more helpful in therapy? How so?

c) Which strengths, if any, did you find to be less helpful in therapy? How so?

10) What about any strengths related to bringing a fresh perspective to client problems?

a) How did you utilize each strength in therapy?

b) Which strengths, if any, did you find to be more helpful in therapy? How so?

c) Which strengths, if any, did you find to be less helpful in therapy? How so?

11) What about any strengths related to incorporating religion into treatment?

a) How did you utilize each strength in therapy?

b) Which strengths, if any, did you find to be more helpful in therapy? How so?

c) Which strengths, if any, did you find to be less helpful in therapy? How so?

12) What about any strengths related to advocating for the client?

a) How did you utilize each strength in therapy?

b) Which strengths, if any, did you find to be more helpful in therapy? How so?

c) Which strengths, if any, did you find to be less helpful in therapy? How so?

13) Are there any other strengths you can think of that resulted from ethnic/racial and religious differences in therapy?

14) Do you think you will encounter the same challenges and strengths with other ethnically/racially and religiously different clients from you who are not South Asian or Middle Eastern Muslim? Please explain.

15) Based on your experiences, what do you wish you had known or done at the time of seeing your South Asian and Middle Eastern Muslim clients?

16) What advice would you give to other non-Muslim Caucasian MFTs working with this population?

Validity and reliability. Methodological rigor was establisheded using guidelines provided by Creswell (2013). Interviews were recorded and transcribed as they were completed in order for the researcher to begin reviewing the data. Data analysis from early on points to emerging themes that may require further questioning in the interviews. The data contained rich descriptions of therapists' experiences. To establish inter-coder reliability, the committee chair of this study also reviewed data, codes, and themes. To ensure reliability, field notes were used for triangulation.

Reflexivity. In adhering to a phenomenological inquiry, the primary researcher, a South Asian (Pakistani) Muslim immigrant to the United States, approached this phenomenon from a fresh perspective by setting aside personal experiences and assumptions. This reflexive process, known as bracketing (Creswell, 2013), helped the researcher to become more open to the lived experiences of others and established validity. The researcher kept a journal to bracket personal experiences, biases, assumptions, ideas, reactions, and thoughts prior to and during the data collection process.

Analysis

Consistent with a phenomenological method, themes were identified, analyzed, and reported in a six-step process known as thematic analysis (Braun & Clarke, 2006). In this process, the researcher (1) became familiar with the data by listening to audio tapes and reading each transcript several times, (2) produced preliminary codes from each transcript by identifying patterns of words and phrases, (3) interpreted the meanings of these patterns and formulated tentative themes that emerged from categorizing the codes, (4) revised, discarded, and refined the themes until they became representative of the sample, (5) clearly defined the themes and named them accordingly, and (6) generated a report of the findings that fit the context of the research questions, existing literature, and the data. The write-up of the findings included examples of participants' quotes from the data as evidence for the themes.

The Experiences of Non-Muslim Caucasian Licensed Marriage and Family Therapists Working with South Asian and Middle Eastern Muslim Clients

Islam is known to be the fastest growing religion in the United States and the rest of the world (Ali, Liu, & Humedian, 2004). Estimates on the American Muslim population vary greatly. According to the Pew Research Center (2011), the Muslim population in the U.S. is expected to rise from 2.6 million in 2010 to 6.2 million in 2030. National Muslim groups report higher statistics, with 6 to 8 million Muslims living in the U.S. (Khan, 2002). The majority of the American Muslim population is foreign born, making 65% of all American Muslims (Pew Research Center, 2007). Within the immigrant American Muslim population, 49% came from the Middle East (Iraq, Iran, Saudi Arabia, Yemen, United Arab Emirates, Qatar, Oman, Bahrain, Kuwait, Turkey, Syria, Lebanon, Palestine, Israel, Afghanistan, Jordan, and Cyprus) (The Cambridge Encyclopedia of the Middle East and North Africa, 1988) and Arab countries in North Africa, 27% came from South Asia (Pakistan, India, Bangladesh, Sri Lanka, Nepal, Bhutan, and the Maldives) (Saleem, 2009), 8% came from Europe, 6% came from non-Arab African countries, and 10% came from other countries.

Muslims living in the U.S. continue to be impacted since the events of September 11, 2001. They have experienced increased hate crimes, discrimination, deportation hearings, religious profiling at airports, vandalism of mosques, and physical violence (Moradi & Hasan, 2004). In a survey by Gallup (2010), American Muslims were found to be the most likely (48%) than other major faith groups to have experienced discrimination due to their race or their religion. In a national poll conducted soon after 9/11, 20% of Middle Eastern Americans reported experiencing discrimination after 9/11 because of their ethnicity, 45% reported knowing about a person who experienced similar discrimination after 9/11, and 61% worried about

discrimination and its long-term effects (Zogby, 2001b). In addition to discrimination, being perceived as terrorists, ignorance about their religion, and stereotyping are among the biggest problems cited by American Muslims (Pew Research Center, 2007).

Barriers to Seeking Services

The climate of discrimination seems to play a role in the low utilization rates of mental health services by Muslims (Altareb, 1996; Kelly, Aridi, & Bakhtiar, 1996). Many Muslims "approach psychology with doubts, antipathy, and suspicion" (Abu Raiya, Pargament, Stein, & Mahoney, 2007, p. 186) since they view it as a Western concept that is secular and anti-religious, making it unsuitable for the Islamic way of life. Other barriers include negative views of Islam or Muslims, fear of stereotyping and discrimination, feeling misunderstood, shame in seeking outside help, and lack of therapists' knowledge of Islam and the culture (Daneshpour, 1998). Thus, Muslims tend to rely on support from God (*Allah*), family members, or religious clergy (Weatherhead & Daiches, 2010). In fact, when compared to other groups, Muslims are most likely to believe in the power of their faith and social support to help manage their depression (Lowenthal, Cinnirella, Evdoka, & Murphy, 2001). Moreover, spiritual or practicing Muslims tend to have a unique relationship with their religion, where religion plays an important role in almost every aspect of life.

Mental Health Issues

Despite the existing barriers, it seems that culturally sensitive mental health services might benefit the American Muslim population considering reports of anxiety and depression symptoms in this population. A recent study with 601 Arab Americans, 70% of whom were Muslim, found that 50% were in the clinically significant range of depression, 22% experienced mild-to-moderate anxiety, 14% experienced moderate-to-severe anxiety, and 11% experienced

severe anxiety (Amer & Hovey, 2012). PTSD symptoms have also been found among American Muslims due to trauma associated with 9/11, discrimination, and wars in their native countries (Abu-Ras & Abu Bader, 2008). Based on reports from Arab therapists, severe postwar trauma exists amongst Iraqi refugees which contributes to attention-deficit hyperactivity disorder, depression, and substance use (Nasser-MacMillian & Hakim-Larson, 2003).

Additionally, American Muslims have been found to be less happy in their lives when compared to the average American population. A national demographic study of 1,050 American Muslims showed that only 78% of American Muslims reported being "happy" whereas 87% of the normative American sample reported being "happy". Immigrant Muslims reported even lower rates of being "happy" (Pew Research Center, 2007). There are a variety of presenting issues that might be prevalent in the American Muslim population, including familial issues relating to boundaries, gender roles, parent-child conflicts, intergenerational conflicts, and extended family issues (Daneshpour, 2009). These issues can all be a great source of distress among American Muslims due to the importance of family in Islam and Muslim cultures. It is also argued that Muslim couples struggle with similar issues faced by couples of other faiths and cultures, such as issues around communication, parenting, financing, division of labor, and decision-making (Daneshpour, 2009).

Ethnicity/Race and Religion of Therapists

When American Muslims do seek mental health services, they are likely to encounter ethnically/racially and religiously different therapists due to the underrepresentation of ethnic/racial minority mental health professionals. Majority of the clinicians practicing in the United States are Caucasians of European descent (U.S. Department of Health & Human Services, 2001). According to estimates by SAMHSA's Mental Health U.S. report (U.S.

Department of Health & Human Services, 2004), only 24.2% of psychiatrists, 17.5% of psychiatric nurses, 15.4% of counselors, 6.2% of psychologists, 5.3% of school psychologists, 8.7% of social workers, and 5.5% of marriage and family therapists (MFT) are racially and ethnically diverse (i.e., Hispanic, Black, Asian, and American Indian). According to these estimates, MFTs are among the least ethnically diverse mental health professionals. Furthermore, majority of MFTs affiliate with various denominations of Christianity (Winston, 1991) and report high levels of religiosity and spirituality. However, no estimates have been reported for South Asian, Middle Eastern, or Muslim MFTs.

