Understanding and addressing Islamophobia through trauma-informed care

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The lethality of anti-Muslim hatred in Canada was highlighted in 2021 when 4 Muslim members of a London, Ontario, family were killed in a devastating act of terrorism on June 6, 2021. This was preceded by the 2017 Québec mosque massacre, in which 6 Muslim worshippers were shot and killed.[1] Alongside outpourings of grief across the country after the London incident, many called for the examination of underlying systems and structures of discrimination that create the context in which Islamophobia manifests. For Canada's medical community, already grappling with increasing calls to address the adverse consequences of multiple forms of racism,[2] more guidance is needed on how to address the impacts of Islamophobia on patients.

Muslim people constitute the second largest faith group in Canada and represent diverse communities.[3] Islamophobia is defined as "social stigma toward Islam and Muslims, dislike of Muslims as a political force, and a distinct construct referring to xenophobia and racism toward Muslims or those perceived to be Muslim."[4] In recent years, the term has garnered critique as potentially euphemizing the issue of anti-Muslim hatred and racism.[5] However, we use Islamophobia in this article as it is the term used most commonly in health literature.

Islamophobia occurs at the individual, societal and structural levels and manifests in many ways. Acts of physical violence against Muslim people take place at alarming rates across North America.[4,6] Anti-Muslim prejudice has also been enshrined in policy and legislation, contributing to frequent microaggressions, travel restrictions and hate crimes, the rate of which has more than doubled over the last 10 years.[6] The impact of Islamophobic hate crimes extends beyond the direct victims and their families, often creating profound fear, hypervigilance and grief within entire communities.[7]

Emerging research shows that experiencing Islamophobia is associated with poorer physical and mental health.[4,5] In addition, intersectional forms of oppression seem to exacerbate negative impacts, given that Black Muslim people and visibly Muslim women experience disproportionately greater rates of Islamophobic violence and discrimination.[4,5] Muslim children are targets of anti-Muslim discrimination as well — a qualitative study in southwestern Ontario outlined themes of fear, hypervigilance and identity disturbances, particularly in the aftermath of the Québec mosque massacre.[8] Importantly, the cumulative effects of Islamophobia contribute to less help-seeking and mistrust of health care systems by patients.[4] Therefore, the medical community must consider the unique nature of Islamophobia and the ongoing harm that health care interactions may cause for both Muslim-identifying patients and health professionals.

Key points

- Islamophobia in Canada has individual, societal and structural manifestations, including extreme violence perpetrated toward Muslims.
- Physical and mental health outcomes and patient experiences of health care settings are affected by Islamophobia.
- Principles of trauma-informed care can be used to address and mitigate the consequences of Islamophobia in health care settings.
- Clinicians should reflect on biases and prejudicial views that they may hold toward Muslim people.
- Based on the clinical context, when appropriate, clinicians should consider exploring the impact of Islamophobia on their patients and supporting them as needed.

Addressing Islamophobia requires understanding its various manifestations as potential forms of trauma. As a practical framework, the trauma-informed care model is meant to be comprehensive and to include multiple levels such as clinics, hospitals and overall systems of care.[9] We use this framework to suggest an approach to direct clinical encounters between health professionals and patients.

First, health professionals can promote a sense of safety. Existing literature on cultural safety emphasizes that clinicians should examine their own biases and potentially discriminatory attitudes or practices.[10] Specifically, clinicians should have an awareness of the impacts of Islamophobia and should reflect on biased views they may hold regarding Muslim people. Clinicians who identify a substantial lack of knowledge or a biased understanding about Muslims should seek credible sources of information to fill these gaps to avoid encounters that harm their patients. An example of an encounter that may contribute to trauma is a physician asking a visibly Muslim woman whether her

male relatives were forcing her to wear a head covering, without her having given any indication that she was subject to this treatment. Another is a physician assuming the use of physical violence was driven by a patient's religious beliefs. These types of assumptions stem from common tropes of Muslim women being submissive and Muslim men being domineering. A health care worker assuming that a Muslim patient immigrated to Canada, or showing discomfort or reluctance in facilitating religious practices (such as fasting or ritualized praying) in health care settings, despite the patient expressing the importance of these practices, can also compromise cultural safety. Such assumptions and behaviours are often rooted in implicit, explicit and structural biases about Muslim people and can indicate to the patient that they are not safe from discrimination in what is meant to be a therapeutic encounter.