A Review of the Literature

Thorough and systematic research on the American Muslim population is insufficient. Much of the research on Muslims presents guidelines on how to do effective culturally sensitive psychotherapy with Muslims and provides anecdotal evidence (e.g., Sauerheber et al., 2014; Ahammed, 2010). However, most of this literature is not grounded in empirical research. Additionally, majority of the literature does not provide discussions related to challenges and strengths that arise in therapy for therapists working with Muslim clients. Moreover, given the likelihood that American Muslims will be seen by non-Muslim Caucasian therapists and, despite the prevalence of South Asian and Middle Eastern Muslims in the U.S., research on cross-cultural therapy with this therapist - client dyad is scarce.

Differences in ethnicity/race and religion between therapists and their clients have been found to impact therapy among other culturally diverse populations. Research on ethnic/racial differences has found mixed results regarding treatment satisfaction (e.g., Chang & Yoon, 2011), treatment outcomes (e.g., Flicker et al., 2008; Erdur, Rude, & Baron, 2003), and client preference for ethnically/racially similar or dissimilar therapists (e.g., Horst et al., 2012; Chang

& Yoon, 2011), which suggests the presence of both challenges and strengths in cross-ethnic/racial therapeutic encounters. Research on religious differences shows that religious clients prefer religiously similar therapists (Worthington et al., 1996), terminate services sooner with nonreligious therapists (Welkowitz, Cohen, & Ortmeyer, 1967), report satisfaction with treatment more often when their religious values are similar to the values of their therapists (e.g., Bergin, 1985), and experience less successful outcomes with nonreligious therapists (e.g., Welkowitz et al., 1967), which suggests the presence of challenges between therapists and clients belonging to different religious affiliations. Additionally, some possible transference (e.g., over-compliance and mistrust) and countertransference (e.g., denial of ethno-cultural differences and guilt) issues have been identified in ethnically/racially different therapist-client dyads (Comas-Diaz & Jacobsen, 1991). Literature on religious differences also discusses challenges related to countertransference issues, such as anger, discomfort, and envy (Aten, 2011; Lijtmaer, 2009) when working with religiously different clients. Sparse research exists on strengths that arise as a result of religious differences between therapists and clients.

If there is discussion presented in literautre regarding the experience of the therapist working with a South Asian or Middle Eastern Muslim client, it is unclear whether the challenges and strengths are related to the impact of ethnic/racial and religious differences. In fact, the ethnic/racial and religious orientation of the clinicians providing the treatment is often unknown or the clinicians are Muslims themselves (e.g., Daneshpour, 2009a; Vasegh, 2011). These examples indicate a lack of focus on issues related to ethnic/racial and religious differences in therapy in Muslim literature.

One such research explored the experiences of Middle Eastern Muslim clients receiving occupational therapy from ethnically/racially and/or religiously dissimilar therapists

(Pooremamali, Eklund, Ostman, & Persson, 2012). Participants discussed some challenges, such as having to conceal themselves to avoid judgment, feeling misunderstood, and therapists' lack of understanding and cultural competence. Another study presented a case illustration which included discussion on challenges encountered by a non-Muslim Caucasian clinician working with a Middle Eastern Muslim client (Cook-Masaud & Wiggins, 2011). For example, the clinician encountered a challenge when her client viewed her as an authority figure which conflicted with the clinician's attempt at collaborative treatment. To resolve this challenge, the clinician focused on taking time to build a strong therapeutic relationship and gaining the trust of her client by employing many therapeutic skills to build rapport, such as empathy, genuine curiosity, validation, asking the client to share her immigration story, and offering in-home counseling to further address the perceived power imbalance between the counselor and the client.

Although there is no empirical literature on challenges encountered by therapists working with the South Asian and Middle Eastern Muslim population, many authors provide suggestions based on Islamic beliefs, cultural practices, and personal experiences. Some argue that therapists might face reluctance or resistance from Muslim clients due to stigma about psychotherapy amongst this population (e.g., Abu Raiya & Pargament, 2010) and suggest addressing this early on in treatment to acknowledge and validate their feelings (Sauerheber et al., 2014). Others argue that Muslims will be hesitant to share their personal or interpersonal concerns or difficulties, and they typically expect a medical cure from therapy (Daneshpour, 2009b). Some authors have discussed the possibility of Muslim clients responding to their therapists' advice out of deference to authority or due to shame (Springer et al., 2009). Others have discussed the challenge therapists might experience in trying to understand the difference between how Islamic

beliefs and country of origin practices influence marriage (Abbott, Springer, & Hollist, 2012). Springer et al. (2009) warn therapists of the impact of their Western values on Muslim clients. The authors write, ‘‘The concept of autonomy, as encouraged by our Western Culture, would be in direct conflict with their world view, and could lead to further alienation of that individual from his or her support group’’ (p. 231).

Literature provides even less information on the strengths that present themselves for therapists working with Muslim clients. One strength suggested in literature is that Muslim clients may feel more comfortable and safer in discussing certain topics, such as substance use or doubts related to religious beliefs, with a non-Muslim Caucasian therapist as they would not feel as guilty or judged (Ali, Liu, & Humedian, 2004). However, the ethnicity/race and religious orientation of the therapists providing treatment in such studies are often unknown. This, once again, points to a lack of focus on issues related to ethnic/racial and religious differences in therapy in Muslim literature. In a case illustration, where the clinician is non-Muslim and Caucasian, strengths as a result of ethnic/racial and religious differences are implied when the clinician collaboratively joined with the client by exploring relevant Islamic texts, helping expand the client's understanding of the religious material, and enhancing her own understanding and interpretations of the Quran (Cook-Masaud & Wiggins, 2011).

The Present Study

Existing literature and research demonstrates that ethnic/racial and religious differences between therapists and clients impact therapy in various ways that result in both challenges and strengths. Therapists working with South Asian and Middle Eastern Muslim clients may also experience certain challenges and strengths in therapy, though literature does not provide an empirical basis for this. Given the lack of research investigating cross-cultural issues relating to

ethnic/racial and religious differences in therapy with South Asian and Middle Eastern Muslim clients, and the lack of an empirical understanding of the challenges and strengths that therapists encounter when working with this population, the present study aimed to bridge the gap in literature by attempting to gain insight into the experiences of non-Muslim Caucasian therapists working with South Asian and Middle Eastern Muslim clients. Furthermore, the present study investigated the experiences of non-Muslim Caucasian therapists in order to contribute to the existing literature, which is mostly from Muslim authors, by providing recommendations and guidelines from an ethnically/racially and religiously different perspective.

In this study, a phenomological framework was used to explore the lived experiences of non-Muslim Caucasian licensed MFTs who have worked with South Asian and Middle Eastern Muslim individuals, couples, and families. Specifically, the study explored the challenges and strengths that arose in therapy as a result of ethnic/racial and religious differences between the therapists and their clients, and how the therapists managed the challenges and strengths in therapy. In-depth, semi-structured interviews were conducted in-person to attain rich and descriptive details of therapists' experiences within their contexts.

Methods

Participants

Eight individuals who self-identify as non-Muslim Caucasian, Licensed MFTs were interviewed for the present study. Using a purposive sampling method, participants were recruited through an electronic mail sent out to various MFT professional listserves. The recruitment mail called on volunteers who had conducted at least one 50-minute therapy session with two different clients (individual, couple, or family) within the past 12 months where at least

one member was a South Asian or Middle Eastern Muslim. After screening for eligibility, participants were recruited and interviewed.

Procedures

Before this research was conducted, the researcher sought approval from the Institutional Review Board. Informed consent was obtained from all participants before interviewing them. The researcher conducted a semi-structured interview with each individual participant in their office. Two participants completed the remainder of their interview over the phone on a later date. Prior to the interview, participants were also asked to fill out a demographic questionnaire which gathered information regarding gender, age, religious affiliation, level of education, multicultural training, and level of experience working with ethnically/racially and religiously different clients, including South Asian and Middle Eastern Muslim clients.

Semi-Structured Interviews

An in-depth, semi-structured interview was employed to gather qualitative data regarding the participants' experiences working with South Asian and Middle Eastern Muslim clients. The questions inquired about specific challenges and strengths the participants' encountered that resulted from ethnic/racial and religious differences and how the participants managed the challenges and strengths in therapy. Paricipants were asked to focus on their experiences from the past 12 months, but some of them occasionally discussed experiences beyond the past 12 months when responding to the interview questions. Participants were also asked about how they perceived their experiences with South Asian and Middle Eastern Muslim clients when compared to experiences of working with other ethnically/racially and religiously different clients. Lastly, participants were asked about what they would do differently with these clients and the advice they would give to other non-Muslim Caucasian therapists working with this

population. Interviews lasted approximately one to two hours. The interviews were audio-recorded and transcribed by a third-party who signed a confidentiality agreement. Throughout the research process, measures were taken to protect the confidentiality of participants and their clients.

Analysis

To analyze the data, the researcher conducted a thematic analysis whereby patterns and themes were identified, categorized, and analyzed within the data (Braun & Clarke, 2006). First, the researcher became familiar with the data by reading each transcript approximately four times. As each transcript was read, preliminary codes were produced and further refined as patterns of words and phrases were identified. Next, the researcher interpreted the meanings of these patterns and formulated tentative themes that emerged into which the codes were categorized. The themes were then reviewed and revised until they became representative of the sample. Lastly, the researcher defined the themes and named them based on the context of the overall analysis.

To establish validity and reliability, the transcripts, codes, themes, and descriptions of the participants were reviewed by a second researcher. The two researchers collaborated on identifying and refining the themes and sub-themes until they fit the overall data.

Demographics

A total of four females and four males were interviewed for the present study. The sample ranged from 33 years to 62 years old. All participants were Caucasian Americans with and majority of them identified as belonging to various denominations of Christianity with varying levels of religiosity. All participants were practicing Licensed MFTs in a Northeastern state of the U.S., with experience ranging from 1.5 years to 19 years. The average percentage of

South Asian and Middle Eastern Muslim clients seen altogether was 26%. Participants identified varying levels of multicultural training experience but all participants, except one, identified receiving multicultural training from coursework in graduate school. See Table 1.

Table 1. Demographics

Name	Gender	Age	Religion	Education	Multicultural training	Years of practicing MFT	Percentage of [1]SA & ME Muslim clients
Cara	F	33	Spiritual, not religious	Masters	Graduate school, diversity training	2.5	20%
Alice	F	57	Catholic	Masters	Workshops	19	20%
Joe	M	62	Episcopal	Masters	Graduate school, workshops, cultural sensitivity workshop for Muslim clients	11	25%
Sheryl	F	43	Raised Catholic/Buddhist Leanings	Masters	Graduate school	11.5	20%
Kathy	F	61	Raised Catholic/Not religious	Masters	Graduate school	15	23%
Hal	M	36	LDS/Christian	Masters	Graduate school, colleagues, clients	1.5	5%
Ted	M	50	Raised Protestant/Not religious	Ph.D.	Graduate school, lived in different countries, personal exposure to Muslim culture	15	43%
Charlie	M	47	Catholic	Masters	Graduate school, workshops	18	50%

[1] South Asian & Middle Eastern

Researcher Characteristics

The primary researcher, who also conducted the interviews, is a 1.5-generation Pakistani American Muslim female. Throughout the data collection and analysis phase, the researcher kept a journal of her reflections in order to bracket her own personal reactions as an individual belonging to the population that the therapists were being interviewed about. Meetings were also held with a second researcher, a first-generation Argentinian, to process the primary researcher's reactions to the interviews.

Findings

Several themes emerged in response to the various areas of inquiry in the interview regarding ethnic/racial and religious differences between therapists and South Asian and Middle Eastern Muslim clients. Themes have been grouped into the following areas: Challenges that come from ethnic/racial and religious differences, strategies and recommendations to address ethnic/racial and religious differences and the challenges created by them, strengths that come from ethnic/racial and religious differences, and what therapists needed.

Challenges that come from ethnic/racial and religious differences

In response to the first area of inquiry, all participants identified challenges they experienced in working with the South Asian and Middle Eastern Muslim population, although nearly all of them expressed their uncertainty of whether the challenges were due to ethnic/racial and religious differences or personal differences. Two initial themes emerged: Similar challenges perceived with other culturally diverse clients and fewer challenges perceived with more assimilated and less religious clients. The other themes that emerged were actual challenges that participants experienced with clients of this population. These include: Clients presenting misinformed expectations about therapy, engaging clients in therapy, clients not

trusting therapists, understanding and accepting a different cultural and religious perspective, staying neutral, concern about negative portrayal of Muslims in the U.S. and the impact of that on the therapeutic relationship, hyper-vigilance and discomfort with clients, and emotional work with male clients.

Similar challenges perceived with other culturally diverse clients. All participants reported experiencing similar challenges with other minority populations, such as those that belong to other collectivist cultures. For example, in talking about how the older generation in some of her Muslim clients were keeping secrets and not opening up, Cara noted experiencing something similar with another minority population:

> I experienced - have experienced, like, this stuff stays in the family, we don't talk about it and so I've experienced that with South and Central American clients before and usually in that case also it's the kids and the multigenerational kind of situation - the more Americanized kids who are saying - who are coming out and speaking more and are the voices for the family because the parent's system who was born in South or Central America is - was more likely to hold the family secrets.

Fewer challenges perceived with more assimilated and less religious clients. All participants described most of their clients as either well assimilated into Western society or as becoming influenced by the Western culture and/or as not devout or practicing Muslims. Three participants implicated that they experienced fewer challenges with more assimilated clients. For example, when discussing the challenge of recognizing his Western lens, Hal stated, "And like I said, some of the – they've already started to assimilate into a lot of Westernized culture, so [it's] not necessarily as big of an issue from what I've seen."

Clients presenting misinformed expectations about therapy. Five participants described how their clients expected therapy to be fast, expected their therapists to give them solutions to their problems, or to take sides. Participants reported that their challenge was to manage their clients' expectations, which were in conflict with how the participants provided therapy. Joe stated:

> The sense that I got at the beginning was he wanted to come in, say, "Here's the problem, tell me what to do with my sons." And I don't quite work that way. He's like, you know, "Tell me what I should go do, tell me what I should tell them," like he was repeatedly asking me for a very specific instructions and step-by-step prescription of what to do. So that kind of took me back a little bit.

Engaging clients in therapy. Although participants did report on experiences with long-term clients, they also expressed concerns about those clients that dropped out of therapy prematurely. In particular, one participant, Kathy, reported how it has been a challenge for her when clients do not attend more than one or two sessions. She stated, "But that kind of captures the dilemma that I find myself in in terms of what's – I may only see them twice or three times or not very often." Even though the other participants did not report this as a challenge, six other participants described how their clients dropped out of therapy between one and five sessions, how they were not able to engage family members into coming in to sessions, or how they hoped to have more time with their clients.

Clients not trusting therapists. Seven participants reported their sense of clients not trusting them, being reluctant to share information with them, or not being completely open with them. Kathy stated: "And I think partly that was because he could not bring himself to trust me, but that's my – he never said that to me except he said it not verbally."

Understanding and accepting a different cultural and religious perspective. All participants reported experiencing challenges related to understanding and accepting various cultural and religious perspectives that were different from there own. These include: marital relations, influence of parents and extended family, parent-child communication, and sexuality.

Marital relations. Six participants reported their challenge in understanding the relationship between husbands and wives, in terms of how they are with each other or view each other, and the concept and procedure of divorce in their clients' cultures. Kathy described a situation where one of her client's was extremely distressed when his wife initiated a divorce and it was difficult for her to compute what his wife meant to her client, explaining:

> He would say, "My wife is my honor, my wife is my honor. I cannot lose my wife, 'cause then I lose my honor." And so I'm hearing him say this, and I – it doesn't compute. It doesn't exactly compute. Now I can sort of make inferences from that, but I really had to question him respectfully with what that meant to him.

Joe described his challenge of understanding divorce: "And a challenge that I had was kind of my American, Christian view of what a divorce entails was entirely different from what she was describing."

Influence of parents and family. Six participants described their experiences of understanding and dealing with the influence of parents and extended family while four out of six participants reported it as a challenge. Kathy described her challenge in understanding the influence of a parent on her client:

> That's a theme that runs through a lot of these family systems is that the mother holds incredible sway, incredible sway....If there is an opinion about a choice of partner or career, a lot of people can get involved in expressing that, so that's really different from my experience as an American....But his mother threatened to disinherit him, cut him off....that was so astonishing to me.

Parent-child communication. Five participants discussed communication between parents and their children while two of them reported it as a challenge for them. Most participants described communication patterns where adolescents, young adults, and adult children either hid things from their parents or lied to them. Cara described how she struggled to assist children in communicating openly with their parents, explaining:

> There was also a lot of avoidance, I mean, it's related but avoidance of the kids addressing the parents and so - and that has been hard, I haven't really found a good way to get them on their own to challenge some of those beliefs.

Sexuality. Three participants reported experiencing challenges related to understanding and dealing with clients' issues related to sexuality in therapy. For example, Cara described how she struggles with the "impenetrable boundary" between the parents and children, where the parents are unaware that their children are gay or bisexual and the children are not able to share that with their parents. Charlie described his challenge in addressing the topic of sex with his clients, explaining:

> I also learned that they're very private. It is very, very difficult for them to share personal lives, you know. Like for example, none of them...would talk about sex.

> Even though it's part of a marriage and everything like that. Would absolutely did not want to talk about sex.