Next, clinicians must seek opportunities to validate and acknowledge the potential for Islamophobia to influence care. Clinicians may be hesitant to raise topics such as Islamophobia for several reasons, including anxiety about offending the patient or lack of knowledge about how to support the patient. However, clinicians should be aware that the decision to consistently remain silent on these issues, especially in the context of a longitudinal patient–provider relationship, may not be perceived by the patient as a neutral decision, but rather as dismissive or lacking compassion. Nonacknowledgement or erasure of experience can be distressing. We acknowledge that each patient–provider dyad is unique, and clinical judgment is required about how and when to raise these issues.

Trauma-informed care could therefore include a nonjudgmental check-in with the patient through verbal or nonverbal cues that validate their identity, particularly after publicized hate crimes. Health professionals should also seek to understand the role that spirituality and culture play for their patients in an ongoing way, with their patients' permission. If the patient chooses to share their experiences, clinicians should listen attentively and validate their emotions appropriately, being careful not to express doubt about their experiences, dismiss their concerns or be defensive.[11]

Third, health professionals should enhance their awareness of spiritually, culturally and racially relevant resources and supports in their geographic areas. Accessing support from individuals with shared lived experiences may be helpful for some patients and has been cited as a component of trauma-informed care.[9] Clinicians should be aware of local organizations that offer such support for Muslim patients and inquire if the patient would be interested in these resources (while being aware that not all Muslim-identifying patients seek out spiritually or culturally congruent organizations or care providers).

Islamophobia can have a detrimental impact on both physical and mental health, and health professionals have a role to play in addressing it. Using a trauma-informed approach may allow clinicians to provide effective and therapeutic care to Muslim patients, while mitigating risk of retraumatization and marginalization.

References

1. Nasser S. A Muslim family was killed in Canada 3 months ago. Many wonder why party leaders are 'silent' on Islamophobia. *CBC News* 2021 Sept. 14. Available: https://www.cbc.ca/news/canada/toronto/canada-election-2021-racism-islamophobia-hate-1.6174511(accessed 2021 Dec. 5).
2. Sharda S, Dhara A, Alam F. Not neutral: reimagining antiracism as a professional competence. *CMAJ* 2021;193:E101-2.
3. *Immigration and ethnocultural diversity in Canada*. Ottawa: Statistics Canada; 203. Cat no 99-010-X2011001.
4. Samari G, Alcalá HE, Sharif MZ. Islamophobia, health, and public health: a systematic literature review. *Am J Public Health* 2018;108:e1-9.
5. Hassouneh D. Anti-Muslim racism and women's health. *J Womens Health (Larchmt)* 2017;26:401-2.
6. Islamophobia in Canada: submission to the UN Special Rapporteur on Freedom of Religion or Belief. [Submitted by] International Civil Liberties Monitoring Group, Islamic Social Services Association, and Noor Cultural Centre; 2020 Nov. 30.
7. Perry B, Alvi S. 'We are all vulnerable': the in terrorem effects of hate crimes. *Int Rev Victimology* 2012;18:57-71.
8. Elkassem S, Csiernik R, Mantulak A, et al. Growing up Muslim: the impact of Islamophobia on children in a Canadian community. *J Muslim Ment Health* 2018;12:3-18.
9. SAMHSA's concept of trauma and guidance for a trauma-informed approach. Rockville (MD): US Department of Health and Human Services; 2014.
10. Laverty M, McDermott DR, Calma T. Embedding cultural safety in Australia's main health care standards. *Med J Aust* 2017;207:15-6.
11. Saha S, Cooper LA. Talking about racism with patients. *J Gen Intern Med* 2021; 36:2827-8.

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