Staying neutral. Four participants reported that staying neutral was a challenge for them in terms of aligning more with one member of the clients' system than another, managing their personal reactions towards clients, prejudice, and not imposing their own values or views. For example, Cara stated:

> I felt sided to with the daughter who did not want to be put into an arranged marriage. I felt biased towards that belief system because that is what I was raised around. And, so, it was hard....but I know that I'm biased towards agreeing with the daughter around allowing her to partner with a woman if she wanted to and all of those things.

Concern about negative portrayal of Muslims in the U.S. and the impact of that on the therapeutic relationship. Three participants reported their awareness of racism, prejudices, negative stereotypes, and discrimination of Muslims living in the U.S. and how it may impact the therapeutic relationship. For example, one participant discussed how she became aware that her clients "hate White people" and how that impacted her work with them. Another participant, Alice, explained how her client might have been reluctant to share information with her because he might have had concerns of the therapist not understanding him or stereotyping him. She stated:

> I think the young man would've had kind of an assumption that I might not have understood like his family background or the fact that he was Muslim….I do think that that was - he might've assumed that I would have perhaps a negative view or he would've come in worrying about the fact that his Muslim faith would be - people might respond negatively.

Hyper-vigilance and discomfort with clients. Three participants reported experiencing feelings of paranoia and hyper-vigilance, or discomfort. One out of the three participants felt "hyper-vigilant" and "paranoia" when she found out how her clients perceived Caucasians and two out of the three participants, both males, reported experiencing discomfort working with an individual female client "behind a closed door". Ted explained:

> Male and female kind of in an enclosed space. I felt a little uncomfortable with it. Like I knew it would, you know, in their world, it would be wrong. And so I'm – I was aware of that. And I think I was just feeling that cultural difference.

Emotional work with male clients. Three participants reported experiencing challenges in exploring or processing emotions with male clients. Joe described his experience:

> Not quite sure where that disconnect was but…I was surprised, 'cause with other couples that typically didn't happen. And then maybe - and it could be a level of emotional vulnerability that he was just not ready to accept. And admittedly an emotionally vulnerable place, I think, with that cultural background in men is even harder to access than it is in American men.

Strategies and recommendations to address ethnic/racial and religious differences and the challenges created by them

In response to the second area of inquiry, all participants identified strategies they implemented to manage ethnic/racial and religious differences and the challenges they experienced as a result of those with their South Asian and Middle Eastern Muslim clients in therapy. Some participants also made recommendations for other non-Muslim Caucasian therapists working with this population. The following themes emerged: Being aware of cultural and religious differences, acknowledging culture and religious differences, clarifying

therapists' role and making client the expert, creating a safe environment, increasing knowledge about the South Asian and Middle Eastern Muslim population, and acknowledging clients' contextual challenges.

Being aware of cultural and religious differences. Five participants reported trying to be aware of the existing cultural and religious differences between them and their clients. Joe explained:

> I think when I went into it, first seeing someone of a vastly different culture than me, vastly different faith background, it – I kind of automatically told myself, "Ok, be awake, be aware. There's many more things than I assume, than I am aware of."

Two participants also made the recommendation to other therapists to have more awareness regarding ethnic/racial and religious differences when working with this population.

Acknowledging cultural and religious differences. Two participants reported acknowledging ethnic/racial and religious differences to their clients in therapy and a third participant made this a recommendation to other therapists. Hal explained how he acknowledged differences to his clients, stating:

> When people come in, I often will say, "Ok, so, you're going to notice that I'm different from you, and we believe differently on certain things. So if I start suggesting things that don't fit for you, let's talk about it."

Clarifying therapists' role and making client the expert. Seven participants reported trying to make clients experts of their own lives by asking them about their personal, cultural, and religious experiences and guiding them in exploring their own choices, options, and solutions. Ted explains how he clarified his role as a therapist and attempted to make his client the expert:

> I would kind of hold my position and in respectful ways I would ask – I would continue to ask them questions about what is their thinking about X situation or what do they think - what do they see as the right thing to do. I would explain to them, "I could give a suggested path, but that's not - that might not be right for you or not – might not work for you."....But I would ask them, "What do you think?" In terms of my role and what I see as expertise, it would be in process...and so I would describe principles of emotional process and then kind of bridge from there. So, "This is what I know and this is what I study, I'll give you this, I'll let you decide what to do from there."

Creating a safe environment. Seven participants reported creating a safe environment for their clients by maintaining an open and curious stance, by remaining neutral and non-judgmental, and by joining, supporting, listening, normalizing, validating, accepting, respecting, and empathizing with their clients. Hal explained:

> I try really hard to join with people. It's probably one of the strengths that I have the most is being able to help people feel at ease and not judged and I certainly try to steer away from shame as much as possible. I think I talk about some of that stuff with people in regards to judgment and shame and how this is a protected environment and stuff like that to help people feel more comfortable.

In describing how she maintained a non-judgmental and curious stance when experiencing personal reactions to her client's situation, Kathy stated:

> What comes up for me are thoughts like, "Wow, that's just so out of bounds," or, "What a lot of enmeshment, this poor guy." So, those sort of thoughts come up and so what seems to help me is to stay curious, "Help me understand how your mom was raised. What were the expectations placed on her? And did she work, did she have a career, was

> she at home?" So, as I experienced more of a full picture, more understanding, ok, that helped me get the – understand my client's dilemma.

Increasing knowledge about the South Asian and Middle Eastern Muslim Population. Two participants reported their efforts to increase their knowledge about the South Asian and Middle Eastern Muslim population. One of these participants, Joe, reported attending workshops on how to work with Muslim clients, consulting with peers, and seeking supervision from a Muslim therapist. He explained, "It was one-on-one, sitting down with a Muslim therapist who could really sit with me and just kind of talk about the detailed case and really specifics. That was really useful." Joe also recommended other therapists to develop a personal relationship with an individual of this population outside of therapy in order to learn, stating: "Find Muslims! Befriend them! Learn from them. Get close and just learn as much as you can just to be comfortable with what's different."

The other participant, Charlie, reported reading the Quran and recommended other therapists to do the same. He explained:

> It got me more interested because I wanted to understand how that could be interpreted in ways like Al Qaida. Like how could they take and interpret that, and because it's a very peaceful book....So that was a big help to me a lot. That's how I learned and after her I read the whole book, I read, it was like - and so I got a very good understanding of that.

A third participant also recommended therapists to welcome experiences with clients of this population and to "inquire about faith issues" in therapy in order to increase their understanding.

Acknowledging clients' contextual challenges. Two participants reported acknowledging to their clients the difficulties their clients might have been experiencing. Both

participants acknowledged in therapy their clients' difficulties related to conflicting cultural values between the Western culture they were assimilating into and the cultural and religious values of their families. In fact, one of these participants made the recommendation that therapists should not align against parents of their clients, explaining:

> You can't align against a parent, the parental generation or you're going to lose...you can't dismiss what the parents think because they're gonna have control whether the therapists like it or not and it's not gonna really be any advantage to your client if the parents feel you're not aligned with the family values and the culture.

One of these participants, Kathy, also acknowledged being aware to her clients about the difficulties they might be experiencing due to the political climate in the U.S. For example, she described acknowledging to her clients that she is aware of and sensitive to the prejudice they may be experiencing:

> That is a piece of joining for me to be aware of that and also to acknowledge to them the difficulties of being targeted in terms of prejudice and just to announce, let them know that I am sensitive to that and I think that's horrendous and, you know, and I want to know how they manage that and how that impacts them.

Strengths that come from ethnic/racial and religious differences

In response to the third area of inquiry, all participants were able to identify strengths that derived from ethnic/racial and religious differences with South Asian and Middle Eastern Muslim clients. The following themes emerged: Easier to make client the expert by being open and curious, opportunity to learn about a different culture and religion from clients, outsider perspective benefits clients, opportunity to incorporate religion into treatment, and facilitation of therapeutic relationship.

Easier to make client the expert by being open and curious. Six participants reported how ethnic/racial and religious differences helped to make their clients experts of their own lives and how different aspects of therapy were made easier as a result of the differences with their clients. These included: normalizing, and being open, accepting, and curious. For example, Hal stated, "I think the strength that's come about as being ethnically and religiously different from them is that it allowed them to be an expert." Kathy stated, "I think also by being different from them religiously and culturally, I can ask any question I want."

Opportunity to learn about a different culture and religion from clients. Four participants reported learning about their clients' culture and religion, and three of these participants identified this as a strength in working with this population. Charlie stated, "But then I would think, you know, wow, it was a learning process. I actually learned from every one of the clients, individually."

Outsider perspective benefits clients. Seven participants reported how their ethnic/racial and religious differences with their clients provided opportunities to create new experiences for their clients, provide fresh perspectives, and make it easier for their clients to talk with them about certain issues as the clients felt less judged by someone outside of their culture and religion. For example, Sheryl explained how she provided a fresh perspective and created a new experience in her clients' culture:

> Even like the ability of introducing boundaries in like this person's family system where there may have been enmeshment and fusion is the norm….to be able to say that you can be a good, kind person and say "no" seemed to her very revelatory and like, "Oh, I can love my parents and still set limits." …and so just the education around that seemed helpful, which could be Western informed.

Opportunity to incorporate religion into treatment. Four participants reported how ethnic/racial and religious differences with their clients brought more opportunities to incorporate religion in the therapy process by way of asking clients about their faith, religious beliefs, and role of prayers to assist clients in managing their presenting issues. For example, one participant asked her client about how his religion views suicide in an attempt to deter him from attempting suicide. Another participant, Charlie, described how he challenged a client by asking him whether there is any basis for domestic violence in the Quran in an effort to deter him from any future domestic violence. He explained:

> I said..."Show me in here where it's okay to do it"....And so I am not, like I told them, I'm not an expert in this but I wanted him – I challenged him to show me where it was ok for him to treat his wife like this. And he couldn't really find anything, you know.

Facilitation of therapeutic relationship. Six participants reported that ethnic/racial and religious differences with their clients offered them opportunities to build a stronger therapeutic relationship when they could understand both the Western culture and their clients' cultures, and when they could understand or be able to relate to their clients due to having prior exposure to cultural diversity, experience with Muslim clients, knowledge of clients' culture or religion, and having similarities with therapists' culture or religion. Hal explained how sharing his knowledge about clients' culture or religion helped him to join with his clients:

> I think, the few things that I do know about those cultures and the Muslim religion, is whenever I knew something, they're like, "Oh yeah, you know about that!" , "Yeah!" So it was an opportunity to join as well. I don't know if celebrate it would be the term, but they're like, "Ok, you get it, you get some of that," so a sense of joining.

What therapists needed

In response to the fourth area of inquiry, all participants identified what they wished they knew or did differently at the time of seeing their South Asian and Middle Eastern Muslim clients. The following themes emerged: Needing more knowledge and cultural training and taking a different approach to engage clients in therapy.

Needing more knowledge and cultural training. Three participants reported needing more knowledge and/or cultural training to gain a better understanding of their clients' cultures and religion and to be able to manage the challenges better when working with their clients. Two of these participants reported wanting to attend workshops on working with Muslim clients, learning from Muslim therapists and the Muslim community, developing a personal relationship outside of therapy, and receiving more cultural training overall. Joe stated, "I wish there had been more awareness just beat in from every single side and every single workshop, every class."

Taking a different approach to engage clients in therapy. Six participants reported wishing they had taken a different approach to engage their clients more in therapy, such as encouraging more family members to attend sessions, being more aware of client discomfort, joining better, asking more questions about culture and religion, providing their client with more suggestions, and managing clients' expectations of therapy. Kathy stated:

> I wish I had known that I only had one shot or two shots at seeing them because I would have worked harder at joining with them and about taking time to elaborate a bit on the values of sticking with therapy even when things are starting to be better....And so I would definitely have, and I will in the future, keep that in mind when I'm meeting with a South Asian or Middle Eastern Muslims. Is just to say, "What's your understanding of therapy? What are your expectations? Let me tell you what my experience is."

Discussion

There is a dearth of research on the American Muslim population, even less on this population in therapy, and virtually no research on the experiences of non-Muslim, Caucasian clinicians working with this population. Therefore, the aim of this qualitative study was to address this gap in literature by understanding the experiences of non-Muslim, Caucasian Licensed MFTs working with the South Asian and Middle Eastern Muslim population. In particular, the study sought to understand the type of challenges and strengths therapists experienced in working with this population and how they managed the challenges and strengths in therapy. To help interpret the findings of the study, literature on ethnic/racial and religious differences, cultural competence, and recommendations and guidelines on how to work with American Muslim clients will be used in the present discussion.

Eight participants provided detailed descriptions of the challenges and strengths they experienced with this population. The experiences of these participants need to be considered in the context of their clients who, for the most part, were described as assimilated and/or as not devout or practicing. While all participants reported experiencing challenges with their South Asian and Middle Eastern Muslim clients, they also reported experiencing similar challenges with clients of other ethnic/racial and religious backgrounds. Moreover, a few participants reported experiencing fewer challenges with more assimilated and less religious clients. This can be explained by previous research where therapists, majority of whom were Caucasian, evaluated the overall treatment more positively when clients were racially similar to the therapists (Murphy, Faulkner, & Behrens, 2004). Although clients reported in the present study were not ethnically/racially similar to the participants, most of them were perceived as being more "Westernized" by the participants. The actual challenges that participants reported

experiencing included clients presenting misinformed expectations about therapy, engaging clients in therapy, clients not trusting participants, understanding and accepting a different cultural and religious perspective, staying neutral, concern about negative portrayal of Muslims in the U.S. and the impact of that on the therapeutic relationship, hyper-vigilance and discomfort with clients, and emotional work with male clients.

Majority of the participants reported experiencing challenges related to clients' expectations of them as their therapists. These included expecting therapy to be fast, expecting therapists to provide advice and solutions to clients' problems, and expecting therapists to take sides. This is somewhat consistent with the argument that this population typically expects a medical cure from therapy (Daneshpour, 2009b) and often looks to their therapist out of deference to authority (Springer et al., 2009). Furthermore, participants seemed to experience challenges in keeping their clients engaged in therapy. Although only one participant reported it as a challenge, most other participants reported having some clients who dropped out of therapy prematurely, usually between one and five sessions. This is consistent with previous research where clients seeing ethnically/racially different therapists demonstrate lower retention rates (Wintersteen, Mensinger, & Diamond, 2005). This was the case even though majority of the clients were described as assimilated into Western culture and some participants reported experiencing fewer challenges with the younger, more-assimilated generation. This finding suggests that there may be a potential disconnect between non-Muslim Caucasian therapists and South Asian and Middle Eastern Muslim clients even if these clients appear to be assimilated.

The challenge of keeping clients engaged in therapy could also be explained by another challenge that nearly all participants reported experiencing, where they sensed mistrust from their clients towards them. The participants reported sensing mistrust through their clients'

reluctance to share information and their lack of complete openness towards their therapists. Client mistrust has been reported in previous literature, especially among ethnic/racial minority clients seeing Caucasian clinicians (e.g., Thompson, Worthington, & Atkinson, 1994; Comas-Diaz & Jacobsen, 1991). Some clinicians have argued that therapists who belong to a majority ethnic/racial and religious group need to take responsibility for issues related to transference and countertransference as they arise in therapy (Ward & Banks, 2002) and others have argued that majority therapists can discuss racial issues and their impact on therapy openly with clients (Erskine, 2002). However, the participants of this study did not report addressing the mistrust directly in therapy.

All participants reported experiencing challenges related to understanding and accepting the different cultural and religious perspectives of their South Asian and Middle Eastern Muslim clients. In particular, participants reported experiencing challenges in understanding and accepting issues related to marital relations, influence of parents and family, parent-child communication, and sexuality among their clients. This finding adds to previous research on ethnic/racial differences where therapists have been found to be less likely to understand their clients' problems when the clients are ethnically/racially different from the therapists (Murphy, Faulkner, & Behrens, 2004). Furthermore, although participants reported experiencing challenges with understanding and accepting influence of parents and family and parent-child communication, only one participant reported working with families in the past year while all other participants reported working with either individuals or couples. Literature on recommendations for how to work with American Muslim clients discusses the importance of inviting family members into therapy (e.g., Abbott, Springer, & Hollist, 2012).

Half of the participants also reported experiencing challenges related to staying neutral. These participants discussed their struggle in remaining neutral when their own Western values made it easier for them to align with one family member over another. It has been argued that non-Muslim clinicians may unintentionally undermine culture and religion by subtly aligning with children and against their parents (Griffith & Abugideiri, 2002). In fact, one of the participants in the present study recommended that therapists should avoid aligning against the parental generation as they will "lose". Some of these participants also reported experiencing a challenge in maintaining neutrality in terms of not imposing their own Western views. Additionally, only one participant reported experiencing a challenge in staying neutral when he felt prejudiced towards his clients. To be a culturally competent therapist, it is argued therapists have to be aware of their attitudes and biases towards Muslims and their faith (Sue & Sue, 2008). It is unknown whether the other participants were aware of their attitudes and biases as they may have chosen not to mention them during the interviews since the researcher belonged to this population. Overall, this finding suggests that some therapists might struggle to remain neutral with their South Asian and Middle Eastern Muslim clients.

A few participants reported experiencing challenges related to their concern about the negative portrayal of Muslims in the U.S. and the impact of that on the therapeutic relationship. These participants speculated that their clients may not have trusted them or been completely open with them out of fear of being negatively stereotyped or misunderstood due to the sociopolitical climate in the U.S. surrounding Muslims. It is argued that this population may underutilize services because of their fears of being negatively stereotyped, discriminated, or misunderstood (Daneshpour, 1998; Muhammad, 2015). This finding also suggests that the

negative portrayal of Muslims in the U.S. might also bring challenges for therapists by impacting their work with this population.

A few participants reported experiencing challenges related to feeling hyper-vigilant or uncomfortable with some of their clients. One of these participants reported feeling hyper-vigilant and paranoid when she found out the negative perception the clients held of Caucasians. The other two participants, both males, reported experiencing discomfort working with some of their individual female clients when "feeling" the cultural and religious differences with them in therapy. While some literature provides guidelines on how to work with Muslim clients that are opposite sex from the therapist (Muhammad, 2015), this finding suggests the need for more guidelines for male therapists working with female clients.

Finally, a few participants reported experiencing challenges related to exploring and processing emotions with their male clients. One reason for this challenge could be the male clients did not feel safe enough to be vulnerable with their therapists, especially if treatment only lasted a few sessions as indicated by one of the findings of this study. Another reason could be the traditional gender role orientation observed in South Asian and Middle Eastern Muslim cultures, where men are considered head of the household and women are in the caretaking role (Daneshpour, 1998; Abbott, Springer, & Hollist, 2012). Thus, emotional expression may be more associated with what is acceptable for women as caretakers and not with men.

In addition to the challenges discussed above, participants identified a variety of strategies they used to address ethnic/racial and religious differences with their clients and the challenges that resulted from these differences. The strategies reported by the participants in the present study provide support for the guidelines proposed by Sue and Sue (2008) for culturally

competent therapy. Nonetheless, they also add further ideas for culturally sensitive work. Sue and Sue (2008) propose that to be culturally competent, therapists need to, 1) Be aware of their own assumptions, values, and biases, 2) Understand the worldview of their culturally diverse clients, and 3) Develop appropriate intervention strategies and techniques (p. 44).

Majority of the participants reported being aware of cultural and religious differences between them and their South Asian and Middle Eastern Muslim clients and also recommended this to other therapists working with this population, which is consistent with the recommendations for culturally competent therapy (Sue & Sue, 2008). Additionally, a few participants also reported acknowledging the differences in therapy with these clients. Based on reports from the participants, the acknowledgement seemed to be helpful as it made the conversation about differences overt, which allowed the clients to feel more comfortable in exploring solutions that fit better within their own cultural and religious background and also gave them permission to speak up when their therapists' suggestions did not seem culturally appropriate. Participants also reported the acknowledgement of differences to be helpful in joining with their clients and in empowering their clients to become experts of their own lives, which was also reported as a strategy by nearly all participants. This finding suggests that in addition to having awareness of differences, the acknowledgement of differences can be helpful for therapists working with the South Asian and Middle Eastern Muslim population. Moreover, one of the participants made the recommendation to other therapists to acknowledge differences in therapy with these clients.

Nearly all participants reported creating a safe environment for their clients, though in different ways. For example, some participants reported listening, supporting, accepting, and empathizing with their clients, which are all strategies that have been endorsed in previous

research (Chang & Berk, 2009; Horst et al., 2012). Other participants reported creating a safe environment by being non-judgmental and avoiding assumptions by taking a curious stance to learn more about their clients within their cultural and religious contexts. Consistent with recommendations for cultural competence (Sue & Sue, 2008), some participants also made this a recommendation by suggesting that therapists working with South Asian and Middle Eastern Muslim clients should avoid judgments or assumptions and be genuinely curious.

Only a couple of participants reported increasing their knowledge about the South Asian and Middle Eastern Muslim population as a strategy to address ethnic/racial and religious differences and the challenges created by them. One of these participants reported going to a workshop on how to work with Muslim clients, seeking supervision from a Muslim therapist, and consulting with peers. The other participant reported reading the Quran to increase his understanding of Islam and to manage his biases. This participant recommended other non-Muslim Caucasian therapists to read the Quran as well in order to understand the faith. This is also one of the important aspects towards building culture competence that Sue and Sue (2008) have recommended, i.e., understanding the ethnic/racial and religious cultures of clients. Furthermore, literature on how to provide culturally sensitive treatment to Muslims strongly recommends that therapists incorporate the Quran in treatment to help spiritual or practicing Muslim clients with their presenting problems (e.g., Razali, Aminah, & Khan, 2002; Vasegh, 2011; Sue & Sue, 2008). However, only one participant in this study reported using the Quran in treatment to manage his clients' presenting problems.

A couple of participants reported showing their clients they understood the different context in which their clients' lived, in terms of living in a non-South Asian, non-Middle Eastern, and non-Muslim culture, and in terms of living in a climate where this population is

negatively portrayed, stereotyped, and discriminated. Moreover, one of these two participants reported keeping up with the news and the overall political climate impacting the American Muslim population and acknowledging it in therapy to her clients. This is consistent with Roysicar's argument that clinicians are responsible for understanding the political climate that affects their Muslim clients (2003). This is also consistent with recommendations for culturally competent therapy where therapists are encouraged to understand their clients within the context of the sociopolitical influences that dictate their reality (Sue & Sue, 2008). It is unknown from the findings of this study whether the other participants were aware of their clients' contextual challenges or whether they showed their clients they understood these challenges.

Participants noted several strengths that were brought about by ethnic/racial and religious differences. Majority of the participants reported finding it easier to make their clients experts by being open and curious since they did not belong to their clients' culture or religion. Nearly all participants reported they were able to provide fresh perspectives and create new experiences for their clients by being nonjudgmental and opening up possibilities for their clients. It is argued by some authors that some Muslim clients may feel safer and more comfortable with a non-Muslim therapist (Ali, Liu, & Humedian, 2004). However, literature appears to be divided on this matter as some authors also suggest that American Muslims fear being stereotyped or misunderstood by non-Muslim individuals (Daneshpour, 1998). Nonetheless, literature on cultural competence recommends that therapists should be aware of circumstances that lead their clients to seek therapy with a culturally similar or dissimilar therapist (Sue & Sue, 2008).

A few participants reported having the opportunity to learn about a different culture and religion from their own by working with South Asian and Middle Eastern Muslim clients. A few participants also reported having the opportunity to incorporate religion into treatment by way of

asking clients about their faith, religious beliefs, and the role of prayers. This finding adds to previous literature recommending therapists to incorporate religion into treatment (e.g., Razali, Aminah, & Khan, 2002; Vasegh, 2011; Sue & Sue, 2008) by suggesting that this can even be a strength in therapy resulting from religious differences between non-Muslim therapists and their Muslim clients. Lastly, participants reported that ethnic/racial and religious differences facilitated the therapeutic relationship through their ability to join and connect with their clients when participants could relate to them due to having prior exposure to cultural diversity, experience with Muslim clients, knowledge of clients' culture or religion, or having similarities with participants' culture or religion. This finding suggests that ethnic/racial and religious differences may also be regarded as opportunities for improving the therapetuic relationship, and not just as creating obstacles. Overall, the findings on strengths in the present study seem to add to existing literature on ethnic/racial and religious differences which mostly discusses challenges. These findings also add to literature providing guidelines on how to work with American Muslim clients by suggesting that therapists can utilize certain strengths in therapy when working with this population.

In response to what they needed at the time of working with their South Asian and Middle Eastern Muslim clients, a few participants reported needing more knowledge and cultural training to have a better understanding of their clients' culture and religion and to be able to better manage the challenges they experienced in therapy. A couple of these participants reported wanting to attend workshops on how to work with Muslim clients, learning from Muslim therapists and the Muslim community, developing a personal relationship outside of therapy, and receiving more cultural training overall. Additionally, majority of the participants reported needing to take a different approach, such as encouraging more family members to

attend sessions, asking more questions about culture and religion, and managing clients' expectations of therapy, in order to engage their clients in therapy. These findings suggest that although the participants were implementing strategies to address ethnic/racial and religious differences and the challenges created by them, they still felt they could do more in managing the differences and the challenges. What participants reported needing at the time, i.e., more knowledge, cultural training, and culturally appropriate strategies, have been highlighted as necessary components to increase cultural competence (Sue & Sue, 2008).

Participants reported experiencing challenges with this population, though less with more assimilated clients. Findings of this study suggest that ethnic/racial and religious differences between therapists and clients do matter for therapists, and from their perspective, the differences can present various challenges and some strengths. Participants spoke about how they addressed these differences and reported ways in which they managed the challenges created by the differences. Some of the strategies and recommendations are consistent with what literature has recommended regarding cultural competence, such as having awareness of differences and understanding clients' culture and religion. Participants also discussed what they needed at the time of seeing their clients and provided a few recommendations for other therapists working with the South Asian and Middle Eastern Muslim population. Overall, participants of this study appeared to be well aware of differences with their clients but still seemed to be in need of culturally appropriate interventions and strategies to manage the challenges. Findings of the present study seem to support discussions, anecdotal evidences, and recommendations in literature on American Muslims that did not have previous empirical support.

Reflexivity. The primary researcher made continuous efforts to bracket her experiences throughout the data collection and data analysis phase to ensure the data was not being

influenced by her own thoughts or reactions. During each interview, the researcher remained aware of any personal reactions and bracketed them in a journal and later processed them by continuing to bracket after each interview. During the data analysis phase, the researcher continued to journal any new thoughts or reactions that came up while reading the transcripts and processed them with peers and the second researcher.

Limitations

The findings of this study are based only on a sample of eight individuals, all practicing on the East coast in a state that is very ethnically/racially and religiously diverse. Thus, the experiences of these participants may not be representative of therapists practicing in other parts of the U.S. that are not as culturally diverse. Given where they practice, these participants are exposed to a lot of cultural diversity in their environment as well as the clients that they see, possibly making them more comfortable, aware, and experienced in working with ethnically/racially and religiously different clients. Therapists working in other parts of the U.S. may have much less exposure to cultural diversity and much fewer opportunities to work with South Asian and Middle Eastern Muslim clients. Therefore, they may experience different challenges and strengths than this sample of therapists did.

Furthermore, six of the participants in this sample consisted of self-referred individuals recruited from a single professional MFT listserv. Thus, the participants who responded to the recruitment mail may have been those with certain experiences with the South Asian and Middle Eastern Muslim population, prompting them to volunteer for this study. For example, individuals who have had fewer challenging and more positive experiences may have been more likely to volunteer than those who may have had more challenging experiences, or vice versa.

One of the recruitment criteria required that only those participants who have seen at least two South Asian and Middle Eastern Muslim clients in the past year could participate. Therefore, the responses from the interviews largely focused on participants' experiences with clients within the past year, which may be different from their experiences in previous years when, perhaps, they were less experienced in working with clients of this population. Additionally, even though the focus of this study was on marriage and family therapists, nearly all participants reported on individual sessions or couple sessions. This is a limitation since more challenges could have occurred in family sessions where therapists would have to work with multiple generations. Although participants reported on their experiences with some long-term clients, they also reported on several experiences with clients they worked with for only one to five sessions. This is a limitation since participants did not have as much time with these clients to build rapport, resulting in many challenges. Working with clients for a longer period of time could result in different types of challenges or even fewer challenges.

Lastly, the participants were aware during the interviews that the interviewer, the primary researcher, belonged to the population they were being interviewed about. Although the researcher encouraged participants to be open about both their positive and negative experiences with this population, participants may have held back from being completely open and honest about their experiences. Lastly, although the researcher bracketed her thoughts during the interviews, the questions she asked may have elicited certain responses from the participants.

Clinical implications

The findings of this study have important implications for non-Muslim, Caucasian marriage and family therapists working with South Asian and Middle Eastern Muslim clients. The challenges experienced by the therapists in the present study can help other therapists to be

cognizant of the types of challenges they may experience and implement strategies to prevent these challenges from occurring. For example, based on the findings of this study, therapists can make efforts to engage their clients in therapy from the first session and assist them in feeling more comfortable in terms of being more open and trusting the therapist.

Therapists can implement the strategies and recommendations that were discussed in the findings of this study, such as acknowledging differences in therapy, focusing on different aspects of therapy, consulting with a Muslim therapist, developing a personal relationship with someone of this population, and becoming familiar with the faith by reading the Quran and utilizing it as part of treatment. Moreover, the findings on strengths in this study can help therapists to appreciate the positive impact that ethnic/racial and religious differences can have when working with this population. When seeing clients of this population, therapists can be more aware of the strengths that can result from differences, such as client's comfort in discussing certain issues with a non-Muslim, Caucasian therapist, and use these strengths to build a stronger therapeutic relationship.

Majority of the participants expressed their uncertainty whether the challenges resulted from ethnic/racial and religious differences or from personal differences. Given the difficulties experienced by American Muslims related to prejudice, discrimination, negative stereotyping, and ignorance about their culture or religion (Pew Research Center, 2007), it is desireable that therapists make more efforts to ask their clients about their perspectives relating to ethnic/racial and religious differences in therapy and how they may impact the therapeutic relationship. Furthermore, since participants reported experiencing fewer challenges with more assimialted and less religious clients and also reporting that many clients dropped out of treatment, therapists should be mindful of connecting with their South Asian and Middle Eastern Muslim clients

beyond the "American persona" some of them might be presenting. Therapists can do this by recognizing, respecting, and addressing the ethnic/racial and religious differences between them and their clients in order to build a strong therapeutic relationship and keep these clients engaged in therapy.

Additionally, since majority of the participants in this study seemed to be working with individuals or couples who were strongly influenced by their parents and their families, it is important for therapists to invite and encourage parents and other relevant family members to attend therapy and make efforts to connect with them as they would with their individual client or couple system who is likely to be more Americanized. If therapists work with families and build that connection with all relevant members of the clients' family system, it might help to engage both the clients and their families into the therapy process. Moreover, with therapists aligning more naturally with the Americanized clients and not seeing other members of the clients' system, they may be encouraging more Western values that conflict with the cultural and religious values of the clients' family of origin, causing further stress and alienation from their families (Springer et al., 2009) and influencing their clients' decision to discontinue therapy. At the very least, it is important for therapists to inquire about the values and perspectives of parents and family members and incorporate those in treatment, as appropriate, with South Asian and Middle Eastern Muslim clients.

Finally, the findings of this study may be helpful for some therapists in becoming aware of the contextual challenges their clients may be experiencing. Therapists can respectfully ask their clients about those challenges and how they may be impacting therapy and the therapeutic relationship. This study can also help therapists to become aware of the importance and influence of family, especially parents, on clients of this population. With this awareness,

therapists can invite and encourage important family members of their clients' system to attend therapy.

Future research

Future research should use a larger sample of non-Muslim, Caucasian Licensed MFTs practicing in different regions of the U.S. in order to capture experiences that are representative of all therapists and not just those practicing on the East coast. Future research should also focus on investigating challenges and strengths experienced by therapists working with South Asian and Middle Eastern Muslim families in addition to those experienced by therapists working with South Asian and Middle Eastern Muslim individuals and couples. Also, a researcher who is not affiliated with the South Asian, Middle Eastern, or Muslim population should conduct the interviews in future research to ensure the comfort of therapists in opening up more regarding some of their experiences with South Asian and Middle Eastern Muslim clients. Finally, future research on the experiences of South Asian and Middle Eastern Muslim clients seeking therapy from non-Muslim, Caucasian therapists can supplement the findings of this study by providing their perspectives of challenges and strengths in therapy. This may further increase the awareness and understanding of therapists working with this population.

Conclusion

The present study investigated the experiences of non-Muslim Caucasian Licensed MFTs who are working with, or have worked with, South Asian and Middle Eastern Muslim clients. Participants discussed the challenges they experienced due to ethnic/racial and religious differences with their clients, and the attempts they made to manage the challenges. Participants also noted experiencing similar challenges with clients belonging to other ethnic/racial and religious populations and fewer challenges with their more assimilated and less religious South

Asian and Middle Eastern Muslim clients. In addition to challenges, participants also discussed strengths they experienced due to ethnic/racial and religious differences. Finally, therapists discussed what they needed or wished they did differently at the time of seeing their South Asian and Middle Eastern Muslim clients and made recommendations to help other therapists working with this population. The findings of the present study provide empirical support for the recommendations that have been made to work with this population based on models of cultural competence (Sue & Sue, 2008). Overall, the findings suggest a need for more cultural training for therapists working with the South Asian and Middle Eastern Muslim population. Such training could help in increasing the knowledge and understanding of cultural and religious values and beliefs of this population. Cultural training could also help therapists in addressing the differences with their clients and the challenges created by them by using more culturally informed interventions.

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Table 1. Demographics

Name	Gender	Age	Religion	Education	Multicultural training	Years of practicing MFT	Percentage of [2]SA & ME Muslim clients
Cara	F	33	Spiritual, not religious	Masters	Graduate school, diversity training	2.5	20%
Alice	F	57	Catholic	Masters	Workshops	19	20%
Joe	M	62	Episcopal	Masters	Graduate school, workshops, cultural sensitivity workshop for Muslim clients	11	25%
Sheryl	F	43	Raised Catholic/Buddhist Leanings	Masters	Graduate school	11.5	20%
Kathy	F	61	Raised Catholic/Not religious	Masters	Graduate school	15	23%
Hal	M	36	LDS/Christian	Masters	Graduate school, colleagues, clients	1.5	5%
Ted	M	50	Raised Protestant/Not religious	Ph.D.	Graduate school, lived in different countries, personal exposure to Muslim culture	15	43%
Charlie	M	47	Catholic	Masters	Graduate school, workshops	18	50%

[2] South Asian & Middle Eastern

Appendix A

Recruitment Electronic Mail

Hi!

I am a student in the Marriage and Family Therapy Masters program at Virginia Tech. I am pleased to announce that I am currently recruiting participants for my thesis study which explores the experiences of non-Muslim Caucasian LMFTs who have worked with, or are working with, South Asian and/or Middle Eastern Muslim clients.

You are eligible to participate if you meet the following requirements:

1. You are Caucasian.

2. You are not Muslim.

3. You are a Licensed Marriage and Family Therapist.

4. In the past 12 months, you have conducted at least one 50-minute therapy session with two different client systems (individual, couple, or family) where at least one member was a South Asian or Middle Eastern Muslim.

The client(s) can be 1st, 2nd, or 3rd generation of immigrants in the U.S. For the purpose of this study, any client(s) with a Pakistani, Indian, Bangladeshi, Sri Lankan, Nepali, Bhutanese, and the Maldivian background is considered South Asian. Any client with an Iraqi, Iranian, Saudi Arabian, Yemeni, Emirati, Qatari, Omani, Bahraini, Kuwaiti, Turkish, Syrian, Lebanese, Palestinian, Israeli, Afghanistani, Jordanian, and Cypriot background is considered Middle Eastern.

Participation will entail the following:

1. Brief screening over the telephone to verify your eligibility to participate.

2. In-person or telephone interview which will last for about an hour. If in-person, the interview will take place either in your office or any location of your choosing. The interview will include questions regarding challenges and strengths you encountered as a result of ethnic/racial and religious differences between you and your client and how you attempted to manage them in therapy. The interviews will be audio-recorded.

3. Brief demographic questionnaire.

4. Possible opportunity to comment on the findings of the study to ensure they are representative of your experiences.

If you are interested in participating, or you know of someone who might be interested in participating, please contact me at zara@vt.edu or 571-274-1305.

Thank you!

Zara Arshad

Appendix B

Telephone Script with Screening Questions

Thank you for your interest in wanting to participate in this research study. To ensure that you are eligible to participate, I will need to ask you some screening questions. If you are eligible, I will tell you a little more about the research I'm conducting. This will only take about 5-10 minutes.

1. Do you identify as White as your only race? _____

2. Are you Muslim? _____

3. Are you a Licensed Marriage and Family Therapist? _____

4. In the past 12 months, how many clients (individuals, couples, families) have you worked with where at least one member was a South Asian or Middle Eastern Muslim? _____

5. Did you have 50-minute sessions with at least two of these clients? _____

6. Do you recall which countries your clients belonged to? If you can't recall, which of the following countries do you think they belonged to: Pakistan, India, Bangladesh, Sri Lanka, Nepal, Bhutan, Maldives, Afghanistan, Iraq, Iran, Saudi Arabia, Yemen, United Arab Emirates, Qatar, Oman, Bahrain, Kuwait, Turkey, Syria, Lebanon, Palestine, Israel, Jordan, and Cyprus? _____

Since you are eligible to participate, let me tell you more about the research study. The aim of this study is to learn about the experiences of non-Muslim Caucasian Licensed Marriage and Family Therapists who have worked with South Asian and Middle Eastern Muslim clients. Particularly, this study will focus on the challenges and strengths that arise in therapy as a result of the differences with clients. To understand your experiences, I will meet with you for an interview in your office, or a location of your choosing. The interview will last for about 1-2 hours. If you are unable to meet with me in-person, I will conduct the interview with you over the phone. I will ask you questions about the type of challenges and strengths that you encountered in therapy as a result of ethnic/racial differences and as a result of religious differences, and how you managed each challenge and strength in therapy. Your experiences, as well as the experiences of other participants, will help inform the work of other mental health professionals working with South Asian and Middle Eastern Muslim clients. It is hoped that by

therapists becoming more culturally competent, it will encourage the trust of this population towards the mental health field, resulting in increased utilization of services. We can schedule the interview right now. What is your availability and where would you like to meet?

Date & time: _____ Location: _____

Telephone # :_____

Before I conduct the interview, I need to send you an informed consent form by mail to get your written consent for participation in this study. To which address would you like for me to mail the form?

Address: _____

Thank you for your time. I look forward to meeting with you and learning about your experiences.

Appendix C

Informed Consent Form

Informed Consent for Participants
in Research Projects Involving Human Subjects

Title of Research: The Experiences of Caucasian Non-Muslim Licensed Marriage and Family Therapists Working with South Asian and Middle Eastern Muslim Clients

Principle Investigators: Mariana Falconier, Ph.D., Assistant Professor/Committee Chair, Department of Human Development, Virginia Polytechnic Institute and State University; Zara Arshad, M.S. Candidate, Department of Human Development, Virginia Polytechnic Institute and State University

I. Purpose of Research

The aim of this study is to learn about the experiences of non-Muslim Caucasian licensed marriage and family therapists who have worked with South Asian and Middle Eastern Muslim clients. Particularly, the study will focus on the challenges and strengths that arise in therapy as a result of the differences and how these are managed in therapy.

II. Procedures

You will be asked to complete an interview and a demographics questionnaire which will last for about an hour, either in-person or over the phone. In-person interviews will be conducted either in your office or a location of your choosing. The interview will be audio-recorded for the purpose of transcription. You may be given the opportunity to collaborate on the findings upon completion of the research.

III. Risks

You may feel some emotional discomfort when thinking about your experiences in therapy. Should you wish to further process any emotions or thoughts that arise from the interview, the researcher will provide mental health referrals. You will be responsible for any costs that incur from rendering a mental health service, and it shall not be covered by the researchers or Virginia Polytechnic Institute and State University.

IV. Benefits

The experiences you share with us about your work with South Asian and Middle Eastern Muslim clients will help other mental health professionals to provide more culturally competent treatment to this population in the future. You may also experience some therapeutic benefit by sharing your experiences. However, there is no guarantee of benefits being offered as an incentive for participation.

V. Extent of Anonymity and Confidentiality

- All of the information provided during the interview and over-the-phone screening is confidential.
- At no time will the researchers release identifiable results of the study to anyone other than individuals working on the project without your written consent.

- All identifying information provided during the audio-recorded interview will be removed and replaced with aliases in the typed transcript and study report. Any identifiable information will be stored separately and securely from coded data.
- All data will be kept in a locked and secured location.
- If you wish to delete any information that may violate your confidentiality, you can bring that to the researcher's attention for omission. If you do not respond by the designated date for your review, the researcher will assume that you have no changes to submit.
- The only individuals with access to the audio recording and original transcript will be the Principal Investigator and the Co-Investigator. If an outside transcriber service is used, the transcriber will be asked to sign a confidentiality agreement.
- The audio tape will be destroyed as soon as it has been transcribed and checked.
- Portions of your interview text may be used verbatim in the report of the project and/or in subsequent publications. No identifying information will be associated with any part of your interview that may be used.
- The Virginia Polytechnic Institute and State University's Institutional Review Board (IRB) may view the study's data for auditing purposes. The IRB is responsible for the oversight of the protection of human subjects involved in research.

I. Participant's Permission

I have read the Informed Consent Form and understand the conditions of this project. I have had all my questions answered. I hereby acknowledge the above and give my voluntary consent.

_____ _____

Participant's Signature Date

_____

Participant's Name (please print)

_____ _____

Researcher's Signature Date

If you have any questions about this research study or its conduct, you may contact:

Mariana Falconier, Ph.D	703-538-8461/marianak@vt.edu
Investigator	Telephone/e-mail
Zara Arshad, M.S. Candidate	571-274-1305/zara@vt.edu
Investigator	Telephone/e-mail

If you have any questions about research subjects' rights or you want to report any research-related injury, you may contact:

Dr. David M. Moore	540-231-4991/moored@vt.edu
Chair, Virginia Tech Institutional Review Board for the Protection of Human Subjects	Telephone/e-mail

Appendix D

Demographic Questionnaire

Please specify the following:

What is your gender?

What is your age?

What is your religious affiliation?

What is your level of education?

Do you have any multicultural training? If so, please elaborate:

How many years have you been practicing as a Licensed Marriage and Family Therapist?

In which state do you practice?

What is the approximate number of ethnically/racially and religiously different clients you have provided therapy to overall?

What is the approximate number of South Asian and/or Middle Eastern Muslim clients you have provided therapy to overall?

Appendix E

Confidentiality Agreement for Third Party Transcribers

I, _____, agree to protect the confidentiality of participants enrolled in The Experiences of Non-Muslim Caucasian Licensed Marriage and Family Therapists Working with South Asian and Middle Eastern Muslim Clients by safeguarding their identity and their information. I will not disclose any participant-related information or material to anyone other than the researcher, Zara Arshad. I will store all participant-related material, which will include audio recordings and typed transcriptions, in a secure manner where no one else can have access to the information.

Signature: _____ Date: _____